



**NURSING EDUCATION & WORKFORCE ADVISORY COMMITTEE (NEWAC)
 AGENDA AND TELECONFERENCE SITES**

**TELECONFERENCE INFORMATION:
 PHONE NUMBER: (877) 950-0357 USER ACCESS CODE: 2158678**

MEETING LOCATIONS

Department of Consumer Affairs 1747 North Market Blvd. HQ-2 First Floor Hearing Room 186, Sacramento, CA 95834	United Nurses Association of California Union of Health Care Professionals 955 Overland Ct. Suite 150 San Dimas, CA 91773
	Mt. San Jacinto College Menifee Valley Campus 28237 La Piedra Road Room 506 Menifee, CA 92584
Fresno City College Health Sciences Building Director of Nursing Office Room HS-1 1443 E. Weldon Avenue Fresno, CA 93741	California State University, Long Beach, School of Nursing, Room 61B 1250 Bellflower Blvd. Long Beach CA 90840

**Monday, October 28, 2019
 10:00 am - 2:00 pm**

Monday, October 28, 10:00 am

- 1.0 Call to Order/Roll Call/Establishment of a Quorum/Approval of Minutes**
 - 1.1 Discussion and Vote Whether to Approve minutes – February 19, 2019**
- 2.0 Executive Officer Report**
- 3.0 Organizational and Governance Matters:**
 - 3.1 Discussion and Possible Action Regarding NEWAC Purposes Document**
 - 3.2 Discussion and Possible Action Regarding Identification of NEWAC Strategic Initiatives for 2019-2021**
 - 3.3 Discussion and Possible Action Setting 2019-2020 NEWAC Meeting Dates**
- 4.0 Information Only: Report on BRN Annual School Survey 2017-2018 Key Findings by Dr. Joanne Spetz, University of California, San Francisco**
- 5.0 Simulation: Discussion and Possible Action Regarding Finalizing Draft Simulation Guidelines and Draft Program Assessment Form Including Review of Comments to Part 1 of the Simulation**

Proposal, the Information Related to OSHPD Pilot Project Applicability/Title 22 Regulations, and NEWAC Members' Written Feedback, and Recommendation to the Education Licensing Committee to Recommend to the Board Adoption of the Simulation Guidelines and Program Assessment Form

6.0 Information only: Public Health Nursing Workforce Update

7.0 Public Comment for Items Not on the Agenda; Items for Future Agenda

Note: The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting. (Government Code Section 11125 and 11125.7(a)).

8.0 Adjournment

NOTICE:

All times are approximate and subject to change. Items may be taken out of order to maintain a quorum, accommodate a speaker, or for convenience. The meeting may be canceled without notice. For verification of the meeting, call (916) 574-7600 or access the Board's Web site www.rn.ca.gov. Action may be taken on any item listed on this agenda, including information only items.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited.

The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at (916) 574-7600 or e-mail webmasterbrn@dca.ca.gov or sending a written request to the Board of Registered Nursing office at 1747 N. Market #150, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone # (800) 326-2297). Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation. Board members who are not members of this committee may attend meetings as observers only and may not participate or vote.

**BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
NURSING EDUCATION AND WORKFORCE ADVISORY COMMITTEE
MEETING MINUTES**

DATE: February 19, 2019 **DRAFT**

LOCATION: Board of Registered Nursing
1625 North Market Blvd.
HQ-1 Hearing Room, Ste. 102
Sacramento, CA 95834

TELECONFERENCE LOCATIONS:

Department of Consumer Affairs 1625 North Market Blvd. HQ-1 Hearing Room, Suite 102 Sacramento, CA 95834 Phone: (916) 574-7600	United Nurses Association of California Union of Health Care Professionals 955 Overland Ct. Suite 130 San Dimas, CA 91773
Samuel Merritt University 3100 Summit Street, Room 3466 Oakland, CA 94609	Mt. San Jacinto College Menifee Valley Campus 28237 La Piedra Road Room 506 Menifee, CA. 92584
Fresno City College Health Sciences Building Director of Nursing Office Room HS-1 1443 E. Weldon Avenue Fresno, CA 93741	California State University, Long Beach, School of Nursing, Room 61B 1250 Bellflower Blvd. Long Beach CA 90840

