

POSITION STATEMENT | December 1, 2021

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

POSITION

We believe that high quality simulation that follows published healthcare standards is equivalent to achieving selected student competencies compared to in-person clinical experiences. Simulation as a mode of instruction designed to promote and reinforce safe nursing practice. Nursing students need to practice managing high risk, low frequency events in a safe and effective way rather than "practicing" on patients which could cause harm. To ensure safe and effective simulation is being delivered, schools should follow established standards; ongoing faculty development - train faculty towards certification and follow best evidence-based guidelines.

In September 2020, due to the pressures of the COVID-19 Pandemic, and lack of clinical placements Business and Professional Code (BPC) 2786.3 was put into California Code (please see Appendix). The bill allows schools of nursing to use to 50% direct patient care hours for geriatric, and medical-surgical and 25% in obstetric, mental health/psychiatric, and pediatrics during a state of emergency. Previously, the California Board of Registered Nursing (BRN) Clinical Experience Guidelines language stated 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 2014, the National Council of State Boards of Nursing (NCSBN) surveyed Boards of Nursing (BON) across the United States. Hayden, Smiley, and Gross noted that out of the 61 jurisdictions that regulate Registered Nursing (RN) practice, only eight states and six international jurisdictions did not allow simulation to replace clinical hours. At the time of the survey, Virginia allowed up to 50% per course, but not to exceed 20% across the entire program. The remaining 77% of jurisdictions at the time (2014) had adopted various percentages to replace clinical practice. For example, 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).

In 2015, 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.

According to the most recent survey by the International Nursing Association for Clinical Simulation and Learning (INACSL) there are 18 states in which boards of nursing have approved the use of 50% simulation; there are two states at 30% and seven states that are at 25%. The remaining 24 states have no written regulations about the use of simulation and therefore are not bound to any particular percentage (INACSL, 2021). INACSL continues to survey states regularly to maintain the current state of simulation in state.

RATIONALE

Simulation is not all manikin based. Simulation activity also include role-play, standardized patients, hybrid, low fidelity or high-fidelity manikins, computer-based or virtual reality. Nurse Educators can guarantee a hands-on, interactive, critical-thinking and clinical-reasoning based clinical experience in simulation, but we cannot ensure the same rich, immersive experiences in the clinical setting as students often are only allowed to observe.

In a 2020 systematic review of the literature that investigated the impact of in-person clinical rotations on learning outcomes, the authors could not find any studies that linked in-person clinical rotations to achieving learning outcomes resulting in an empty review. Also, a recent study just published this month was one of the first studies to quantify the quality and safety of new graduate nurses that was conducted pre-pandemic. The study found that 100% of new graduates made errors and failed to rescue their patients. However, the researchers used an online simulation program to improve clinical reasoning and decision-making, and there was a significant improvement in the quality and safety of the new graduates. This is a concrete example of the value of simulation. Simulation creates transformational learning experiences 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 the 2014 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. Please refer to the CSA White Paper on the Value Proposition for Simulation:

<https://www.californiasimulationalliance.org/white-paper-value-proposition-for-simulation-in-nursing-education/>

REFERENCES

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APPENDIX

CALIFORNIA LEGISLATIVE CODE WEBSITE, California Law

Business and Professions Code / Div. 2 Healing Arts / Chapter 6. Nursing / Article 4. Nursing Schools

LINK:

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC§ionNum=2786.3