

North Carolina Nurses Association (NCNA) Position Statement on

Use of Simulation for Up to 50% of Traditional Clinical Experiences in Prelicensure Nursing Education Programs

This position statement does not imply endorsement of any piece of related legislation.

Issue

Prelicensure nursing education programs face increasing challenges in securing high-quality traditional clinical learning experiences. Simulation offers a viable, as well as valuable, alternative learning experience. Research by the National Council of State Boards of Nursing (NCSBN) (Hayden, Smiley, Alexander, Kardong-Edgren & Jeffries, 2014) has now provided evidence that the same learning outcomes and post-graduation work performance can be achieved when up to 50% simulation is used in place of traditional clinical experiences. These outcomes are dependent on numerous requirements to ensure high-quality simulation. This evidence provides the basis for administrative and policy decisions regarding use of simulation as “on campus clinical” to fulfill clinical experience requirements in prelicensure nursing education programs.

Background

Historically, nursing programs have been challenged to find high-quality traditional clinical learning experiences for students. Shorter patient lengths of stay, higher patient acuity, disparities in learning experiences, and the amount of time instructors spend supervising skills have long been issues. More recently, challenges have included competition for limited clinical sites, faculty shortages, lengthy facility clinical orientations, facilities not granting students access to electronic medical records, facilities limiting skills students can perform, and patient safety initiatives that decrease the number of students allowed on a patient unit or restrict their activity to observing care (Hayden et al., 2014).

These challenges have required nursing programs to identify alternative learning experiences to traditional clinicals. Simulation mimics supervised clinical experiences while providing students similar opportunities to demonstrate procedures, participate in clinical decision-making, utilize critical thinking, and communicate with each other in a nonthreatening, standardized environment (Jeffries, 2005). The use of simulation by nursing programs has grown over the last 15 years as increasing evidence has demonstrated its value as a learning pedagogy (Berndt, 2014; Fisher & King, 2013; Foronda, Liu, & Bauman, 2013; Lapkin, Levett-Jones, Bellchambers, & Fernandez, 2010). This has prompted many nursing programs to request permission from their Boards of Nursing (BON) to use simulation experiences in place of traditional clinical experiences.

A survey conducted in 2006 of the BONs in the United States (US), the District of Columbia, and Puerto Rico found that 16 states approved of simulation as a replacement for clinical hours (Nehring, 2008). More recently, in 2014 a survey was conducted of the BONs from the 50 states, the District of Columbia, and four U.S. territories found that 18 BONs had registered nurse (RN) regulations that address the use of simulation, 8 had a maximum amount of

simulation allowed to replace student clinical time, and almost half said they would be creating regulations or reviewing current regulations to determine if changes were needed in the near future (Hayden, Smiley & Gross, 2014).

BONs had little rigorous research evidence to support any decision regarding the use of simulation experiences in place of traditional clinical experiences until the landmark NCSBN national simulation study (Hayden et al., 2014) results were published in 2014. The results of this multi-site, longitudinal, randomized, controlled study provided evidence that there were no significant differences in learning outcomes or post-graduation work performance for students who had up to 50% of their traditional clinical replaced with high-quality simulation experiences. These findings were dependent on sufficient numbers of faculty, faculty adequately trained in simulation pedagogy, and committed faculty. In addition, there needed to be a dedicated simulation lab with appropriate resources, simulations that were realistically and appropriately designed according to International Nursing Association for Clinical Simulation and Learning (INACSL) (2013) *Standards of Best Practice: Simulation*SM, and the use of a theory-based debriefing methodology.

In October, 2015, the NCSBN published simulation guidelines for prelicensure nursing programs (Alexander et al., 2015). These guidelines addressed evidence needed to support the use of simulation and provided information for faculty and program directors on preparation and planning for using simulation successfully in their nursing programs. Checklists for faculty and program preparation were included in the guidelines to ensure high-quality simulations.

On May 19, 2016, the North Carolina Board of Nursing (NCBON) Education and Practice Committee proposed several new amendments to the Administrative Code Rules to the full BON, and they were accepted. Three items in the amendments to Rule 21 NCAC 36 .0321 Curriculum were specifically related to simulation and read:

- (m) For all programs using simulation experiences substituted for clinical experience time, the nursing education program shall:
 - (1) demonstrate that simulation faculty have been formally educated, and maintain competencies in simulation and debriefing theory; and
 - (2) provide a simulation environment with adequate faculty, space, equipment, and supplies to simulate realistic clinical experiences to meet the curriculum and course objectives.
- (n) Programs not holding national nursing accreditation shall limit simulation experiences to no more than 25% in any course, including the focused client care experience.
- (o) Programs holding national nursing accreditation shall limit simulation experiences to:
 - (1) no more than 25% in the focused client care experience, and
 - (2) no more than 50% of clinical experience time in any other course. (NC BON, 2016, p.3)

A public hearing is scheduled for July 20, 2016 at the NC BON offices to allow for public comment by anyone who has a written objection to all or part of the proposed Rule amendments. The amendments are currently scheduled to take effect on November 1, 2016.

NCNA Position

NCNA supports the use of simulation in nationally accredited prelicensure nursing programs for up to 25% of clinical experience time in focused clinical courses, and up to 50% of clinical time in other clinical courses. The use of simulation for up to 25% of clinical experience time is also supported in nursing programs that are not nationally accredited. This support is based on the condition that there are adequate programmatic structure and resources, the INACSL *Standards of Best Practice: Simulation*SM are used to develop and implement evidence-based simulations, there are a sufficient number of dedicated faculty members who are formally trained in simulation pedagogy to support the student learners, at least one faculty member is nationally certified as a Certified Healthcare Simulation Educator (CHSE), subject matter experts are present to conduct theory-based debriefings according to the *Standards*, and resources are available to create a realistic environment.

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