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## **PATIENTS' INVOLVEMENT IN NURSING STUDENTS' CLINICAL EDUCATION: A SCOPING REVIEW**

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## **Abstract**

**Background:** Actual contacts with patients are crucial in developing the skills that students need when working with patients. Patients are accustomed to the presence of students. The concept of learning from patients has emerged recently, shifting the focus from learning from professionals as role models to the relationship between the student and patient.

**Aim:** With focus on patients' perspective in clinical practice placements, this scoping review aims to review and summarize the existing empirical literature regarding patients' involvement in nursing students' clinical education.

**Design and method:** A broad search without time limitations was performed in the databases CINAHL, Medline, PsycINFO and ERIC. A manual search was also performed. Only empirical studies describing aspects of patient involvement in nursing education from the patient's perspective were taken into account. Thirty-two studies published from 1985 to June 2016 met the selection criteria and were analysed using inductive content analysis.

**Results:** The perspective of real patients focused on their role in students' learning and assessment processes. In general, patients appreciated the opportunity to contribute to a student's learning process and thus enhance the quality of patient care. However, the patients' approaches varied from active to passive participants, comprising active participants contributing to students' learning, followers of care and advice, and learning platforms with whom students practised their skills. Some patients perceived themselves as active participants who facilitated students' learning by sharing knowledge and experience about their own care and wellbeing as well as assessed students' performance by providing encouraging feedback.

**Conclusion:** The state and degrees of patient involvement in nursing students' clinical education were made explicit by the literature reviewed. However, the number of studies examining the involvement of real patients in students' education in clinical settings is very limited. To understand this untapped resource better and to promote its full realization, recommendations for nursing education and future research are made.

## **Contributions of the paper**

### **What is already known about the topic?**

- Patient involvement in clinical education is essential for helping future professionals work in partnership with patients, delivering high-quality patient-centred care.
- Patients have valuable perspectives to enrich nursing students' clinical education, but their active involvement is still not well established in everyday clinical practice.
- A dialogue on patient involvement in clinical learning and assessment enables us to include and deepen our understanding of patients' needs, preferences and values and to address any gaps in the patient-centred approach in clinical education and practice.

### **What this paper adds?**

- Patient involvement in clinical nursing education can vary from active participants contributing to students' learning and followers of care and advice to learning platforms with whom students practise their skills.
- The determinants of patient involvement such as patients' views of themselves, students and the environment for caring and learning are related to their level of involvement.
- From the perspective of patients as well as students, the benefits, barriers and outcomes regarding the involvement of patients in clinical nursing education are still ambiguous.

## Introduction

Health care delivery founded on the principles of patient-centredness is widely held as one of the core aims of healthcare providers around the world. Socio-demographic and epidemiological challenges increase the pressure on health systems, and patient empowerment and patient-centred care are seen as key elements in responding to emerging and varied health challenges in ways that are efficient and of high quality. Hearing patients' voices and involving them to become partners in decisions about their own care are pivotal in delivering high-quality health services that are truly responsive to patients' individual needs and potentials. Equally, nursing education has to keep pace with the challenges that the patient-centred approach poses in order to guarantee that new graduates have the knowledge and skills they need in the rapidly evolving health care setting and the changing scope of clinical practice. (OECD 2017, Salminen et al. 2010, WHO 2015.) In the literature, the various terms used interchangeably with involvement include engagement, participation, collaboration and cooperation while the words user, service user, client, consumer, people with a certain condition, disease, disability and expert by experience often replace the term patient in relation to involvement in healthcare education (Scammel et al. 2015, Towle et al. 2010).

Patients provide the reality of practice for students. Encounters with patients help students integrate their academic learning to a real-life context and thus improve the quality of their clinical learning. Over the past 20 years, the active involvement of patients in education has expanded greatly: examples can now be found from basic training through postgraduate and continuing professional development. Patient involvement in education includes a wide spectrum of educational activities including student selection, a variety of teaching roles, feedback and assessment, curriculum development and decision-making at an institutional level. Most of the initiatives described come from medical education, but some come from nursing, social work or multi-professional education. (Morgan & Jones 2009, Repper & Breeze 2006, Scammel et al 2016, Tew et al. 2012, Towle et al 2010, Wykurz & Kelly 2002.) These previous literature reviews highlight the diversity of patient involvement within education, but they do not address the perspective of the patients themselves as concerns their involvement in students' clinical learning and assessment processes. Even though some recent practices have changed this role so that patients share their expertise in a more active manner, their involvement in education is still not well established in the mainstream of educational practice and their knowledge and experience have been underutilized in clinical settings. (Scammel et al. 2016, Towle et al. 2010.)

Globally, patients and patient care have featured prominently in clinical learning, which thus includes various relationships and interactions between students, patients and healthcare professionals. However, the interactions and relationships between patients and students are mostly ones between parties from

different worlds, different generations and different cultures, including the professional culture and the world of lived experience (WHO 2015), and students' clinical learning always takes place under the supervision of preceptors and other professionals (European Commission 2013, Sedgwick M & Harris 2012). This power imbalance is challenged by the attention on patients' views and experiences when patients are involved in students' learning, contributing collaboratively to clinical teaching. Patients usually provide a safe learning environment because the power imbalance in a patient–student relationship is reduced as compared to a preceptor–student relationship. In clinical settings, the role of patients as teachers is, however, almost always informal, and it is complicated by the fact that the patients' primary reason for being in the place of care is to expect and receive competent care; being involved in the education of students is secondary to that. (Sedgwick M & Harris 2012). Hence, it is important to offer patients an informed choice to be involved so that they are clear about their role and rights and confidentiality aspects, what students are allowed to do, and how patient safety is always guaranteed by the preceptors. (Repper & Breeze 2007).

