

# The Impact of University-Industry Integration on Teaching and Learning in Gerontological Nursing Education

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## 1. Executive Summary

China's aging population and the "Healthy China 2030" initiative have created an urgent demand for a highly skilled gerontological nursing workforce. University-Industry Integration (UII), or "产教融合", is a key national policy lever to bridge the gap between academic training and clinical/service realities. The nursing discipline, with its strong practice-based ethos, serves as a critical site for observing how UII policies are operationalized in health professional education. In the framework of the research project "University-Industry Integration Policies and Practices in China-Potential Applications in Hungary" of Wekerle International University (<https://wsne.hu/en/about-us/uii-research>), this report analyzes the implementation of UII within Chinese geriatric nursing education. Its objective is to understand the operational models, governance structures, pedagogical impacts, and key challenges of these university-industry partnerships. The analysis seeks to move beyond policy description to examine how integration is enacted on the ground and to assess its effectiveness in bridging the gap between academic training and clinical practice. The findings are based on a qualitative analysis of in-depth interviews with eight leaders and key stakeholders from both educational institutions (e.g., deans, program directors, senior faculty) and clinical industry partners (e.g., hospital nursing directors, senior clinicians, care facility managers). The analysis employed a thematic approach to synthesize insights on roles, teaching methods, partnership logistics, assessment innovations, and perceived outcomes. The analysis reveals that university-industry integration in geriatric nursing is a strategically driven, state-aligned initiative that has successfully institutionalized partnerships to address critical workforce shortages. This has led to significant pedagogical reform, shifting education toward immersive, scenario-based learning and competency assessments

co-designed with clinical partners, which in turn produces graduates with demonstrably higher licensure pass rates and accelerated job readiness. However, the model's effectiveness is constrained by enduring systemic tensions, including a fundamental clash between the predictable rhythms of academia and the crisis-driven pace of clinical care, divergent evaluation logics, and a shortage of educators who authentically bridge theory and practice, indicating that deep operational synthesis remains an ongoing challenge. The integration of industry and education in geriatric nursing represents a sophisticated and necessary response to a national priority, effectively embedding policy goals into the structure of professional training. While it has established robust partnership frameworks and demonstrably improved graduate readiness in key areas, its long-term efficacy is constrained by deep-seated systemic frictions. The ultimate success of this ambitious model depends on continuous, ground-level efforts to reconcile the conflicting rhythms, cultures, and capacity gaps between academia and industry, ensuring it fulfills its promise of transforming both education and the quality of care for China's aging society.

## 2. Introduction

### 2.1. Background and Rationale

The profound demographic shift toward an aging population in China constitutes one of the most pressing societal challenges of the 21st century. In direct response, the ambitious "Healthy China 2030" initiative has been established as a cornerstone national strategy, outlining a comprehensive roadmap to elevate public health standards and build a robust, tiered healthcare system (Tan et al., 2017). A critical, yet vulnerable, link in this system is the preparation of a competent healthcare workforce capable of meeting the complex, chronic care needs of older adults. Concurrently, China's education policy has strongly emphasized University-Industry Integration (UII, or 产教融合<sup>1</sup>), promoting it as a key mechanism for enhancing the quality and relevance of applied talent development. In the context of nursing, these two policy streams converge with compelling logic: the success of "Healthy China 2030" is inextricably tied to the availability of a highly skilled gerontological nursing workforce, whose training efficacy is theoretically amplified through genuine UII (Li et al., 2016). Therefore, UII is not merely an educational model but a strategic policy lever intended to directly support national health objectives by aligning academic output with real-world health service demands (An et al., 2025). This study was conducted within the framework of the research project "University-Industry Integration Policies and Practices in China – Potential Applications in Hungary" at Wekerle International University. More

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<sup>1</sup> 产教融合 (Chǎn jiào róng hé): University-Industry Integration (UII); a national education policy promoting deep collaboration between academia and industry.

information about the project is available at: <https://wsne.hu/en/about-us/uii-research>.

At the national level, UII has been enacted through a series of guiding policies and directives from ministries such as Education and Health. These policies advocate for deep collaborative mechanisms between nursing schools and healthcare institutions, including shared curriculum development, co-construction of practical training bases ("实训基地"<sup>2</sup>), dual-appointment of clinical and academic faculty, and joint research on clinical problems. The intended outcome is a seamless "nursing education ecosystem" where theoretical knowledge is continuously informed and refined by clinical practice. For gerontological nursing, this has translated into initiatives to develop specialized training modules on chronic disease management, palliative care, and geriatric rehabilitation within curricula that are co-designed by universities and elderly care hospitals or community health centers (Dijkman et al., 2022). The national push positions nursing, with its inherent practice-based ethos, as a frontline discipline for piloting and demonstrating the potential of UII to bridge the notorious gap between academic preparation and the evolving realities of healthcare service delivery.

Despite strong policy endorsement, the implementation of UII in gerontological nursing (老年护理<sup>3</sup>) education for older adult care faces significant dilemmas. A primary structural challenge is the misalignment of incentives between universities (focused on research and publication) and industry partners (focused on clinical service efficiency

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<sup>2</sup> 实训基地 (Shíxùn jīdì): Practical training base; often co-constructed by universities and enterprises for student internships.

<sup>3</sup> 老年护理 (Lǎonián hùlǐ): Gerontological nursing / Elderly care nursing.

and resource constraints), which can hinder sustained, deep collaboration.

Furthermore, the clinical sites for training, particularly in elder care, often lack standardized teaching capacities and the advanced preceptors needed to mentor students in specialized geriatric competencies. Consequently, nursing graduates may still enter the workforce underprepared for the psychosocial intricacies and multi-morbidity management required in geriatric care (Hu et al., 2021). In response, strategic discussions are increasingly focused on creating institutionalized and sustainable UII models. These include exploring legislative or financial incentives for deep cooperation, establishing nationally recognized gerontological nursing practice standards and preceptor certification programs, and leveraging technology through virtual simulations and tele-health collaborations to extend training resources.

Given this context of high policy stakes yet complex implementation challenges, it is necessary to conduct a nuanced investigation into how UII policies are being operationalized on the ground within a specific, strategically selected gerontological nursing education program. And to explore the dynamics of curriculum co-development, shared resource utilization, and the transition of graduates into the eldercare workforce. The implications of this study are twofold. Practically, it will generate evidence-based insights that can inform the design of more effective and sustainable UII frameworks for nursing and other health professions. Theoretically, it will contribute to a deeper understanding of the micro-processes through which macro national policies in education and health interact and are enacted within a critical sector, offering a model for analyzing professional education reform in China and similar contexts globally.

