POSITION STATEMENT
SUPPORT OF MAXIMIZED UTILIZATION OF HEALTHCARE SIMULATION
TO PROVIDE HIGH QUALITY CLINICAL HOURS
IN UNDERGRADUATE AND GRADUATE NURSING EDUCATION

Current State:
The current California Board of Registered Nursing (BRN) Clinical Experience Guidelines language states that "the program may use up to 25% of each clinical rotation in planned simulations. The simulations must include actual scenarios that encompass the nursing process, critical thinking, and evidence based practice." (EDP-B-02 [REV. 08/14]).

In surveying National Council of State Boards of Nursing (NCSBN) Boards of Nursing (BON) across the United States, Hayden, Smiley, and Gross (2014) noted that out of the 61 jurisdictions that regulate Registered Nursing (RN) practice, eight states and six international jurisdictions did not allow simulation to replace clinical hours. Virginia allowed up to 50% per course, but not exceeding 20% across the entire program. The state of Massachusetts was not regulating simulation hours and Louisiana, Ohio, and South Carolina did not support the use of simulation in lieu of clinical hours (Hayden et al., 2014).

A recent survey of BON simulation regulations was conducted by a graduate student in summer, 2015. This survey revealed that the following states specifically indicate a 25% maximum amount of simulation that can replace clinical hours: California, Vermont, Colorado, Michigan, Nevada, and North Carolina. In comparison, Washington, Florida, New York, and Texas allow up to 50% of simulation that can be used to replace clinical hours. Clearly, there is a wide variation in BON regulation of allowable simulation hours in nursing programs across the United States.

Desired State:
The NCSBN conducted a landmark, multi-site, longitudinal study that explored the role and outcomes of simulation in pre-licensure clinical nursing education in the United States (Hayden, Smiley, Alexander, Kardong-Edgren & Jeffries, 2014). Based on study findings, the California Association of Colleges of Nursing (CACN) membership supports the suggested maximized utilization of healthcare simulation, 50% of inpatient clinical training hours, as a pedagogy that is able to provide high quality clinical hours in substitution of traditional clinical experiences under conditions comparable to those described in the NCSBN study.

BRN Position:
The current California BRN position is that a change in the clinical hour regulation is not warranted until the efficacy of an increased percentage of simulation use is validated in further replication studies. BRN consultation and input in the work of this position statement stated that Nursing Education Consultants will handle case by case situations for schools needing more hours in simulation through the established Clinical Experience Guidelines. Program Directors should work directly with their Nursing Education Consultant in determining program specific strategies to maximize simulation utilization in situations where simulation will best achieve desired student learning outcomes.

CACN Position:
The CACN supports the use of simulation as an evidence-based strategy in creating high-quality and transformational student learning experiences across clinical settings and along the continuum of care. Simulation allows the opportunity for situated cognition --- or learning in context --- that promotes experiential learning through the replication of clinical practice situations.

Changes in health care access and technological advances in health care delivery have contributed to the increasing complexity of patient care, a growing lack of clinical placements for students in general and in particular specialty areas, as well as the need for innovation in creating high quality learning experiences outside of the clinical setting. These factors are all drivers in considering the increased utilization of healthcare simulation. Today's educators are called to integrate quality simulation experiences that foster critical thinking and clinical reasoning skills in undergraduate and graduate education. This shift in pedagogy requires that nurse educators have the requisite knowledge, skills, and resources to use simulation to its full potential. Learner self-reflection is foundational to all simulation methods to promote learning and requires educators to be trained and skilled in creating effective student debriefing opportunities.

Planned simulations should be evidence-based, quality simulations. While there are noted variations in simulation resources across nursing programs statewide, CACN recognizes that the implementation of a quality simulation program is foundational to its effectiveness in promoting optimal and effective student learning. Evidence-based components of a quality simulation program include student preparation, pre and post-testing, and debriefing. Simulation quality can best be achieved by ensuring that faculty participating in simulation is trained at an expert level in conjunction with faculty development programs such as the California Simulation Alliance (CSA). A debriefing assessment tool like the Debriefing Assessment for Simulation in Healthcare (DASH) provides an exemplar of a standardized tool to evaluate faculty debriefing competencies (Center for Medical Simulation, 2015). CACN also supports the use of simulation quality standards available through the International Nursing Association for Clinical Simulation and Learning (INACSL) and certification and accreditation through the Society for Simulation in Healthcare Accreditation (SSH), as well as the work of the CINHC Nursing Education Plan White Paper (now Health Impact: Optimizing health through nursing) in developing strategies to apply evidence-based practice to the amount of time regulated by the BRN for clinical hours in simulation.

<u>The CACN supports ongoing and future collaboration with the BRN in pursuing evidence-based regulation changes that support the maximized use of simulation in providing quality student learning experiences and outcomes.</u>

Rationale:

"Simulation creates transformational learning experience for all nursing students and provides diverse perspectives on caring for patients across the continuum of care. Learning in simulation allows for situated cognition – or learning in context – a concept at the forefront of contemporary educational reform" (NLN, 2015). The results of a recent nationwide study conducted by the NCSBN provides substantial evidence that up to 50% of simulation can be effectively substituted for traditional clinical experience under the following conditions: faculty members are formally trained in simulation pedagogy; there are an adequate number of faculty members to support student learners; there are subject matter experts who conduct theory-based debriefing and self-reflection; and equipment and supplies are available to create a realistic environment (Hayden et al., 2014). When implemented according to these identified conditions, research indicates that quality simulation can be used as an effective replacement for traditional clinical education hours without compromising the quality of student learning and readiness for clinical practice. The advantages of using simulation as a teaching strategy include student application of critical thinking skills, enhanced content retention, increased decision making skills, immediate faculty feedback, and controlled learning experiences that optimize the student learning experience (Sleeper & Thompson, 2008).

Passive learning methods are being replaced by nursing educators today with more interactive methods, in conjunction with experiential learning modalities. Simulation is a form of contextualized learning that fully engages the learner to reflect and reframe their understanding of the simulated event by successfully combining thinking and action. When students come to clinical, the available patient population provides the scope of learning experiences. Simulation can complement these direct care experiences by ensuring that every student strategically encounters a full range of patient care experiences necessary to becoming a competent practitioner through high quality simulation, versus learning being solely limited to the available patient care experiences in the clinical setting at any given time.

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