Patients are increasingly involved in the development and evaluation of healthcare services and patient collaboration is thus essential in the current and future education of practitioners. In their capacity as experts of their own situation, patients provide an additional teaching resource in students' learning. They also feel that their experiential knowledge should be included in education and they mainly become involved for altruistic reasons. (Morgan and Jones 2009, Wykurz and Kelly 2002.) Relationships and actual contacts with patients as experts in their own illness and more insight into sharing the human experience of health care are seen as feasible, beneficial and pivotal in developing the skills that all health professionals, including nursing students, need when working with patients. This expertise is derived from patients' unique experience of health, illness, disability or the effects of the social determinants of health, and their perspective cannot be identified by other means. (Morgan and Jones 2009, WHO 2015.) Thus, the value of the opinions of patients should be appreciated in learning and in assessing students in relation to the perceptions of nursing care delivered by students as well as students' competencies, such as compassion and communication skills. (Tew 2012.)

This review focuses on the rarely described perspective of patients in patients' involvement in the clinical education of nursing students. In this review, the widely used term 'patient' is used to encompass clinical encounters in which people with health problems are involved in nursing students' clinical learning and assessment processes. Patient involvement in clinical education refers to the ways in which patients collaborate and provide feedback, helping students as future nurses to learn to work in partnership with patients to deliver high-quality patient-centred health care.

## **Aims**

The aim of this scoping review is to review and summarize the existing empirical literature regarding patients' involvement in nursing students' clinical education with a focus on patients' perspective in clinical practice placements. We started with the following research questions: *What is the degree of patient initiative in clinical education? What are the determinants of patient involvement in clinical education?* In particular, this paper seeks to identify the central issues of what is currently known about patient involvement in nursing students' learning and assessment processes during the clinical practicum and to make recommendations for nursing education and future research.

## **Methods**

This scoping literature review investigates the breadth of research on a particular topic, in this case, generating an intellectual overview of what is known about the topic as concerns the role of patients in nursing students' learning and assessment processes during clinical practicum (Levac et al. 2010, Rumrill et al. 2010). An inductive content analysis was used to summarize and disseminate what is known about the topic.

### *Literature search*

A systematic search without time limitations was conducted in August 2017 across the following electronic databases: MEDLINE, CINAHL, PsycINFO, and ERIC (Figure 1). Searches were limited to English language studies and focused on peer-reviewed publications with an abstract available. In order to explore further, additional studies were identified by hand-searching the reference lists of the studies included in the review and those studies in ResearchGate which cited the studies included in this review.