## 2.2. Case Study Focus and Research Questions

This study will employ an embedded, single-case study design to investigate how University-Industry Integration (UII) are operationalized within the specific context of gerontological nursing education. This report presents a case study of the Gerontological Nursing program at Jiaying University, and integrated service provider.. It investigates the following questions derived from the project framework:

1. What specific institutional structures, formal agreements, and informal practices constitute the UII partnership? How are curriculum development, practical training, and quality assurance jointly managed?
2. How do the motivations, expectations, and perceived benefits of university and industry partners align or conflict? What are the key facilitators and barriers to deep, sustainable collaboration?
3. How do educators, clinicians, and students perceive the impact of this UII model on (a) students' gerontological nursing competencies and (b) the partners' respective institutional goals? What are the perceived gaps between intended policy outcomes and on-the-ground reality?

## 2.3. Report Structure

The report details the methodology, presents findings on cooperation forms, analyzes their impact on teaching and learning, discusses the findings within the broader policy context, and concludes with implications.

## 3. Methodology

### 3.1. Case Study Design

This study adopts a qualitative-dominant, mixed-methods approach within an exploratory sequential design, situated within an interpretive paradigm. The primary aim is to gain a deep, contextual understanding of how UII policies are operationalized. The paradigm is appropriate as it seeks to capture the complex, socially constructed realities of stakeholders while using descriptive statistics to illustrate broader patterns within the case.

### 3.2. Data Collection

The primary data source was semi-structured interviews, supplemented by document analysis to provide contextual depth. Interviews followed a guide (see Appendix A) covering strategy, cooperation models, impacts on teaching/learning, and challenges.

- **Semi-structured Interviews:** Conducted with key stakeholder groups from both sides of the UII partnership. Interview guides were tailored for each group (see Appendix A) but centered on core themes: motivations for collaboration, operational processes, perceived benefits/challenges, and outcomes related to student competency.
- **Participant Sampling:** A purposive sampling strategy was employed to identify information-rich participants. A list of interviewee roles (anonymized) can be found in Appendix B. The final sample comprised:

1) University Educators (n=4): Including program deans, curriculum designers, clinical course teachers, teaching reform project leaders and theory instructors involved in the UII.

2) Nursing Care or Program Director (n=6): Including head nurses, clinical instructors, and hospital administrators from the partner institution.

### 3.3. Data Analysis

Interview transcripts were analyzed using thematic analysis. The findings were merged during the interpretation phase. Qualitative interview data were quoted to explain and provide context for specific themes.

### 3.4. Ethical Considerations

This study was approved by Ethical Committee of Jiaying University (ID: YX-2025012).

## 4. Regional and Policy Context

Jiaying University is a growing comprehensive public university in Zhejiang Province, strategically located in the core area of the Yangtze River Delta. It is classified as an “application-oriented” undergraduate institution, a designation central to national and provincial educational reforms that emphasize the development of practical, industry-ready talent. Its development is closely aligned with regional socio-economic needs, including the urgent demand for high-quality healthcare and elderly care services driven by an aging population.

The university’s College of Medicine hosts its flagship nursing program. The program is explicitly built on the principle of “deep integration of production and education” (产教

融合), featuring long-standing, institutionalized partnerships with local and regional hospitals, community health centers, and elderly care institutions.

## 5. Findings: Forms and Mechanisms of Cooperation

### 5.1. Strategic Positioning and Partner Selection (Relates to Interview Part A)

Based on the interviews conducted with leaders across educational and clinical institutions, several key themes emerge regarding the integration of industry and education in geriatric nursing. A central insight is that leaders see themselves as essential bridges and strategic coordinators between academia and the healthcare industry. Their roles involve not only forging partnerships with hospitals, palliative care centers, and community organizations but also ensuring these collaborations translate meaningfully into the curriculum. This work is supported by creating detailed internship frameworks, specialized courses in areas like geriatric assessment, and systematic feedback mechanisms that gather input from students, teachers, and industry partners to enable continuous improvement. The ultimate aim is to move beyond superficial cooperation and build a dynamic, sustainable system that responds to real-world needs.

The leaders unanimously highlight that geriatric nursing possesses unique priorities that distinguish its approach from other medical fields. The integration process places exceptional emphasis on humanistic care, advanced communication, and adaptive clinical skills. This focus arises from the complex nature of elder care, which involves managing chronic conditions, providing emotional support for individuals with cognitive impairments, and communicating effectively with families. Consequently,

training is designed to be highly scenario-based, immersing students in simulations and real-world settings to cultivate crisis management abilities, risk prevention, and teamwork across disciplines like rehabilitation and nutrition. The educational goal is to prepare nurses for the full continuum of care, from acute medical intervention to long-term support and palliative care, fostering a holistic, person-centered perspective.

Institutions engage with a diverse ecosystem of partners to provide this comprehensive training, primarily including specialized geriatric hospitals, community health centers, and various elder care facilities. An emerging trend involves collaboration with technology companies to develop virtual simulations and smart health tools. The selection of these partners is guided by deliberate criteria centered on depth and quality of engagement. The most valued partners are those whose specialty aligns closely with specific learning objectives, such as dementia care or palliative services, and who demonstrate a genuine commitment to co-designing curricula and providing experienced clinical mentors. Furthermore, partners must offer a standardized, high-quality learning environment with diverse patient cases and robust safety protocols, ensuring that student placements are educationally rich and not merely observational. This selective approach ensures mutual benefit, where students gain critical competencies, the industry secures a pipeline of well-prepared talent, and academic institutions enhance their teaching and research outputs.

- *"产教融合" is fundamentally a cyclical system requiring rigorous quality control. Their work centers on creating feedback mechanisms from industry, educators, and students, analyzing data to assess impacts on teaching and employment, and making evidence-based adjustments. Their quote would frame the process as " a*

*continuous improvement loop," where success is measured by the ability to "guarantee sustained enhancement and ensure the integration truly fulfills its purpose." The role is that of an evaluative overseer who ensures the partnership yields tangible, measurable improvements in graduate quality. ..."* (Program Director).