PRESENT: Judy Martin-Holland, PhD, MPA, RN, FNP, UC San Francisco, Chair
 Judith G. Berg, MS, RN, FACHE, HealthImpact
 Jose Escobar, MSN, RN, PHN, Los Angeles County Department of Public Health
 Sabrina Friedman, EdD, DNP, FNP-C, PMHCNS-BC, FAPA, UCLA School of Nursing
 Jeannine Graves, MPA, MSN, RN, OCN, CNOR, Sutter Cancer Center
 Marketa Houskova, RN, BA, MAIA, American Nurses Association\California
 Katherine Hughes, SEIU Nurse Alliance of California
 Victoria Bermudez for Saskia Kim, California Nurses Association
 Robyn Nelson, PhD, RN, West Coast University
 Joanne Spetz, PhD, Institute for Health Policy Studies,
 Garrett Chan, PhD, RN, HealthImpact
 Sandra J. Miller, MBA

TELECONFERENCE: Loucine Huckabay, PhD, RN, PNP, FAAN, CSU Long Beach, Co-Chair
 Stephanie Robinson, PhD, MHA, RN, Fresno City College
 Carol Jones, MSN, RN, UNAC/UHCP

VOTES	CJ	SR	JS	PZ	KH	JMH	SK	RN	SM
	Y	Y	Y	Abstain	Abstain	Y	Absent	Y	Y

2.0 Executive Officer Report

- 2.1 Report on BRN Current Initiative – Report given by Dr. Joseph Morris
No public comment.

3.0 Report on Nursing Education Issues

- 3.1 Update regarding use of simulation for clinical education requirements
Public comment: Garrett Chan
- 3.2 Report on BRN Annual School Survey - Report presented by Joanne Spetz, PhD
No public comment.

4.0 Regional Nursing Summit Update

- 4.1 Report on Regional Nursing Summits Summary
Report presented by Judy Berg and Garrett Chan
No public comment.

- 5.0 **Discussion of Associate Degree Nursing and Bachelor of Science Nursing Dual Enrollment Pilot Program** – Report presented by Sandy Baker
No public comment.

6.0 California Directors of Public Health Nursing

- 6.1 Discussion, review, and possible action regarding recommendations to Public Health Nursing Certificate qualifications and requirements - Report given by Jose Escobar
Public comment: Cindy Watson

- 7.0 **Public Comment for Items Not on the Agenda**
No public comment.

8.0 Adjournment

Meeting adjourned at 2:30 pm.

Joseph Morris, PhD, MSN, RN
BRN Executive Officer

Judy Martin-Holland
Committee Chair

BOARD OF REGISTERED NURSING
Nursing Education & Workforce Advisory Committee (NEWAC)
Agenda Item Summary

AGENDA ITEM: 3.1
DATE: October 28, 2019

ACTION REQUESTED: Organizational and Governance Matters-Discussion and Possible Action Regarding NEWAC Purposes Document

REQUESTED BY: Dr. Joseph Morris, PhD, RN, BRN Executive Officer

BACKGROUND: The NEWAC 2017 Purposes document is being updated to:

- Be consistent with the Board of Registered Nursing current 2018-2021 Strategic Planning document as attached;
- Reflect the most recent changes in the Board's business processes, including advisory committee review processes;
- Reflect advisory committee membership and expert consistent with the nursing education and nursing workforce charge and purpose of the NEWAC committee;

- Describe in writing NEWAC alignment with the Open Meeting Act requirements.

Attached please find the DRAFT 2019 Purposes document the NEWAC members will be discussing and possibly voting on adopting with minor edits as needed at today's meeting. Also included is the previously NEWAC approved 2017 NEWAC Purposes document for reference.

NEXT STEPS: Identify any needed edits to the proposed 2019 document and approve the document with the suggested edits included.

PERSON(S) TO CONTACT: Joseph Morris, PhD, RN
BRN Executive Officer

California Board of Registered Nursing

NURSING EDUCATION AND WORKFORCE ADVISORY COMMITTEE (NEWAC)

The mission of the California Board of Registered Nursing is to protect and advocate for the health and safety of the public by ensuring the highest quality of registered nurses in the State of California. Board values include consumer protection, customer service, effectiveness, integrity and trust.