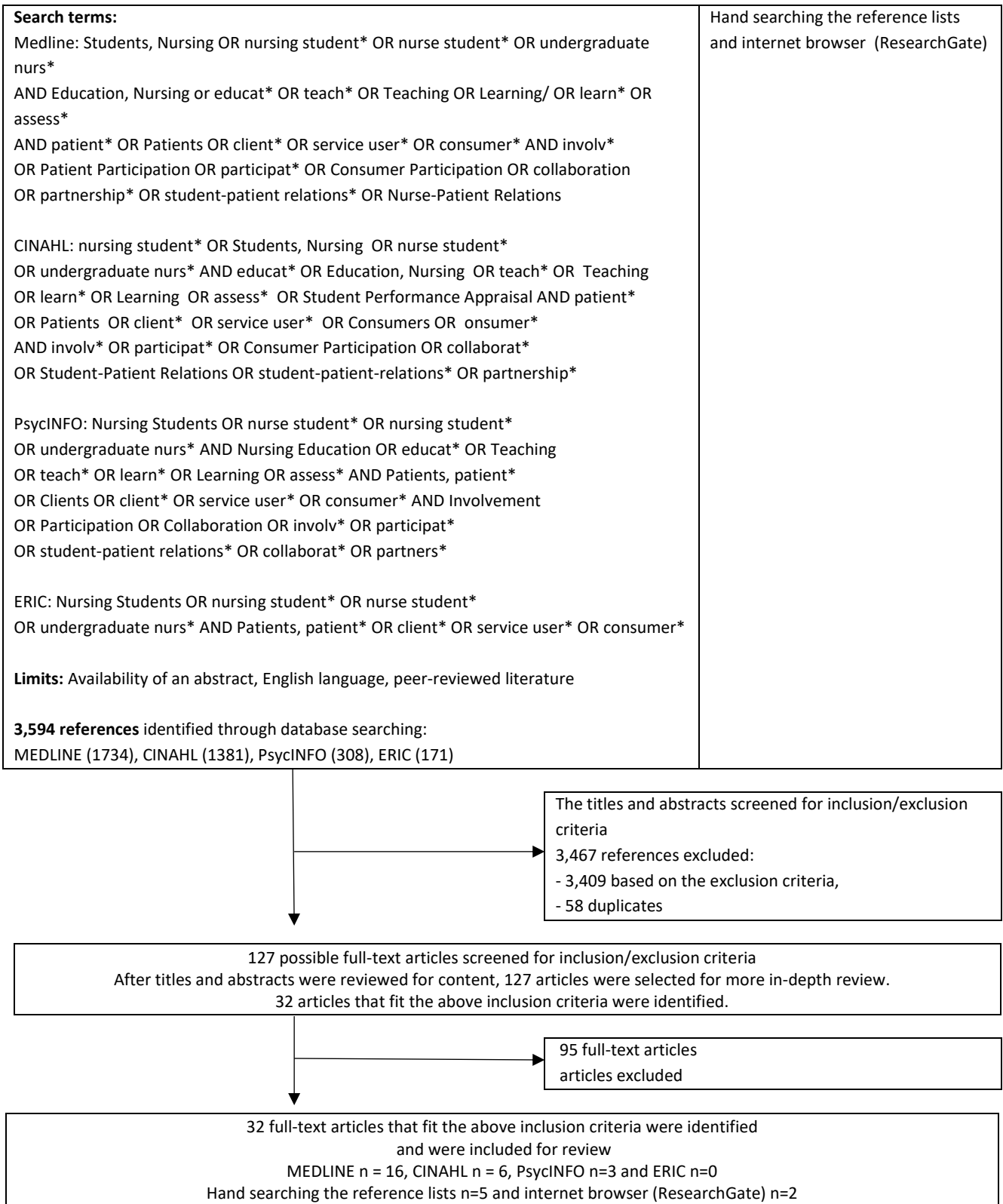


Figure 1 Flowchart of search and results.



Papers were included if they were empirical studies published in English and addressed any aspect of real patient, client or service user involvement in clinical education of nursing students in relation to research and from the patient's perspective. The database searches identified 3,594 references. Papers were selected using a two-stage screening process (Figure 1). At Stage 1, titles and abstracts were screened (AS, SK) against predetermined inclusion and exclusion criteria, followed by a consensus discussion to ensure match and relevancy (Table 1). An initial screening of 3,594 titles and abstracts was undertaken and any papers not meeting a broad inclusion/exclusion criterion were discarded. At Stage 2, 127 full-text articles were reviewed independently against the inclusion and exclusion criteria. Furthermore, a manual search of the reference lists of the included full-text papers and Research Gate yielded an additional seven studies; after a consensus discussion, 32 studies were included in the review.

Table 1 Inclusion and exclusion criteria

| Inclusion criteria  | Exclusion criteria   |
|---|--|
| English language  | Non-English language   |
| No time limits  | Non-peer reviewed literature   |
| No geographical limits  |  |
| Peer-reviewed literature  |  |
| The study participants or part of them were real patients, clients or service users   | The study participants were other than real patients, clients or service users (e.g. simulated or standardized patients or patient instructors)  |
| Patients', service users' or clients' involvement in education of pre-registration or undergraduate nursing students undergoing clinical practice | Papers in domains other than patient involvement in nursing education during students' clinical practicum (e.g. in curricula design and planning, in classroom teaching or simulation) |
| Empirical research that used recognizable and replicable methodology (qualitative, quantitative, and mixed methods approaches)                    | Papers that did not include empirical research elements (editorials, letters, news, comments etc.) or were reviews   |

### *Analysis of the studies*

The analysis of the data began by collecting the following information from each included article: author(s), the year and country of publication, the aim of the study, sample, methods, and the findings of the study. Qualitative, quantitative and mixed method studies were combined in the same analysis because the analysis was descriptive. When collecting this information, the authors' original terms were used. The information in the data matrix was analysed inductively so that categories were constructed directly from the data. Only the manifest content was analysed. In coding, units of analysis ranging from a single word to several sentences were condensed, and those referring to the same content were grouped into subcategories by drawing comparisons between the data concerning a particular subcategory and other observations. (Cavanagh 1997.) Related subcategories were combined to form categories and main categories pertaining to patients' involvement in nursing students' clinical education. The categories were named based on their contents. (Dey 1993, Elo & Kyngäs 2008.) One researcher made the initial categorization (AS), which was then refined and confirmed with the research team. The findings of this review were organized around the aim set at the outset of the study.

### *Quality Appraisal*

The methodological quality of the selected studies was evaluated to get a general snapshot to inform education policy, practice as well as new research, although quality is generally not appraised (Levac et al. 2010) in scoping reviews even if it is recommended (Whittemore et al. 2014). However, regardless of the outcome of the quality evaluation, all the studies were included in the analysis in order to achieve a broad view of the current research and to avoid bias.

The quality of the selected studies was evaluated according to the criteria by Reilly et al. (2008), which provide generic quality assessment criteria for research quality by measuring internal, descriptive, construct and external validity (Table 2). These quality assessment criteria were regarded suitable for a rather high-volume review that included a range of research designs (Reilly et al. 2008, Whittemore et al. 2014). Studies with various designs can be assessed because the importance of matching the study design to the question posed – rather than a judgement based on the study design alone – is acknowledged in these criteria. The criteria consist of seven items rated either 'yes' or 'no' for the first item concerning clarity of the research question while the rest are rated 'yes', 'no' or 'unclear'. Items rated either 'no' or 'unclear' are scored zero

whereas items rated 'yes' are assigned one point and summed to provide a total score. The maximum score was seven, denoting high methodological quality.

Irrespective of study design, all the included studies were evaluated by two reviewers (SK, AS). Both reviewers conducted the quality assessment independently. The ratings were then compared and a consensus of the assessments was reached after discussion; there were no major disagreements about individual studies. The information was limited to what was presented in the articles; the authors were not contacted for more details. It is therefore possible that in reality, some issues had been addressed but were not included in the article.