- *"this perspective interprets "产教融合" as a practical alignment of curriculum and industry standards. Their primary task is to translate specific workplace demands—like those from local nursing homes—into clear teaching objectives and student assessments. This role involves bridging the gap between classroom theory and clinical practice. A fitting quote would highlight " converting industry job requirements into teaching goals" and "integrating workplace evaluation criteria into student performance standards." They act as the operational translator of industry needs into the academic framework." (Curriculum Integrator )*
- *"the core of geriatric nursing integration is cultivating empathy and sophisticated communication skills alongside technical proficiency. They stress that while other medical fields may prioritize technical diagnoses, elder care is about "accompanying seniors through daily life." Their approach would emphasize training students in "establishing trust with cognitively impaired patients" and using "gentle communication to ease distress." This role is the practitioner-mentor, grounding the integration in the relational and humanistic essence of elder care." (Clinical Nurse Leader)*

## 5.2. Models of Clinical Teaching and Curriculum Integration (Relates to Interview Part B)

The successful implementation of industry-education integration in geriatric nursing is operationalized through three interconnected pillars: reformed clinical teaching models, co-creative curriculum design, and structured governance that grants industry partners substantive authority. This structured approach transforms the partnership from a conceptual agreement into a living, daily educational practice that directly responds to the evolving needs of elder care.

A hallmark of the reformed clinical education is the shift from passive observation to active, immersive participation. The traditional "bedside teaching" model has been re-engineered into a scenario-based immersion process, where instruction is entirely situated within authentic clinical environments like hospital wards or nursing home rooms. Instructors carefully select real, complex patient cases, and students conduct assessments, develop care plans, and perform procedures at the bedside, followed by immediate group debriefings. This model is often scaffolded within a staged practicum structure, where students progress through a curated sequence of settings—from acute hospital geriatrics to specialized palliative care centers and finally to community-based long-term care—to build a comprehensive understanding of the care continuum. Supporting this immersion is the widespread adoption of a synergistic Dual-Tutor System, where a school-based academic tutor and a clinical-based practitioner mentor coordinate closely to align theoretical learning objectives with hands-on skill development, providing students with consistent, integrated guidance.

This deep collaboration naturally extends into the very fabric of the curriculum through concrete co-design initiatives. Courses are no longer developed solely within academic departments but are jointly reshaped with industry partners to address identified competency gaps. A prime example is the co-creation of emergency response training programs with hospital partners, where clinical experts design realistic simulation scenarios based on common geriatric crises, such as falls or choking, and lead joint drills that replace less effective lab-based simulations. Similarly, entire courses, like geriatric rehabilitation, have been restructured into modules co-taught by academics and clinical therapists, culminating in student-led projects where they design and track rehabilitation plans for actual nursing home residents. Furthermore, to bridge the technology gap, partnerships with tech firms and clinical sites have led to the integration of smart care technologies into the curriculum, with nurses and engineers jointly teaching students how to use advanced tools while explaining the underlying nursing principles.

To ensure these practices are sustained and institutionalized, industry partners are formally embedded into academic governance through dedicated mechanisms. The most significant is their membership on “Professional Development Steering Committees”, where head nurses, care home directors, and community health managers have permanent seats and a direct vote in the annual revision of the overarching talent development plan. Their influence extends to the micro-level through participation in “Course Development Groups”, where they contribute real-world cases and updated

industry standards directly into textbook revisions and lesson planning. This formal role is reinforced by structured feedback loops, such as mandatory end-of-semester evaluations from partners on graduate performance, which are systematically analyzed and used to trigger prompt revisions to course content and practical requirements. Through these committees and feedback channels, industry input moves beyond anecdotal suggestion to become a mandated and integral part of the curriculum's evolution, ensuring that the education provided remains dynamically aligned with the frontline demands of geriatric care.

- *" Their focus is not on initiating partnerships but on establishing feedback mechanisms and evaluation loops to measure impact on teaching quality, graduate competitiveness, and industry satisfaction. Their role is that of an auditor and strategic improver, ensuring the collaboration delivers tangible, measurable value rather than existing as a formality. ..." (Project Evaluation Leader).*
- *"While other medical fields integrate for technical proficiency, they see the core purpose as instilling empathy, communication, and a person-centered approach. Their role is the practitioner-philosopher, ensuring the humanistic essence of accompanying elders through daily life remains the non-negotiable center of the training."( Senior Clinician)*
- *"“产教融合” is a pedagogical transformation. It is the active relocation of learning from abstract theory to contextualized practice. Their role is that of an instructional designer, using real clinical environments and scenarios as the primary curriculum to create immersive, competency-based learning experiences that replace passive knowledge transfer."( Clinical Education Reformer)*

- *“Success is defined by the partner's commitment to co-creation, moving beyond providing internship slots to actively shaping curriculum and assessment. Their role is the operational architect, translating industry's concrete job requirements and evaluation standards directly into the academic framework to ensure alignment.”( School Administrator)*

### 5.3. Structures for Collaboration

The university-industry partnership is strategically managed through a tiered system of formal governance structures designed to provide oversight, facilitate integration, and ensure accountability. At the highest level, a Professional Development Steering Committee serves as the primary strategic council. This committee is formally constituted with membership from both academia and industry, including senior faculty, hospital nursing directors, and leaders from elder care facilities. It meets on a scheduled, often annual or semi-annual basis, with the explicit mandate to review and approve the overarching talent development plan. This formal body ensures that the curriculum's strategic direction remains responsive to industry-wide trends, policy changes, and projected workforce demands, thereby aligning long-term educational objectives with the sector's evolving needs.

Operational execution and day-to-day administration are delegated to a dedicated, standing Liaison or Teaching-Research Office. This office functions as the institutionalized hub for coordination, typically staffed by administrative personnel from the university and designated representatives from major partner hospitals. Its formal responsibilities are codified and include managing the logistics of student placements, overseeing the flow of contracts and compliance documents, organizing

joint training events, and compiling performance data from all stakeholders. This structure provides a permanent, reliable channel for communication and logistical support, preventing collaborative activities from becoming ad-hoc or dependent solely on individual relationships.

At the most granular level of curriculum development, formal collaboration is embedded within Integrated Course Development Groups or Teaching-Research Sections. These are officially recognized committees for each core academic subject, such as Geriatric Nursing or Palliative Care, and their membership is explicitly defined to include both university faculty and clinical experts from partner institutions. The group's formal charter is the co-creation, review, and revision of all course-specific materials, including syllabi, textbooks, case studies, and assessment rubrics. This structure institutionalizes the direct infusion of practical, frontline knowledge into the academic curriculum, ensuring that teaching content is not developed in isolation but is continually validated and enriched by current clinical practice.