The Board's 2018-2021 Strategic Plan (SP) describes seven broad goal areas:

- Licensing
- Enforcement
- Continuing Education
- Educational Oversight
- Laws and Regulations
- Organizational Development
- Communication and Public Education

Examples of Strategic Plan goals specific to NEWAC include, but are not limited to:

Goal Four (4) related to Licensing states ...The Board advances higher education standards to increase the quality of education and ensure public protection.

Strategic Plan Licensing Goal 4.6 states...Analyze trends in nursing education, nursing practice and patient advocacy. In addition, look for future areas in need of improving the health for the California population.

Strategic Plan Goal Six (6) related to the BRN's Organizational Development states...The Board builds on excellent organization through proper Board governance, effective leadership, and responsible management. Strategic Plan Goal Organizational Development 6.4 states... Evaluate current committee structure to assure that it is meeting the current Board's needs for efficiencies and public protection.

<https://www.rn.ca.gov/pdfs/consumers/stratplan18-21.pdf>

NEWAC Purpose/Charge:

NEWAC brings together in one advisory group nursing educators, employers, practice representatives and other key stakeholders to accomplish the following:

- Communicate, collaborate and coordinate with members of the nursing and healthcare professions to identify current nursing education and nursing workforce issues, challenges, and possible solutions including potential regulatory solutions/changes;
- Provide the Board and the BRN survey contractor/vendor input and guidance on the content of the BRN's RN workforce survey and the RN Annual School nursing education programs pre-licensure and post-licensure survey;
- Provide information updates and make recommendations to the Board based on relevant nursing education and nursing workforce survey results, evidence-based practice research and standards.

Relationship to the BRN:

NEWAC is an advisory committee of the California Board of Registered Nursing (BRN). NEWAC functions according to the Bagley-Keene Open Meeting Act as set forth in Government Code Sections 11120-11132.

http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=GOV&division=3.&title=2.&part=1.&chapter=1.&article=9

California Board of Registered Nursing

NEWAC provides information and recommendations relevant to nursing education, nursing workforce and nursing practice. Trends, issues, concerns and potential regulatory solutions may be forwarded to the various BRN standing committees such as the Education/Licensing Committee, Nursing Practice, Legislation, Enforcement/Diversion and Discipline, and the Administrative committees and the full Board. The Board's Executive Officer (EO) or designee will facilitate referral of NEWAC recommendations to the appropriate BRN standing committee(s) or full Board. Referral to a Board committee or the full board will depend on the relevance of the topic/issue to the Board's mission, public protection mandate, strategic plan and laws and regulations. Referred recommendations may be information only or request Board or Board committee action in some instances.

Anticipated NEWAC Outcome Evidence:

NEWAC meetings, materials, minutes and actions/recommendations will be used as the outcome evidence of NEWAC's advisory work and effort to promote achievement of evidence-based excellence and quality in nursing education, workforce planning, and nursing practice in California.

Membership:

The Committee shall be composed of nursing education, nursing practice, industry/employers, workforce experts, other California nursing professionals and other key stakeholders reflecting a variety of backgrounds, experiences, and viewpoints.

The BRN Executive Officer (EO) or designee coordinates NEWAC committee appointments, membership composition, and committee member terms. NEWAC members will be appointed to a two years term. Members will be selected by the Board Executive Officer. Selection will be based on the variety of subject matter expertise and viewpoints selected members will be able to bring to NEWAC's work. Members shall serve no more than two consecutive terms or a total of four consecutive years.

NEWAC members will identify two committee co-chairs to facilitate NEWAC meetings in collaboration with the Board's Executive Officer. One of the NEWAC appointed co-chairs will represent the practice/industry sector and one co-chair will represent the nursing education sector. Ordinarily NEWAC co-chairs will serve as one of the co-chairs until the member's term ends.

NEWAC co-chair(s) will develop the meeting agendas in collaboration with the Board's EO, NEWAC NEC staff liaison and other Board support staff. The NEWAC co-chairs and the BRN EO will facilitate NEWAC meetings. Only appointed NEWAC committee members vote on meeting agenda items when a vote is required. This may include items such as approval of minutes and specific recommendations to be moved forward to BRN committees or the full Board.