Table 2 Attainment of different aspects of methodological quality in each article.

| Aspect of quality<br>Article | 1 Clear research question | 2 Appropriate design | 3 Generalizable | 4 Sufficient detail on context / setting / intervention | 5 Rigorous data collection / analysis demonstrated | 6 Presentation of results | 7 Conclusion justified | Overall QA* score (max 7) |
|------------------------------|---------------------------|----------------------|-----------------|---|--|---------------------------|------------------------|---------------------------|
| Helgeson & Berg 1985         | Yes                       | Yes                  | No              | Yes   | No   | No                        | No                     | 3                         |
| Pulliam 1991                 | Yes                       | Yes                  | No              | Yes   | Unclear  | No                        | No                     | 3                         |
| Andresen & McDermott 1992    | Yes                       | Yes                  | No              | Yes   | No   | No                        | No                     | 3                         |
| Richards 1993                | No                        | Unclear              | No              | Yes   | No   | No                        | No                     | 1                         |
| Twinn 1995                   | No                        | Yes                  | No              | Unclear   | Unclear  | No                        | No                     | 1                         |
| Morgan & Sanggaran 1997      | No                        | Yes                  | No              | No  | Yes  | Yes                       | No                     | 3                         |
| Morin et al. 1999            | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| Reeves et al. 2002           | Yes                       | Yes                  | No              | Yes   | Yes  | Unclear                   | No                     | 4                         |
| Turner et al. 2004           | Yes                       | Yes                  | No              | Yes   | Unclear  | Yes                       | No                     | 4                         |
| Mehta & Singh 2005           | Yes                       | Yes                  | No              | Yes   | No   | Unclear                   | No                     | 3                         |
| Suikkala & Leino-Kilpi 2005  | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| Mossop & Wilkinson 2006      | Yes                       | Yes                  | No              | Yes   | Yes  | No                        | No                     | 4                         |
| Speers 2008                  | No                        | Yes                  | No              | No  | No   | No                        | No                     | 1                         |
| Suikkala et al. 2008         | Yes                       | Yes                  | Yes             | Yes   | Yes  | Yes                       | Yes                    | 7                         |
| Middleton & Uys 2009         | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| Stockhausen 2009             | Yes                       | Yes                  | No              | No  | Yes  | Yes                       | No                     | 4                         |
| Suikkala et al. 2009         | Yes                       | Yes                  | Yes             | Yes   | Yes  | Yes                       | Yes                    | 7                         |
| Freed et al. 2010            | No                        | Yes                  | No              | No  | Yes  | Yes                       | No                     | 3                         |
| Stickley et al. 2010         | Yes                       | Unclear              | No              | Unclear   | Unclear  | Yes                       | No                     | 2                         |
| Debyser et al. 2011          | Yes                       | Yes                  | No              | Yes   | Yes  | No                        | No                     | 4                         |
| Hallin et al. 2011           | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |

| Aspect of quality<br>Article | 1 Clear research question | 2 Appropriate design | 3 Generalizable | 4 Sufficient detail on context / setting / intervention | 5 Rigorous data collection / analysis demonstrated | 6 Presentation of results | 7 Conclusion justified | Overall QA* score (max 7) |
|------------------------------|---------------------------|----------------------|-----------------|---|--|---------------------------|------------------------|---------------------------|
| Rutherford 2011              | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| Kinnair et al. 2012          | No                        | Yes                  | Unclear         | Yes   | Yes  | Yes                       | Yes                    | 5                         |
| Austria et al. 2013          | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| Walton & Blossom 2013        | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| Barksby 2014                 | Yes                       | Yes                  | No              | No  | No   | Yes                       | No                     | 3                         |
| Manninen et al. 2014         | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| Eskilsson et al. 2015        | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| Moores et al. 2015           | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| Mukumbang & Adejumo 2015     | Yes                       | Yes                  | No              | No  | Yes  | Yes                       | No                     | 4                         |
| Reitmaier et al. 2015        | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |
| McMahon-Parkes et al. 2016   | Yes                       | Yes                  | No              | Yes   | Yes  | Yes                       | Yes                    | 6                         |

\*QA=quality appraisal

## Results

### *General study characteristics and quality assessment*

Thirty-two papers published in peer-reviewed journals from 1985 to June 2016 met the criteria for review (Table 1). Twenty-six articles were published between 2000 and 2016, demonstrating a growing interest in using patients in nursing education. The studies were conducted in ten different countries, mostly in the UK (n=9) and USA (n=8). Other countries represented were Finland (n=3), Sweden (n=3), Australia (n=2), South Africa (n=2), Canada (n=2), Belgium (n=1), New Zealand (n=1) and Nepal (n=1). The study samples typically consisted of a convenience sample of patients, clients or service users. In addition to patient participants, 16 studies included other participants, such as nursing students, nurses, teachers, students of other disciplines, faculty members or other stakeholders. The most common data collection methods involved using individual or focus group interviews and questionnaires with Likert-type or dichotomous rating scales. The number of participants ranged from 2 to 242 participants. The most commonly used methods of analysis were content analysis and descriptive and inferential statistics. (Table 3.)