Alongside the formal hierarchy, the partnership's agility and responsiveness are sustained by a network of informal governance structures that operate through professional relationships and adaptive communication. A critical informal mechanism is the peer-to-peer coordination between the Dual Tutors—the assigned school faculty member and the clinical site mentor. While the Dual-Tutor system itself is a formal policy, its effectiveness hinges on the unstructured, ongoing dialogue between these individuals. They communicate directly, often via instant messaging or phone calls, to customize learning plans, discuss a student's progress in real-time, and tailor clinical

experiences to exploit specific learning opportunities as they arise in the ward or care facility, allowing for micro-adjustments that formal plans cannot predefine.

Furthermore, a vital continuous feedback loop operates outside of scheduled evaluation periods. Clinical staff, from head nurses to seasoned caregivers, routinely share informal observations and insights with their academic counterparts during site visits, over meals, or through digital channels. This flow includes not just feedback on student performance but also practical intelligence on emerging health issues among the elderly, new technologies in use, or procedural challenges. This constant, informal exchange enables the academic side to adjust teaching emphasis and student preparation dynamically, ensuring the curriculum remains immediately relevant to the realities of daily practice.

Finally, a culture of reflective practice and spontaneous collaboration acts as an informal governance mechanism, particularly following joint educational events. After major simulations, community health projects, or complex clinical immersions, the participating educators and clinicians naturally engage in debriefing sessions. These discussions, which are often organic and conversational, serve to collectively analyze what succeeded or failed, share perspectives from different professional angles, and generate ideas for improving future collaborations. This process fosters a shared sense of ownership and continuous co-learning between partners, strengthening the relational bonds that underpin and energize the more formal contractual and committee-based structures.

## 6. Analysis: Impact on Teaching, Learning, and Challenges

The integration of university and industry in geriatric nursing education has fundamentally reoriented the pedagogical paradigm, shifting from a model of theoretical preparation to one of situated, competency-based formation. This shift answers the core "so what?" of the initiative: it directly produces a graduate who is not merely knowledgeable but is practice-ready and contextually adaptive. The impact on teaching is profound; instructors are no longer just conveyors of textbook content but have become curricular designers and learning facilitators who must constantly translate real-world clinical scenarios into structured educational experiences. For learning, the impact is the cultivation of "tacit knowledge and clinical judgment"—skills that are nearly impossible to acquire in a classroom. Students learn not only what to do but how to think and act under the complex, unpredictable conditions of elder care, developing professional identity through authentic experience. The "why" behind this impact is the imperative to close the costly and risky competency gap that traditionally existed between graduation and independent practice, thereby enhancing patient safety and accelerating the new nurse's contribution to the workforce from their first day.

However, this transformative model introduces significant and systemic challenges that reveal the tension between academic and industrial logics. The foremost challenge is the risk of partnership asymmetry, where the collaboration devolves into a transactional provision of internship slots rather than a deep, co-equal educational alliance. The "so

what?" of this challenge is that it can undermine the pedagogical intent, reducing student learning to passive observation or menial tasks if industry partners view them primarily as supplemental labor. The "why" this persists is often rooted in misaligned incentives; clinical sites operate under intense pressure for efficiency and productivity, which can conflict with the time-intensive, mentorship-heavy demands of optimal student training. This creates a constant negotiation between the educational need for guided, reflective practice and the industry's operational realities.

A second, related challenge is the sustainability of curriculum agility and pedagogical depth. While integration provides immediate relevance, there is a danger that curricula become overly reactive to the specific, immediate needs of today's partner institutions, potentially at the expense of foundational theory and forward-looking competencies. The "so what?" is that programs might train students for the industry of yesterday or today, but not for its future. The "why" stems from the difficulty of synchronizing the slow, deliberative pace of academic governance and curriculum revision with the rapid evolution of clinical technology, care models, and policy. This challenge asks whether the partnership is merely adaptive or genuinely transformative—capable of not just responding to industry but also innovating within it by educating nurses who can critically evaluate and improve practice.

Ultimately, the analysis suggests that the success of university-industry integration hinges on navigating beyond a functional partnership to forge a co-constructed educational ecosystem. The enduring "so what?" for stakeholders is that the model's

true value is not realized in the signing of agreements but in the daily, reflective collaboration between faculty and clinicians, and in institutional structures that share governance and accountability. The central "why" for its necessity is that the complex, human-centric field of geriatric care demands professionals formed through a synthesis of rigorous science and relational art—a synthesis that can only be achieved through sustained, intentional synergy between the academy and the clinic. The greatest impact, therefore, may be the cultivation of a shared culture that views education not as a preparatory phase but as a continuous, collective responsibility for the quality of care.

### 6.1. Impact on Teaching Practice (Relates to Interview Part C)

In terms of pedagogy, the core shift reported is from abstract, textbook-driven instruction to immersive, problem-based learning. Teachers consistently describe moving away from "reciting textbooks" and "one-way knowledge output" towards a facilitator role. The infusion of real-world cases from clinical partners—such as managing a diabetic patient with dementia or an elderly person refusing medication—provides the raw material for this change. These complex, "dilemma"-laden cases form the basis for Problem-Based Learning (PBL) and group discussions, forcing students to synthesize knowledge and design solutions under realistic constraints. Furthermore, the partnership has accelerated the adoption of advanced simulation technologies, including VR systems and intelligent patient manikins that replicate emergencies like falls or choking. This technological integration, often sourced directly from industry partners, creates a "safe-to-fail" practice environment that was previously unavailable, allowing students to build procedural confidence and clinical judgment before encountering real patients.

Regarding curriculum content, the partnership acts as a critical conduit for ensuring relevance and 前沿性 (frontier knowledge), closing the persistent gap between slow-updating textbooks and rapid clinical innovation. Interviewees emphasize that collaboration provides a direct pipeline to the "latest dynamics" of the industry. This manifests in the swift integration of smart healthcare technologies —such as remote fetal monitoring, intelligent turning beds, and digital management systems—into course modules. The process is not passive; it involves joint efforts where industry technicians explain new devices, and clinical nurses demonstrate their application, ensuring students learn both the "button to press" and the "clinical reasoning for when to press it." This co-development extends to revising entire curriculum standards and core competencies every few years, systematically removing obsolete content and embedding new industry protocols and care guidelines (e.g., for palliative care or pressure ulcer management) to ensure graduates can "hit the ground running."