A listing of NEWAC members will be maintained by the BRN and include appointment start and end dates. Appointed members resigning before their appointed term ends are asked to automatically submit a letter of resignation directed to the attention of the NEWAC co-chairs and the Board's EO. The BRN EO or designee will facilitate filling committee vacancies as needed if vacancies occur between NEWAC meeting dates.

The Board's President, in collaboration with the BRN Executive Officer, may assign one Board member to attend NEWAC meetings. The Board member attending NEWAC meetings is considered an observer, and will not vote, comment or ask questions during NEWAC meetings.

Meetings:

NEWAC will routinely meet two to three times per year. NEWAC members not able to attend live face to face meetings may participate via audible teleconferencing per Government Code Section 11123, and as

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pre-arranged and listed on the meeting agenda. The NEWAC agenda will be posted on the BRN website 10 days before the meeting per Government Code Section 11125. Each teleconference location listed on the posted meeting notice/agenda shall be accessible to the public. Teleconference sites may not be added after the NEWAC agenda is posted on the BRN website. The meeting location must meet the accessibility requirements of the American Disabilities Act per Government Code Section 11123.1.

The routinely scheduled live face to face meetings (October and then the first or second quarter of next calendar year) will have teleconferencing access if requested/arranged prior to posting the meeting agenda on the BRN website. As needed, other teleconference NEWAC meetings with a quorum may be held at a date and time between June-August to carry out NEWAC committee work/tasks such as finalizing the next annual school survey tool as necessary. NEWAC will report any action taken and the vote or abstention on that action of each member present at the public meeting via member rollcall. Anyone may audio or video record a meeting per Government Code Section 11124.1.

All NEWAC meetings will be open to the public and require a 10-calendar day notice in advance of the meeting and following the Bagley-Keene Open Meetings requirements at dates, times, location/address, teleconference addresses, and member/public call in numbers when applicable as posted on the meeting agenda available on the BRN website at www.rn.ca.gov. From the BRN home page, select Meetings> Year of Board and Committees Meetings>Select NEWAC Committee listing>Select NEWAC Meeting Date>Select currently posted Agenda, Location, Materials. To access archived NEWAC meetings information go to the BRN website>Select Meetings>Archived Board and Committee Meetings>Next select Past Meetings>Select NEWAC>Select Year and meeting dates agendas, materials, and minutes to be accessed.

Meeting members will be asked to provide agenda items, a brief agenda item summary and meeting materials in advance of meetings according to the requested submission timelines established by BRN staff. Meeting materials will be posted on the BRN website in the same location as the specific meeting agenda, meeting location, minutes etc. Meeting materials received during or after a meeting will subsequently be posted on the BRN website along with other already posted meeting materials and will be labeled as meeting/post meeting addenda/supplemental materials.

NEWAC members unable to attend a meeting may have an agency/institutional representative attend a NEWAC meeting in the absence of the appointed committee member. However, such representatives will be part of the meeting audience. Such representative may provide public comment for agenda items or items not on the meeting agenda but only appointed NEWAC members vote. BRN Board members who wish to attend a NEWAC meeting are free to observe the meeting proceedings as part of the audience but may not vote, ask questions, or comment during meetings.

Meeting agenda items will be discussed using standard meeting management procedures. Individuals in the NEWAC meeting audience/members of the public will be provided opportunities to speak during public comment times/or as requested by committee members during meetings. Other interested parties in attendance at NEWAC meetings may provide public comment when meeting proceedings invite public comments and as reflected on the BRN website posted meeting agenda. Time allocated for public comment may be limited by the NEWAC meeting co-chairs to facilitate effective meeting time management consistent with Government Code Section 11125.7.

NEWAC meetings will be recorded and meeting minutes prepared by the designated BRN staff. The NEWAC co-chairs and the EO/or EO designee will review meeting minutes in advance of submission to the NEWAC members for purposes of review/accuracy/needed edits before member approval at a NEWAC meeting. Finalized meeting minutes will be signed and dated by the EO and NEWAC co-chairs

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and subsequently posted on the BRN website in the same section as the meeting agenda and the meeting materials are posted.

Quorum:

Participation/attendance of a majority of appointed NEWAC members at any NEWAC meeting constitutes a quorum.