Table 3 (Continued)

| Author, year, country   | Sample                             |                |  | Data collection |                                     |             | Data analysis   |                      |                  |                   |                 |                     |                                       |                       |               |
|---|------------------------------------|----------------|--|-----------------|-------------------------------------|-------------|---|----------------------|------------------|-------------------|-----------------|---------------------|---------------------------------------|-----------------------|---------------|
|   | Patients, clients or service users | Nurse students | Nurses, students of other disciplines, supervisors, nurse teachers, faculty members or other | Questionnaire   | Individual or focus group interview | Observation | Textual data (diaries, journals, online blogs, online reflections, field notes) | Statistical analysis | Content analysis | Thematic analysis | Grounded theory | Discursive analysis | Qualitative phenomenological analysis | Ethnographic approach | Not mentioned |
| Eskilsson, Carlsson, Ekebergh and Hörberg 2015, Sweden                        | X                                  |                |  |                 | X                                   |             |   |                      |                  |                   |                 |                     | X                                     |                       |               |
| Moores, Lidster, Boyd, Archer, Kates and Stobbe 2015, Canada                  | X                                  |                |  |                 | X                                   |             |   |                      |                  | X                 |                 |                     |                                       |                       |               |
| Mukumbang and Adejumo 2015, South Africa                                      | X                                  |                |  |                 | X                                   |             |   |                      |                  | X                 |                 |                     |                                       |                       |               |
| Reitmaier, Davies, Smith, Mangan-Danckwart, Hongerholt and Klinkner 2015, USA | X                                  | X              |  |                 | X                                   | X           |   | X                    |                  |                   | X               | X                   |                                       |                       |               |
| McMahon-Parkes, Chapman and James 2016, UK                                    | X                                  | X              | X  |                 | X                                   |             |   |                      |                  | X                 |                 |                     |                                       |                       |               |

x = reported in the article

For the methodological quality of the selected studies, the median quality appraisal score was 6 (range 1–7, mean 4.4). Nearly half (46.9%, n=15) of the studies received five or more points out of seven. Most, but not all, had a clear research question (1) and a study design (2) that was appropriate for the research question. Only two studies reported results that were generalizable or transferable (3) to a wider population. A quarter of the studies failed to provide adequate details on either the nature of the educational solution (if relevant) or the context, sample or setting (4), making it difficult for the reader to relate the findings to other settings. More than a quarter of the studies were rated as not demonstrating rigorous data collection and analysis (5). To get a positive score, both description of data collection and data analysis should be reported. Many studies mentioned the data analysis method (e.g., content analysis) but failed to provide any details of how it was conducted. More than a quarter of the studies were also rated as not presenting enough data to permit independent interpretation of the results (6). Conclusions (7) were rated as justified in less than half (42.9%) of all publications. This was related to the quality of reporting. A study was rated as stating justified conclusions when all of the following three criteria were met: Sufficient details were given about the nature of the educational solution (if relevant) or the context, sample and setting (4), rigorous data collection and analysis were demonstrated by providing detailed information about both (5),

and enough data were presented to permit independent judgement of results and the reader was able to interpret the results (6).

In the review of the studies, the main areas of research into patient involvement in clinical education were categorized into the degree of patient initiative in clinical education and determinants of patient involvement in clinical education. (Figure 2.) Patient involvement in the learning and assessment of students varied from very high to very low level of intensity. Actively participating patients could be found in the literature although studies describing patients in a more passive role were dominant.

### *The degree of patient initiative in clinical education*

**Patients as active participants contributed to students' learning** by taking an active part in the care and decision-making (Manninen et al. 2014, Stockhausen 2009, Suikkala & Leino-Kilpi 2005). Reciprocity enriching relations for both students and patients where both participants exhibited strong initiative and a relational bond were reported (Austria et al. 2013, Barksby 2014, Eskilsson et al. 2015, Freed et al. 2010, Manninen et al. 2014, Mossop & Wilkinson 2006, Reitmaier et al. 2015, Stickley et al. 2010, Stockhausen 2009, Suikkala & Leino-Kilpi 2005, Twinn 1995, Walton & Blossom 2013). Patients facilitated the students' learning experience by sharing knowledge, advice and experiences with students as concerned their own health care and well-being (Freed et al. 2010, Manninen 2014, Morgan & Sanggaran 1997, Mossop & Wilkinson 2006, Reitmaier et al. 2015, Stockhausen 2009, Suikkala & Leino-Kilpi 2005, Walton, & Blossom 2013) with an aim to develop new understanding but also to overcome stereotypes among students (Freed et al. 2010, Reitmaier et al. 2015, Walton & Blossom 2013) and to teach students the qualities they expected from qualified nurses (Rutherford 2011, Walton & Blossom 2013). Relationships where both patients and students felt valued and respected offered patients an opportunity to process their own situation and related feelings, gain a new perspective or get help for their situation (Mossop & Wilkinson 2006, Reitmaier et al. 2015, Rutherford 2011, Suikkala & Leino-Kilpi 2005, Walton & Blossom 2013 ).

Even if patients appreciated the opportunity to contribute to a student's learning process there were only some patients who perceived themselves as active participants in student learning. However, they appeared to be co-operative, supportive and encouraging towards the students (Austria et al. 2013, Richards 1993, Stockhausen 2009, Suikkala & Leino-Kilpi 2005). Some of them also felt positive about giving feedback to and about students, thereby adding the patient dimension to assessment with an aim to improve learning outcomes (Austria et al. 2013, Debyser et al. 2011, Kinnair et al. 2012, McMahon-Parkes

et al. 2016, Morgan & Sanggaran 1997, Reeves et al. 2002, Speers 2008, Stickley et al. 2010, Stockhausen 2009, Suikkala & Leino-Kilpi 2005, Twinn 1995). Patients, however, felt diffident about giving critical feedback (Debyser et al. 2011, McMahon-Parkes et al. 2016, Morgan & Sanggaran 1997, Speers 2008, Stickley et al. 2010, Twinn 1995). Some patients preferred direct feedback or confidential assessment discussions while others preferred an assessment questionnaire (McMahon-Parkes et al. 2016, Speers 2008, Twinn 1995).