For teacher development, schools are institutionalizing support mechanisms that incentivize and validate industry engagement, moving it from a personal pursuit to a recognized career pathway. Reported supports are multifaceted. Logistically, schools provide dedicated industry practice mechanisms, including scheduled clinical placement days for faculty, with protected time and reimbursement for travel and training. Financially and professionally, there are clear incentives: participation is linked to performance pay, bonuses for developing teaching resources, and significant weight in 职称评审 (professional title evaluation). Crucially, outcomes like co-authored

practice manuals, developed teaching cases, and "Double-Qualified" teacher recognitions are formally counted as teaching achievements, granting them the same status as traditional academic research. This structured recognition answers the "what's in it for me?" for educators, transforming industry engagement from an extracurricular burden into a core, rewarded component of professional growth and teaching excellence.

- *"Therefore, the combination of the two significantly promotes the reform of teaching methods, making inquiry-based learning with real problems as the starting point the norm. Our clinical front line continuously provides school teachers with many typical, sometimes even dilemma-filled, practical cases. Teachers use these real, structurally complex problems as the driving force for teaching. Students work in groups to analyze the problem background, consult materials, and design feasible solutions. Clinical nurses, serving as industry-specialized mentors, appear in the classroom during the students' participation process, using practical operational experience to address students' questions or provide supplements. This method completely changes the 'teacher speaks, student listens' model, turning students into active problem-solvers who must synthesize knowledge and consider real-world constraints. This is crucial for cultivating students' clinical thinking and ability to solve complex problems."( Professor / Project Coordinator)*
- *"The deep integration of universities and industries has also changed teachers' teaching methods, with a greater use of industry-frontier technology simulation teaching replacing previous lecture-based teaching. We collaborated with a*

*medical technology company to introduce a VR geriatric nursing simulation teaching system. Teachers use this system to create various real scenarios; students then work in the virtual environment to identify risks and formulate care plans, and the system provides immediate feedback on the results of their operations. This method is more immersive than classroom lectures, allowing students to experience the actual work environment in a safe setting. The utilization rate of cutting-edge technology in teaching has significantly increased, and students' learning enthusiasm has also greatly improved, with many actively booking the equipment for extra practice after class. Changing this teaching method makes abstract nursing knowledge more intuitive, and students' knowledge application ability improves accordingly."( Academic Leader)*

- *"Now, compared to when I first started teaching, the teaching methods are completely unrecognizable. Back then, I would just hold the textbook and read, flip through a few pages of PPT, and the students would be bored to death. Teaching was utterly uninteresting; it was just the teacher outputting knowledge one-way. But since increasing cooperation with the industry, this situation has completely changed. After spending more time in clinical settings and nursing homes, I have gathered many real patient case materials. For example, there is an elderly patient with both diabetes and some dementia. I turned this patient's care process into a case study, had the students form groups to discuss how to best arrange this patient's diet, how to help them take medicine on time, and so on. Also, through cooperation with hospitals, we acquired simulation teaching equipment, like intelligent geriatric care mannequins that can simulate emergencies such as sudden falls or choking in the elderly, allowing students to practice how to respond in the classroom. This method gives students a stronger sense of participation and*

*makes it easier to turn book knowledge into practical skills. Now, I also feel a sense of achievement in teaching; seeing their gradual progress is more gratifying than anything." (Experienced Instructor)*

- *"Through industry cooperation, we ensure the practicality and 前沿性 (frontier nature) of the course content from two aspects: strengthening practical skills and following industry trends. Partner institutions directly provide feedback on the skill directions needed by the industry, and based on this, we modify our course modules. Upon learning that the demand for palliative care is increasing, we strengthened the teaching of related skills in the end-of-life care course, adding content on pain management and psychological counseling, and arranged for students to intern in the palliative care units of our partner institutions. Frontline personnel from partner institutions share practical clinical techniques; these experiences summarized from practice are immediately incorporated into the courses, ensuring students learn methods that are practical within the industry. In response to new needs such as geriatric nutritional assessment, we jointly revise the relevant course content with specialized partner institutions, incorporating the latest assessment methods and dietary approaches. Through these adjustments, students can quickly apply the skills they learn to solve practical problems during internships and work, ensuring the 课程的前沿性 (frontier nature of the courses)."( Program Director/ Curriculum Lead)*
- *"The school uses a special fund for industry practice to support teachers' participation in industry activities. A special fund for teacher industry practice is established to support teachers in undertaking full-time practice at partner hospitals and elderly care institutions. During the practice period, the teachers' original 待遇 (remuneration/benefits) remain unchanged, and the school also provides subsidies for transportation and accommodation. Last year, I used this fund to practice for two*

*months at an elderly care institution in Jinhua, gaining a deep understanding of the institution's operational management and elderly care processes, and collected a large number of teaching cases. The school considers teachers' industry practice experience as a factor for 加分 (extra points) in professional title evaluation and performance assessment, equating it with scientific research achievements. This enables teachers to participate in industry practice without worries, thereby improving their professional abilities and teaching standards, and promoting the teachers' own comprehensive development."( University Teacher)*

## 6.2. Impact on Student Learning and Outcomes (Relates to Interview Part D)

The integration of industry into geriatric nursing education extends far beyond traditional clinical rotations, creating a multi-layered system for student engagement and a fundamental shift in how their competencies are measured. Concrete evidence suggests this approach yields significant improvements in graduate outcomes.

Students engage with industry in structured, non-rotational ways that provide holistic exposure to the field. A key innovation is the use of virtual simulation systems, co-developed with industry partners, which allow students to repeatedly practice complex scenarios like palliative care or managing cognitive impairment in a risk-free environment. Beyond digital tools, engagement is systematized through "enterprise classrooms" where courses are taught on-site at partner facilities by industry experts,

such as a nutritionist in a nursing home kitchen. Students also undertake authentic project-based work, like conducting community health management for seniors, and participate in a curated series of industry expert lectures and panel discussions that cover operational management, policy, and technological trends, providing a macro-level understanding of the sector.

Innovations in student assessment focus on authentic, competency-based evaluation co-judged by industry professionals. There is a decisive move away from reliance on final exams toward complex, multi-component assessments. A prominent model is the industry-expert panel review, where students defend comprehensive care plans or project reports to a committee of clinicians and care facility managers, whose scores carry significant weight. Assessment is increasingly process-oriented, with 60% or more of a grade derived from practical performance evaluations by dual tutors, project reports, and reflective portfolios. Practical exams are now often conducted by partner institution nurses as examiners, who assess not just technical skill but also the humanistic quality of care, directly embedding workplace standards into academic evaluation.