Board Staff:

NEWAC ex-officio (non-voting) BRN members include the BRN Executive Officer (EO) and the two Supervising Nursing Educational Consultants (from the northern and southern CA regions), the NEWAC NEC staff liaison, other NECs as periodically assigned, the BRN appointed UCSF contractor/vendor staff for the BRN Annual School Survey and RN Workforce survey. In addition to other Board staff that support the committee by providing meeting assistance, advice, consultation, reports/presentations and other forms of help as requested by and or assigned by the EO or his/her designee.

Periodic Review of this NEWAC Advisory Committee Purposes document:

The NEWAC Committee shall periodically review and update this document to ensure the document remains relevant to current statutes, regulations, the Board's mission and strategic plan, nursing education and nursing practice and workforce changes/updates. At minimum it will be reviewed and re-approved by the NEWAC membership at least every four years from the last NEWAC membership effective approval date. This document will include a signature page for the Board's Executive Officer and the two NEWAC co-chairs to sign and date once this document is approved by the membership in each review cycle.

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Nursing Education and Workforce Advisory Committee (NEWAC)
NEWAC Review and Approval Signature Page

California Board of Registered Nursing, NEWAC facilitator

Joseph Morris, PhD, RN

Executive Officer

Signature: _____

Date: _____

NEWAC Co-Chair

Loucine (Lucy Huckabay, Ph.D., RN, PNP, FAAN

Nursing Program Director and Professor, California State University School of Nursing, Long Beach

Signature: _____

Date: _____

NEWAC Co-Chair

Judy Martin-Holland, Ph.D., MPA, RN, FNP

Associate Dean Academic Programs & Diversity Initiatives

University of California San Francisco

Signature: _____

Date: _____

DRAFT

**BOARD OF REGISTERED NURSING
NURSING EDUCATION AND WORKFORCE ADVISORY COMMITTEE
BACKGROUND, PURPOSE, GOALS, AND MEMBERSHIP**

BACKGROUND

The combining of the Board’s Nursing Workforce Advisory Committee (NWAC) and Education Issues Workgroup (EIW) into one committee, later named the Nursing Education and Workforce Advisory Committee (NEWAC), was approved by the Board in June 2015. This combining of committees was in response to a recommendation from the legislature during the BRNs sunset review process. This recommendation was made so that a combined committee could address issues impacting both nursing education and the nursing workforce. Meetings of the NEWAC will be conducted in accordance with the rules of the State’s public open meetings requirements.

PURPOSE

The purpose of the NEWAC is to bring together educator, employer and practice representatives and stakeholders to:

- communicate, collaborate and assist one another on relevant nursing issues
- identify how the Board might assist in these efforts
- provide guidance to the Board on the content of surveys regarding RN workforce issues and surveys of RN nursing education programs

That will lead to positive outcomes for the future of registered nursing to benefit the health and safety of health care consumers in California.

GOALS

Goal #1

Collaborate to identify current and relevant issues that impact quality registered nursing education, employment, and workforce trends in California.

Goal #2

Facilitate work to resolve, improve and/or continue work and dialogue on the identified issues with the goal to improve quality registered nursing care to consumers in California.

Goal #3

Provide recommendations and guidance to the Board of Registered Nursing on identified issues and topics in areas for which the Board could assist and/or facilitate the work of the committee.

Goal #4

Review and provide input, when requested by the Board of Registered Nursing, on the content of surveys regarding RN workforce issues and education programs.

MEMBERSHIP PROCEDURES

Members’ terms will be two year terms with half of the committee beginning/expiring at the beginning of each calendar year, thus for the first year (2018), to avoid having all terms expire at the same time, half of the committee will serve for three years. Terms may be renewed or extended in cases where stakeholder representation would be compromised and the BRN Executive Officer or designee determines continuation of an individual’s membership is important to the committee work. Members’

who are appointed to replace an outgoing member during the term, shall carry the term expiration as the original member and may be appointed for another term. The BRN Executive Officer or designee will coordinate committee appointments and membership and has final approval of all committee appointments and terms. A listing of the members terms, appointment and expiration dates will be maintained by the BRN.

Appointed committee members are the only individuals allowed to participate and vote as a member. Representatives or designees will not be allowed to participate as a committee member in an appointed committee members absence. Others attending, who are not members of this committee, may attend meetings as an audience member and speak during public comment times but may not otherwise participate or vote.