**Patients as followers of care and advice** complied with the contributions made by students in caring situations (Eskilsson et al. 2015, Freed et al. 2010, Manninen et al. 2014, Middleton & Uys 2009, Mossop & Wilkinson 2006, Richards 1993, Stockhausen 2009, Suikkala et al. 2008, Suikkala & Leino-Kilpi 2005) indicating partial involvement of patients. The patients experienced that the focus of students' performance was to help patients meet their needs by planning and providing care and patient education. In almost all conversations, the patients themselves did not express their opinion on their care. They thus assumed the role of recipient in either answering questions or receiving caring-related information delivered by the student (Andresen & McDermott 1992, Manninen et al. 2014, Mehta & Singh 2005, Middleton & Uys 2009, Stockhausen 2009, Suikkala & Leino-Kilpi 2005.)

**Patients as learning platforms with whom students practised their skills** was a metaphorical name to indicate that patients assumed a passive role in their encounters with students, with patients describing themselves as learning apparatuses or objects rather than subjects in students' learning. Patients helped students to learn by letting them train practical skills and observed how the student and preceptor co-operated as they were cared for. (Austria et al. 2013, Barksby 2014, Eskilsson et al. 2015, Manninen et al. 2014, Rutherford 2011, Suikkala & Leino-Kilpi, 2005, Suikkala et al. 2008, Suikkala et al. 2009, Stockhausen 2009, Twinn 1995.) In these encounters, the interaction between patients and students was scarce and dialogue was lacking. Instead, the preceptors usually contributed the conversation by offering information, asking questions and supervising students in the care of their patients. (Manninen et al. 2014, Stockhausen 2009, Suikkala & Leino-Kilpi 2005).



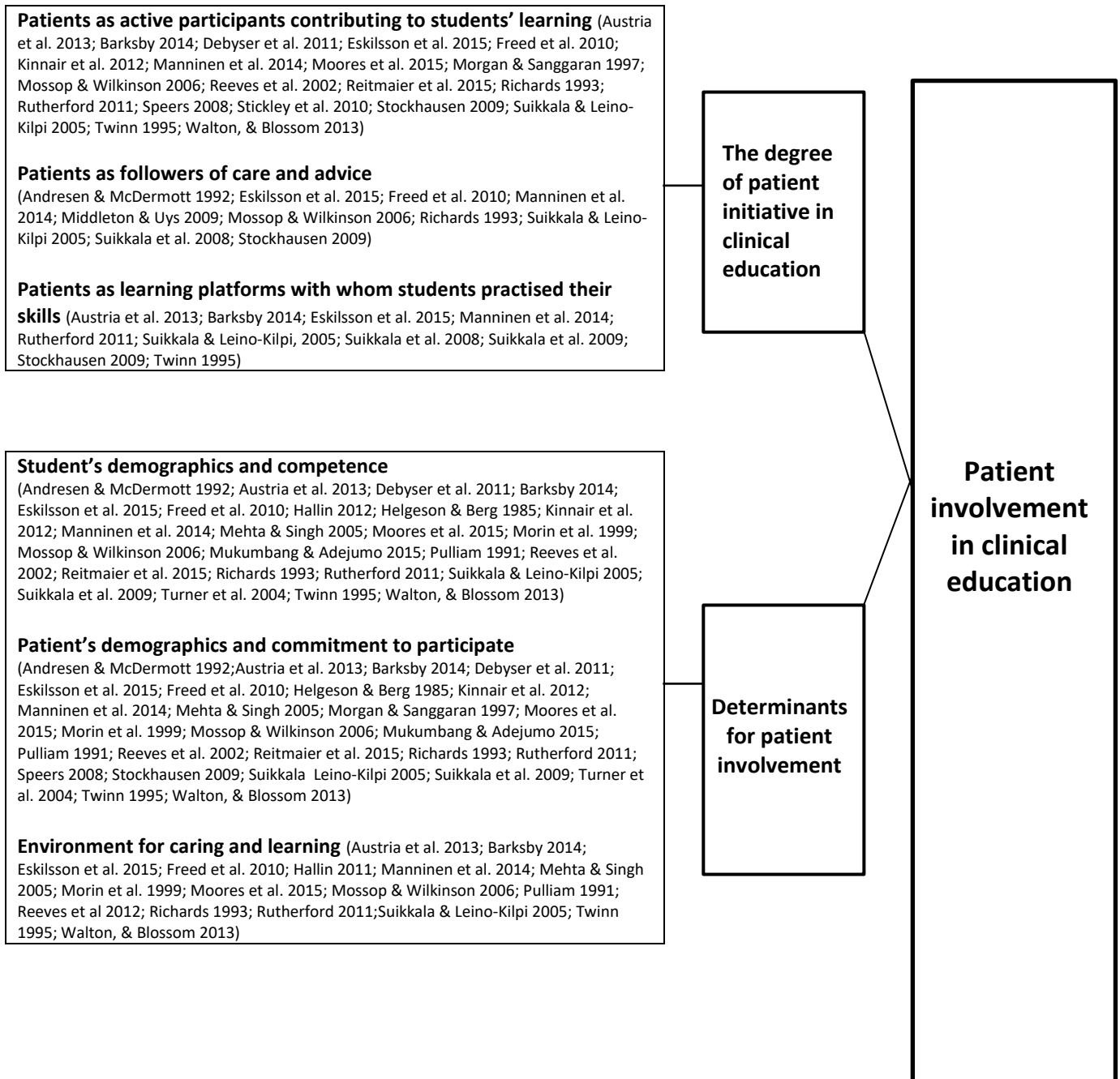


Figure 2 Summary of main areas regarding patient involvement in clinical education