Perceived evidence of improved student outcomes is reported across multiple, compelling indicators. Quantitative data shows a higher pass rate on national licensure exams for students in integrated programs compared to peers, with particular strength in geriatric-specific content. From an employment perspective, graduates demonstrate accelerated job readiness and superior adaptability; employers report they become

independently functional in 1-2 months versus 3-6 months for others, leading to near 100% employment rates in the geriatric sector for some programs. Qualitatively, clinical supervisors observe that these graduates exhibit markedly better clinical judgment, communication skills, and initiative in complex, non-routine situations. Longitudinal tracking indicates stronger career advancement potential, with a higher proportion of graduates moving into specialist or management roles within a few years, suggesting the integrated model builds a foundation for sustained professional growth.

- *"Virtual simulation industry practice allows students to engage with industry practice within the course. Using a geriatric nursing virtual simulation system co-developed through school-enterprise cooperation, we simulate real industry scenarios for practices like elderly emergency care, dementia patient care, and palliative care. Students can repeatedly practice operations in the virtual environment, familiarize themselves with nursing procedures, and improve emergency response capabilities... It compensates for the limitations of few on-site practice opportunities and short durations, ensuring every student has sufficient practical opportunity."( Curriculum Developer)*
- *"In addition to traditional internships, we cultivate students' experience of the geriatric care industry through a large number of non-clinical practical activities. For foundational courses, we organize students to visit elderly care industry associations... At the same time, we invite various industry experts to hold lecture series on topics like nursing home operations management, community nursing work content, and smart elderly care technology applications... We also organize students to conduct industry research projects, where they visit various types of elderly care*

*institutions in groups to understand service models, analyze strengths and weaknesses, and write a research report judged jointly by industry experts and school teachers."( Program Director)*

- *"First is the 'enterprise classroom.' For example, the 'Geriatric Nutrition and Diet' course moves the classroom to the nutrition kitchen of a local nursing home, where the institution's dietitian teaches, and students personally prepare a nutritional meal for the elderly... Second is authentic project practice. Taking the collaboration with a community health center on elderly health management as an example, students engage in practical tasks like filing records for seniors in the community, conducting follow-ups, and health education—all real work, with no simulation."( Experienced Instructor)*
- *"In the practical skills assessment for geriatric nursing techniques courses, we invite senior nurses from partner institutions to serve as examiners. The assessment items are all common clinical tasks. The examiners strictly evaluate students' operations against clinical standards, focusing on the practicality of their skills and their level of care for the elderly."( Program Director)*
- *"Looking at the long-term development of graduates, industry-education integration experience improves graduates' career development potential. One or two years after graduation, the proportion of these students promoted in geriatric care management or specialized nursing is higher than that of graduates from traditional training models. Many become backbones in geriatric care, and some move into nursing management positions."( Project Evaluation Leader)*

### 6.3. Key Challenges and Enabling Factors (Relates to Interview Part E)

The interviews reveal that the integration of academia and industry, while beneficial, is fraught with significant systemic and operational challenges. These can be categorized into three major areas: logistical and temporal misalignment, divergent professional logics and standards, and pressing human resource gaps. The persistence of these challenges directly impacts the quality, equity, and sustainability of the educational experience.

The most frequently cited operational hurdle is the fundamental misalignment of rhythms and priorities between academic and clinical systems. Academic schedules are fixed and planned months in advance, while clinical work is inherently unpredictable, dictated by patient influx, seasonal demands (e.g., busy winter geriatric wards), and emergency situations. This creates a recurring conflict where meticulously designed student learning plans—such as scheduled case discussions or guided practice—are disrupted or rendered ineffective when clinical staff are overwhelmed. As one leader poignantly illustrated, planned learning activities are often "pushed aside" during peak periods, leaving students as passive observers rather than active learners. This tension exposes a core ethical and practical dilemma: the competition between the educational imperative to provide learning opportunities and the clinical imperative to prioritize patient care and safety. Balancing student learning needs with the uncompromising priority of patient welfare remains a constant, unresolved negotiation.

Beyond logistical hurdles, a more profound and systemic challenge stems from the inherent conflict between the professional logics and evaluative frameworks of academia and clinical practice. The educational system is engineered for the comprehensive transmission of knowledge and favors process-oriented assessments that reward theoretical mastery and adherence to procedural protocols. Conversely, the healthcare industry operates on a paradigm of efficiency and results, prioritizing reliable outcomes, practical judgment, and the situated competency to adapt and perform effectively in real-time, high-pressure environments. This fundamental misalignment creates dissonance for students, who may achieve academic excellence yet be assessed as inadequately prepared by clinical mentors scrutinizing their immediate, applied performance. Interviewees emphasize the urgent necessity for a co-constructed, hybrid evaluation system to reconcile these divergent standards. However, forging such an integrative framework demands persistent, deliberate effort and negotiation between the two ecosystems.

- *"The biggest headache is scheduling... The school sets the teaching plan in advance, but clinical work and nursing home operations are unpredictable. For example, when we arrange for students to intern at the hospital, the plan is for them to join doctor rounds and case discussions. But if the hospital suddenly admits a group of critically ill elderly patients, the nurses are too busy to even drink water, and no one has the capacity to teach them procedures. The students just stand and watch anxiously, learning nothing... At the nursing home, when there are many visiting families during holidays, service quality takes priority, and student training gets put aside."( Experienced Instructor)*

- *"We in the clinic place more emphasis on practical ability, while the school may focus more on theoretical grades... Also, in the hospital, any situation can arise, but students' learning progresses step-by-step. So sometimes, a relevant clinical case might suddenly appear, but the students haven't yet learned about that aspect."(Experienced Nurse)*
- *"In geriatric care settings, students face elderly patients with complex conditions and volatile emotions, and also participate in work like end-of-life care. Some students experience significant psychological pressure. Seeing elderly patients suffering from illness or facing patient death can trigger anxiety, depression, and other emotions in students, making them unable to adapt to high-intensity clinical work... How to adjust students' mindset, improve their psychological adaptability, and face geriatric care work with a positive attitude is a major problem we currently encounter."( Department Head)*
- *"The biggest problem in practice is the natural difference in value objectives and evaluation logic between the education system and the industry system. The logic of school education focuses on systematic and comprehensive knowledge transmission and complete learning processes; assessment looks more at students' mastery of knowledge and the quality of the learning process. The logic of the industry side focuses more on efficiency, reliable operational results, and standardization; its evaluation is more results-oriented. This leads to different focuses, or even differing opinions, between the school and clinical mentors when evaluating the same practical performance of a student."( Educational Leader)*

## 7. Discussion

This study elucidates the intricate mechanisms and inherent tensions of university-industry integration within Chinese geriatric nursing education. Moving beyond a generic model of partnership, the findings reveal how this integration is distinctly shaped by three intersecting forces: the urgent logic of workforce development, a strong regulatory and policy environment, and the practical challenges of translating top-down directives into effective, sustainable educational practice. The discussion is structured to unpack these forces and their implications.

