Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Editorial

GUEST EDITORIAL: The impact of Covid-19 on clinical practice hours in pre-licensure registered nurse programs

The arrival of the Covid-19 pandemic has propelled nursing education into a previously unimagined reality. Despite being deemed an essential service by some professional bodies (CASN, 2020) nursing education has been critically disrupted by sweeping cancellations of clinical placements in Australia, Canada, United Kingdom and the United States of America (Carolan et al., 2020; Dewart et al., 2020; Jackson et al., 2020; Spurlock, 2020). While these cancellations are understandable, they create challenges for both students and teachers who have been compelled to reconceptualize, reorganize, and rethink clinical practice education. These changes occur in the context of a lack of unanimity required for clinical practice hours and their relationship for the achievement of student competencies.

The clinical hour requirements in pre-licensure RN programs vary significantly both within and across countries. For example, the European Union requires 2300 clinical practice hours, Australia mandates 800 hours, South Africa authorizes 2800 hours, and New Zealand supports a range between 1100 and 1500 hours (Miller & Cooper, 2016). In Canada, there are no regulatory guidelines for standardized clinical hours (CASN, 2015) and wide variation exists across the United States with only 10 states specifying minimum numbers of clinical hours, the average of which is 500 hours (Bowling, Cooper, Kellish, Kubin & Smith, 2018).

In the absence of regulatory guidelines for clinical practice hours, the decision becomes the responsibility of individual nursing education institutions. Regardless of who makes the decision, Bowling et al. (2018) claimed that determination of clinical practice hour requirements is frequently driven by what other education institutions do to ensure successful NCLEX results rather than evidence about clinical practice hours needed to attain pre-licensure nursing competencies. Our review of the nursing literature revealed no current studies about the relationship between clinical time and achievement of required competencies. The inconsistencies and lack of empirical evidence for the clinical hours required by pre-licensure students to achieve nursing competencies exacerbates the effects of Covid-19 restrictions on access to clinical practice, while generating additional pressure to replace clinical time with alternative approaches.

During Covid-19, diminished access to clinical practice and the necessity to replace clinical time with other forms of practice, such as simulation, is complicated by the pressure to waive students' supernumerary status (in some jurisdictions) and/or complete their programs as quickly as possible with fewer practice hours in order to enter the registered nursing workforce. The availability of clinical practice hours and decisions to "allow" students to attend clinical placement are influenced by social distancing, ethical controversy about the appropriateness of students caring for clients with Covid-19, worldwide scarcity of personal protective equipment (Spurlock, 2020), the risks and benefits for both students and instructors (who may have co-morbidities or age-related risks), and sensitivity to the impact of a pandemic on students' and instructors' mental and physical health.

As always, it is crucial to include students' voices as decisions are considered, plans are changed, expectations unmet, and supports put in place. Findings from Cervera-Gasch, González-Chordá and Mena-Tudela's (2020) survey with nursing and medical students during Covid-19 revealed that 82% of participating students agreed with the decision to close down their clinical practice placements because of the risks involved as well as feeling unprepared to care for patients during a global pandemic. Although 74.2% of participating students said they would care for patients with Covid-19 if needed, 65.3% believed that they were not prepared or were barely prepared to do so. Dewart et al. (2020) claim that many students were willing to take the risk if it meant they could finish their studies. Keeping in mind the priority of safety for all (patients, students, nurses, and others), adhering to institutional directives is challenging because they are sometimes ambiguous or, on occasion, contradictory. For example, in response to Covid-19, the Canadian Association of Schools of Nursing (2020) directs that "a) high-quality nursing education must be maintained to safeguard the health of Canadians and b) educational shortcuts for registered nurses must be avoided" (para 3) while also directing that graduation of nursing students "should not be delayed given the urgent health service needs" (para 5).

In the United Kingdom, the Nursing and Midwifery Council (NMC, 2020) created emergency education standards for pre-licensure nursing students during Covid-19. In so doing they determined that students could complete the final 6 months of their program in clinical practice. These standards waived some of the regulation pertaining to the proportions of students' clinical practice and theoretical hours for the duration of the Covid-19 pandemic. Although the regulation specifies that students *must* be supervised directly or indirectly, and *must* have dedicated protected learning time, students are paid by the NHS as employees and are no longer considered supernumerary. Australia has taken up similar modifications for students in the final 6 months of their programs (Jackson et al., 2020). In the United States many nursing regulatory bodies have provided guidance to schools of nursing during Covid-19 (NCSBN, 2020). For example, the Oregon State Board of Nursing (OSBN) has approved that students' employment by healthcare institutions count as clinical practice hours in their final placement. The above examples provide guidance not specified in other jurisdictions. We suggest that differing regulatory

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structures and requirements for clinical hours make it challenging to launch a standardized approach to managing clinical practice hours during a global pandemic.

The Covid-19 pandemic is bringing many issues to the foreground in nursing education. Cervera-Gasch et al. (2020) argued that Covid-19 is a "turning point . . .in the education of future health care professionals" (p.2) and Dewart et al. (2020) claimed it has already shifted the educational landscape. We have raised questions about the implications of sending students and instructors into the clinical area during the time of Covid-19. We do not, however, argue that clinical practice time is dispensable. If indeed this is a turning point in the education of healthcare professionals, it is time to seriously grapple with recommendations for number of clinical hours and their implications for student achievement of their required competencies. A crisis is an opportunity for thoughtful change. We can either put our effort into trying to maintain the status quo or we can reconceptualize, reorganize, and rethink clinical practice education.

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