### *Determinants for patient involvement*

Patients' involvement in student learning was related to their positive experiences, perceptions of and attitudes towards students' demographics and competence, patients' demographics and commitment to participate, and the environment for caring and learning, while reluctance towards patients' involvement in students' clinical learning was linked to the opposites or absence of the above-mentioned preconditions of their involvement. (Figure 2.)

Student's gender was the only demographic characteristic that was shown to be an important issue for some patients. They might feel uncomfortable or embarrassed about receiving care that involves intimate contact by a student of the opposite sex (Morin et al. 1999, Mossop & Wilkinson 2006). Instead of students' demographic characteristics, patients emphasized students' favourable interpersonal competence as a prerequisite for building successful relationships with students (Austria et al. 2013, Barksby 2014, Freed et al. 2010, Mehta & Singh 2005, Moores et al. 2015, Morin et al. 1999, Mossop & Wilkinson 2006, Mukumbang & Adejumo 2015, Pulliam 1991, Reeves et al. 2002, Reitmaier et al. 2015, Richards 1993, Rutherford 2011, Suikkala & Leino-Kilpi 2005, Suikkala et al. 2009, Walton, & Blossom 2013). Intellectual competence, such as students' professional attitudes and attributes related to adequate knowledge and skills, were also regarded as important (Andresen & McDermott 1992, Austria et al. 2013, Barksby 2014, Eskilsson et al. 2015, Freed et al. 2010, Hallin 2012, Helgeson & Berg 1985, Manninen et al. 2014, Mehta & Singh 2005, Morin et al. 1999, Moores et al. 2015, Mossop & Wilkinson 2006, Mukumbang & Adejumo 2015, Pulliam 1991, Reeves 2002, Reitmaier et al. 2015, Richards 1993, Rutherford 2011, Suikkala et al. 2009, Twinn 1995, Turner et al. 2004, Walton, & Blossom 2013). Furthermore, patients' positive perception of themselves and their views about promoting student learning were emphasized by the patients (Austria et al. 2013, Barksby 2014, Eskilsson et al. 2015, Helgeson & Berg 1985, Kinnair et al. 2012, Manninen et al. 2014, Morgan & Sanggaran 1997, Morin et al. 1999, Mossop & Wilkinson 2006, Reeves et al. 2002, Reitmaier et al. 2015, Richards 1993, Rutherford 2011, Stockhausen 2009, Suikkala Leino-Kilpi 2005, Suikkala et al. 2009, Turner et al. 2004, Twinn 1995, Walton, & Blossom 2013).

Further preconditions for patient involvement included a favourable environment for caring and learning; in particular, this involved informed consent as an invitation for them to participate in clinical education (Barksby 2014, Eskilsson et al. 2015, Manninen et al. 2014, Morin et al. 1999, Moores et al. 2015, Mukumbang & Adejumo 2015) as well as a sufficient amount and quality of time spent with the student (Barksby 2014, Eskilsson et al. 2015, Freed et al. 2010, Hallin 2011, Mehta & Singh 2005, Morin et al. 1999, Moores et al. 2015, Mossop & Wilkinson 2006, Pulliam 1991, Richards 1993, Suikkala & Leino-Kilpi 2005, Suikkala et al. 2009). A positive and supportive atmosphere between patients, students and preceptors is

important for patients' involvement as active participants in students' clinical learning (Eskilsson et al. 2015, Manninen et al. 2014, Moores et al. 2015, Suikkala & Leino-Kilpi 2005, Suikkala et al. 2009, Walton & Blossom 2013). Patients appreciated the presence and the supervision of the preceptor (Eskilsson et al. 2015, Moores et al. 2015, Morin et al. 1999, Twinn 1995), but on the other hand, they also appreciated bilateral interactions between themselves and students. (Austria et al. 2013, Hallin 2011, Reeves et al. 2002, Richards 1993).

## **Discussion**

The degree of patient initiative in clinical nursing education and the determinants of patient involvement vary greatly. In general, patients appreciate being involved in students' clinical education, but there is much variation between individual patients, ranging from active participants contributing to students' learning and followers of care and advice to learning platforms with whom students practise their skills. Active involvement in nursing students' clinical learning empowers patients to play a greater role in their own care, and at the same time, to have an opportunity to influence the qualifications of future nurses. As experts of their own situation, patients not only have valuable perspectives which offer students authentic learning opportunities that enrich and facilitate their clinical learning, but they also give students useful information to improve clinical practice. (Repper and Breeze 2007, Tew et al. 2012, Towle et al. 2010, Wykurz and Kelly 2002.) Information from patients, such as patients' life histories or experiences of their quality of life, offers valuable information about patients that enables delivery of care that shapes the needs, preferences and values of patients and allows students to integrate their academic learning in a real setting, thus improving the quality of clinical learning. Besides an educational role, patients can have an assessment role (Repper and Breeze 2007, Wykurz and Kelly 2002) on issues such as the care they receive, how their healthcare needs are met when students are working either on their own or together with a preceptor, how they are listened to and engaged in student learning, and how their perceptions are taken into account in assessing students' performance.