### 7.1. Confirming Sectoral Specificities

The findings robustly confirm that the driving logic of integration in this sector is not merely pedagogical enhancement but a strategic, demand-led response to a profound demographic and workforce crisis. The pervasive focus on "practice-ready" graduates, accelerated job readiness, and alignment with concrete "industry needs" and "post standards" underscores an instrumental view of education as a direct pipeline for skilled labor. This is a classic example of a workforce-shortage-driven logic, where educational processes are consciously reconfigured to mitigate a critical societal and economic pressure. The severe shortage of specialized geriatric care professionals makes the efficiency and relevance of nursing education a matter of public policy urgency, elevating industry-education integration from an innovative option to a strategic imperative.

Furthermore, the partnership models are deeply embedded within a strong regulatory and state-steered context. The consistent emphasis on "national standards," "updated care guidelines," and "industry norms" in curriculum co-design reflects an ecosystem where the state, through bodies like the National Health Commission, sets the parameters of professional practice. Industry partners, primarily public hospitals and state-sanctioned care institutions, act as conduits for these regulatory standards into the academic sphere. This differs markedly from market-driven integration in other fields; here, the "industry" is often an extension of the state's public service arm. Consequently, integration serves a dual purpose: it is both a mechanism for skill development and a vehicle for ensuring that the future workforce is standardized and compliant with a centrally governed healthcare framework. The formal governance structures, such as steering committees with institutional representatives, can be seen as mechanisms for aligning educational output with this regulated, public-service-oriented industry. The findings robustly confirm that the driving logic of integration in this sector is not merely pedagogical enhancement but a strategic, demand-led response to a profound demographic and workforce crisis. The pervasive focus on "practice-ready" graduates, accelerated job readiness, and alignment with concrete "industry needs" and "post standards" underscores an instrumental view of education as a direct pipeline for skilled labor. This is a classic example of a workforce-shortage-driven logic, where educational processes are consciously reconfigured to mitigate a critical societal and economic pressure. The severe shortage of specialized geriatric care professionals makes the efficiency and relevance of nursing education a matter of public policy urgency, elevating industry-education integration from an innovative option to a strategic imperative.

## 7.2. The "Medical-Elderly Care Integration" in Action

The national policy of 医养结合 (yiyang jiehe, integrated medical and elderly care) is not a mere abstract directive but is tangibly manifested in the operational choices and pedagogical designs uncovered in this study. This policy aim, which seeks to blend healthcare services with daily life support for the aging population, directly shapes the typology of partnerships and the structure of the student learning journey.

The deliberate selection of partners across the care continuum—from comprehensive hospital geriatric departments and specialized palliative care centers to community health stations and residential care facilities—creates an educational model that mirrors the policy's integrated vision. The widespread adoption of a staged practicum model, where students rotate through these different settings, is a direct pedagogical translation of 医养结合. It ensures students develop competencies not just in acute medical intervention ("医") but in long-term support, rehabilitation, and holistic well-being ("养"). The curriculum innovations, such as modules on chronic disease management in the community, smart home care technologies, and palliative care, are explicit attempts to equip students with the hybrid skill set required for this integrated service model. Therefore, the university-industry partnership becomes a critical meso-level implementation site for this macro-level policy, actively constructing the professional identity and competencies needed to realize integrated care on the ground.

### 7.3. The Limits of Policy Translation

Despite strong policy impetus and strategic alignment, the findings expose significant limits and tensions in translating the integrative vision into seamless educational practice. These implementation gaps reveal the friction points between different systemic logics. First, the persistent challenge of temporal and priority misalignment—where fixed academic schedules clash with the unpredictable, crisis-driven rhythms of clinical care—highlights a fundamental conflict. The policy goal of deep integration runs up against the operational reality that patient care will, and must, always take precedence over student learning during moments of clinical strain. This creates inherent inequities in learning opportunities and risks reducing student roles to passive observation, undermining the policy's goal of immersive, hands-on training. Second, the identified clash of professional logics and evaluation standards points to a deeper, unresolved issue in policy translation. While the policy mandates collaboration, it does not automatically reconcile the academic culture of comprehensive, process-oriented assessment with the industry culture of efficient, outcome-focused competency. The reported student confusion and the call for hybrid evaluation systems indicate that policy has successfully mandated partnership structures but has not yet fully resolved the underlying epistemological and evaluative divides. True integration requires the co-creation of a new, shared "language" of competency that satisfies both academic rigor and clinical utility. Finally, the human resource bottlenecks, particularly the shortage of genuine "Dual-Qualified" teachers, represent a critical capacity constraint. Policy can create frameworks and demand outcomes, but it cannot instantly produce a cohort of educators who are both scholarly experts and seasoned clinical practitioners. This gap can lead to a reliance on practitioners who may lack formal pedagogical training or on academics whose knowledge may lag behind clinical frontiers, potentially diluting the quality of the integrated education the policy seeks to promote.

## 8. Conclusion and Implications

### 8.1. Summary of Conclusions

Based on this in-depth analysis, the integration of industry and education within geriatric nursing in China emerges as a sophisticated, state-aligned initiative strategically engineered to address a profound demographic and workforce crisis. The model is not a voluntary collaboration but a demand-driven imperative, meticulously designed to transform education into a direct pipeline of "practice-ready" professionals. This is operationalized through a multi-layered ecosystem: formal governance structures like joint committees ensure strategic alignment with national healthcare objectives, while pedagogical reforms immerse students in scenario-based learning and competency assessments co-designed with clinical partners. The national policy of \*\*医养结合 (integrated medical and elderly care)\*\* is directly manifested in curriculum design and partnership choices, ensuring graduates are equipped with the hybrid skills necessary for the continuum of care. Evidence suggests this approach yields tangible results, including higher licensure pass rates, accelerated job readiness, and strong graduate employability.

However, the initiative's ambitious translation from policy into practice encounters significant systemic friction. The analysis reveals persistent and profound challenges that expose the limits of top-down integration. These include an unresolved clash between the fixed rhythms of academia and the unpredictable, crisis-driven pace of clinical care; a dissonance between academic evaluation standards focused on theoretical mastery and industry needs for practical, situational competency; and a critical shortage of authentic "Dual-Qualified" teachers who can bridge these divides.