According to this review, patients' involvement in clinical learning and assessment of students' clinical practice performance is limited, reflecting their quite passive role. Involvement of patients as followers of care and advice and as learning platforms with whom students practise their skills enables the development of student competency in caring situations (Scammel et al. 2016). However, the expertise of patients is underutilized in these situations due to the exchange of thoughts and information initiated by the student or the preceptor. In the context of nursing education, the expertise of patients is valued in

patient-centred care, shared decision-making, and the promotion of self-care. Patients provide the reality of practice for students and thus they should be at the core of students' clinical learning. Patient-centred orientation should form the foundation of education and emphasize an advanced switch from traditional and paternalistic ways towards active and collaborative involvement of patients in education, thus promoting and ensuring that nursing students adapt to delivering genuinely close and empathic relationship-based care (Lathlean et al. 2006, Morgan & Jones 2009, Scammell et al. 2015, Towle et al. 2010, Wykurz & Kelly 2002.) There is scope for further development, implementation and research in the field of clinical education as concerns patients' perspective of their involvement in both the learning process and the caring process and their relationships with students.

Patients' involvement in clinical education was determined by their views of students' demographics and competence, patients' personal views of themselves and their commitment to participate, as well as by the environment for caring and learning. It seems that when students manage to create a good atmosphere and a positive patient-student encounter, patients are quite active participants and supportive of students' learning. The evidence also suggests that, in most cases, patients become involved for predominantly altruistic reasons, such as appreciating the opportunity to contribute to a student's learning process, and as an acknowledgement of their expertise as benefiting future health professionals and patients, or a desire to give something back to health services and the community (Morgan and Jones 2009, Wykurz and Kelly 2002). At the same time as there is a demand for a more active role for patients in healthcare education there is also a need to take into consideration how much active involvement of patients in clinical education is feasible and desirable and how patients are actually involved in particular clinical settings. Not all those who are involved are patients; some are people from specific age or ethnic groups, people who are marginalized or disadvantaged, or carers, and they, too, have perspectives or experiences valuable to nursing students' learning. On the other hand, patients with new acute conditions and young people may be interested and may have the capacity, but not yet the expertise, to be involved in the clinical learning of students or to comment on students' performance. Furthermore, ethical considerations concerning patients' vulnerability, confidentiality, anonymity and capability to be involved in students' learning and assessment are particular issues to consider, as is the timing of the request as well as by whom, how and when the patients are invited to participate. Patients might be concerned with matters of consent, and it is important that patients' right to self-determination is respected and their consent for the presence and involvement of students in their care is asked in advance. (Repper and Breeze 2007.)

The methodological quality of the selected studies varied considerably. Irrespective of which research question, paradigm, design or data collection method is adopted, high-quality research evidence is vital in providing a strong evidence base in nursing education. The suggestive evidence from this review was not

always promising in this respect. The rigorous reporting of research, preferably by following design-specific guidelines, could also enhance the adoption of the results. Moreover, despite the innovativeness of several local educational experiments and gathering participants' experiences about them, more generalizable information is needed to inform nursing education internationally as patient involvement in health care education is a global concern. To achieve this, larger, as well as randomized, samples are required.

We conducted a comprehensive literature search using several databases, which provided a wide range of citations to ensure adequate coverage in our literature search. As the search strategy was limited to studies published in English there is no guarantee that all studies were located. However, there is good probability that the full breadth of available research was covered. The scientific quality of the studies was formally assessed at general level to increase the probability of the uptake and relevance of the findings of this review. From the beginning, we had two researchers working independently with the literature search and quality appraisal of the included studies to strengthen the review process.

## **Conclusions**

This scoping review made explicit the degrees of patients' involvement in clinical education. Patient involvement can vary from active participants contributing to students' learning and followers of care and advice to learning platforms with whom students practise their skills. The most frequent determinants related to the degree of patients' involvement were patients' views of themselves, students and the environment for caring and learning. Real patients have valuable perspectives to enrich nursing students' clinical learning and assessment; however, the benefits, barriers and outcomes regarding their involvement are still ambiguous. This fact should be acknowledged as the role of patients in clinical education has been highlighted and strengthened in many countries, but their involvement still rather limited (OECD 2017). The reviewed studies represented research in different fields of nursing and in a number of countries. National and international collaboration is therefore important in sharing experiences and good practices of patient involvement in clinical education. Although there are indications that patient involvement in clinical education benefits both students and patients, further experimental and longitudinal research is needed to learn more about how the potential of this untapped resource could be fully realized in terms of the impact and processes of patient involvement in clinical education.

Nursing curricula should be developed to promote students' learning from patients. New pedagogical approaches organized around patients as active partners are an essential precondition in clinical education. Multidisciplinary health care could also facilitate patient-student partnerships by offering patients an opportunity to communicate and collaborate with different students. To build collaborative relationships leading to patient-centred clinical learning, for instance by implementing student-led units, learning content and activities aimed at maximizing students' learning from and with patients can be created (Eskilsson et al. 2015, Hallin et al 2011, Manninen et al. 2014.) Nurse educators have a key role in promoting dialogue and co-operation with clinical staff and in defining and developing new ways for more active patient involvement, as well as in disseminating examples of good practices that inspire learning and supervision of students with the patient in focus. For nurses as preceptors, training may be required to build their capacity to enable patient involvement in clinical education and to make it more appreciated.

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