Consequently, while the partnership structures are successfully mandated and the workforce logic is clear, the deeper synthesis of institutional cultures, priorities, and professional epistemologies remains incomplete. The ultimate success of this model, therefore, hinges not merely on the existence of partnerships but on the continuous, ground-level work of reconciling these enduring tensions to sustainably transform both education and the quality of care for China's aging population.

## 8.2. Implications

- **For Practice:** Suggest actionable recommendations for similar programs (e.g., establishing clear faculty time-release policies for industry engagement, creating joint faculty-clinician appointment models).
- **For Policy:** Suggest policy adjustments that could address identified challenges (e.g., more flexible funding for coordination roles, national standards for "dual-role" faculty qualifications).
- **For Research:** Propose future studies (e.g., longitudinal tracking of student outcomes, comparative studies across different nursing schools).

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## Appendices

- **Appendix A:** Interview Guide (English Translation)
- **Appendix B:** List of Interviewee Roles (Anonymized)

## Appendix A

### **Interview Outline: The Impact of Industry-Education Integration on Teaching and Learning in Gerontological Nursing Education**

**Interviewees:** Dean of the Nursing School, Program Director for Gerontological Nursing, Lead Instructors of Clinical Nursing Courses, Head of Teaching Reform Projects, Nursing Education Administrators from Affiliated Hospitals.

**Interview Introduction:** This interview aims to gain an in-depth understanding of the cooperation between the Gerontological Nursing program in the health/medical education field and industry partners (including hospitals, pharmaceutical companies, health technology companies, etc.). It will focus on how these collaborations concretely influence teachers' instructional methods as well as students' learning experiences and outcomes. Thank you for sharing your insights.

#### **Part A: Strategy and Philosophy**

1. Could you briefly introduce your role and your unit's work in the "Industry-Education Integration" for the Nursing program, particularly the Gerontological Nursing direction?
2. Compared to other medical disciplines, what do you think are the unique characteristics or special emphases of "Industry-Education Integration" in the Gerontological Nursing direction? (e.g., greater focus on humanistic care, communication skills, clinical adaptability, teamwork, etc.).

3. What types of institutions does your Gerontological Nursing program primarily partner with for "Industry-Education Integration"? (e.g., general hospitals, specialized hospitals, community health service centers, elderly care institutions, internet-based nursing platforms, etc.). What are the core criteria for selecting partners?

### **Part B: Cooperation Models and Mechanisms**

4. Could you specify how the nursing program has reformed its clinical teaching and internship models? (e.g., Is a "Dual-Tutor System" implemented? How is "bedside teaching" conducted?).

5. Could you share a successful case where "Industry-Education Integration" in gerontological nursing directly improved "teaching and learning"? (e.g., How was a specific course, teaching module, or training program reshaped?).

6. How do elderly care industry partners substantively participate in the design and revision of the talent cultivation plan? (e.g., through mechanisms like Professional Development Steering Committees, Curriculum Committees).

### **Part C: Specific Impact on "Teaching" and "Learning" (Core Section)**

7. Impact on Pedagogy: How has the university-industry collaboration changed teachers' instructional methods? Has it promoted more real case-based teaching, problem-based learning, or simulation teaching utilizing cutting-edge industry technology?

8. Impact on Teaching Content: How does the collaboration ensure the relevance and practicality of the curriculum content? (e.g., Has new content like digital health, smart medicine, innovative medical devices, or modern hospital management been introduced?).

9. Impact on Faculty Development: How does the school support and incentivize teachers to participate in hospital, enterprise, or industry activities beneficial to teaching? (e.g., Are there mechanisms for faculty industry practice? How are teaching achievements recognized in terms of industrial application?).

#### **Part D: Student Participation and Learning Outcomes**

10. Beyond traditional internships, how are students systematically exposed to industry practice within the curriculum? (e.g., projects solving real enterprise problems, non-clinical course lectures with deep involvement from industry experts).

11. What innovations have been made in student assessment methods within these gerontological nursing-related courses? (e.g., increased use of project reports, defenses evaluated with industry expert participation, learning portfolios as alternatives to traditional written exams).

12. What evidence or observations indicate that such experiences enhance nursing students' employability, job adaptability, or performance on licensure exams?

#### **Part E: Challenges, Enabling Factors, and Future Prospects**

13. What have been the most significant challenges in the joint practical training and education of nursing students? (e.g., coordinating academic and industry schedules, intellectual property ownership, avoiding excessive commercialization of teaching, faculty workload, scheduling conflicts between academic plans and busy clinical work, differing student assessment standards between school and hospital, lack of "dual-qualified" teachers, psychological support for students adapting to high-intensity clinical work, etc.).

14. What do you believe are the most critical enabling factors for achieving successful integration? (e.g., stable university-enterprise relationships, dedicated coordination and management bodies, strong policy support, shared vision and trust).

15. Facing new trends like "Internet + Nursing Services" and "Smart Elderly Care," what new explorations does your unit plan in "Industry-Education Integration"? (e.g., collaborating with tech companies to develop teaching for intelligent care devices, partnering with communities/elderly care institutions to innovate practical teaching in long-term care, hospice care, etc.).

## Appendix B

### List of Interviewee Roles (Anonymized)

<b>ID</b>	<b>SEX</b>	<b>Years of working experience</b>	<b>Affiliation</b>	<b>Title</b>
01	Female	30	Jinhua Central Hospital Geriatrics Department &Jinhua Vocational and Technical University	Head Nurse
02	Female	16	Jinhua Vocational and Technical University	Program Director of Geriatric Nursing
03	Female	13	Wuyi County Health Training School	Director of Academic Affairs Office
04	Female	17	Wuyi County Second People's Hospital	Head Nurse, Integrated Medical and Elderly Care Ward
05	Male	22	Jinhua Hospital of Traditional Chinese Medicine& Department of Nursing,	Head Nurse, Teacher

			Xingzhi College, Zhejiang Normal University	
06	Female	N/A	Jiaying University	Director of the Department of Nursing
07	Female	18	Jiaying University	Professional Director of the Obstetrics and Gynecology Nursing Course
08	Female	16	Jinhua Vocational and Technical University	Project Leader for Geriatric Nursing Teaching Reform
09	Male	23	Jinhua Central Hospital	Director of the Nursing Department
10	Male	20	Jinhua Central Hospital	Teaching Management Director, Nursing Department