Committee chair or co-chairs and a secretary will be decided by the committee and will serve for two years or until their term expires. The chairs or co-chairs will assist the BRN staff with the meeting agendas and facilitating the meetings. The secretary member will draft minutes of each meeting and assist the BRN staff in preparation of draft and final minutes.

The NEWAC will include representatives from the following:

- 2 - Nursing program representatives appointed by COADN (one from Northern and one from Southern California)
- 2 - Nursing program representatives appointed by CACN (one from Northern and one from Southern California)
- 3 (minimum) - Nursing program dean/director representatives appointed by the BRN Executive Officer or designee
- 2 - RN employer representatives
- 2 - Currently practicing RN representatives
- 2 - Currently practicing APRN representatives
- 2 - Public representatives
- 1 - Office of State Health Planning & Development – Health Professions Education Foundation Representative
- 1 - Office of State Health Planning & Development – Health Workforce Development Division Representative
- 3 – College Chancellor’s Office Representatives (i.e., Community College, CSU and UC)
- 3 to 4 - Professional Nursing Organization Representatives (i.e., American Nurses Association/ California, Association of California Nurse Leaders, California Hospital Association, HealthImpact)
- 2-3 - Union Organization Representatives (i.e., California Nurses Association, SEIU, UNAC/UHCP)
- 1 - BRN Board Member
- 1 - BRN research vendor

California Board of Registered Nursing
Nursing Education and Workforce Advisory Committee Appointment Info
Contact Information –

MEMBER	TITLE/ORGANIZATION	Appointment Term	PHONE	EMAIL
Loucine (Lucy) Huckabay, Ph.D., RN, PNP, FAAN Co-Chair	Director and Prof, School of Nursing; CSU, Long Beach Educator Rep: Public BSN – South	October 1, 2019-September 30, 2021		
Judy Martin-Holland, PhD, MPA, RN, FNP Co-Chair	Associate Dean, Academic Programs & Diversity Initiatives University of California, San Francisco Educator Rep: Public ELM – North	October 1, 2019-September 30, 2021		
Tanya Altmann, PhD, RN	Chair and Professor, School of Nursing, CSU, Sacramento Educator Rep: Public BSN – North	October 1, 2019-September 30, 2021		
Norlyn Asprec	Executive Director, Health Professions Education Foundation OSHDP – Health Education Rep	October 1, 2019-September 30, 2021		
BJ Bartleson, RN, MS, NEA-BC	Vice President, Nursing & Clinical Svcs California Hospital Assoc./North Nursing Workforce Employer Stakeholder Representative	October 1, 2019-September 30, 2021		
Barbara Barney-Knox, RN	Chief Nursing Executive, Health Care Services, Nursing Services Branch, California Department of Corrections and Rehabilitation Nursing Workforce Employer Stakeholder Representative-North	October 1, 2019-September 30, 2021		
Garrett Chan, PhD, RN, APRN, FAEN, FPCN, FCNS, FNAP, FAAN	President & CEO HealthImpact	October 1, 2019-September 30, 2021		

California Board of Registered Nursing

MEMBER	TITLE/ORGANIZATION	Appointment Term	PHONE	EMAIL
Denise Duncan, BSN, RN	Executive Vice President, UNAC/UHCP Union Representative	October 1, 2019-September 30, 2021		
Jose Escobar, MSN, RN, PHN	Nurse Recruitment and Retention Manager-LA County Dept of Public Health (DPH) Nursing Workforce Employer-Public Health Member- South	October 1, 2019-September 30, 2021		
Brenda Fong	Specialist Community Colleges Chancellor's Office Education Representative	October 1, 2019-September 30, 2021		
Sabrina Friedman, EdD, DNP, FNP- C, PMHCNS-BC, FAPA	Clinical Director UCLA School of Nursing Health Center at the Union Rescue Mission APRN Practice Representative	October 1, 2019-September 30, 2021		
Jeannine Graves, MPA, BSN, RN, OCN, CNOR	Clinical Coordinator, Oncology Programs Sutter Cancer Center RN Practice Representative-North	October 1, 2019-September 30, 2021		
Marketa Houskova, RN, BA, MAIA	Government Affairs Director Senior Policy Analyst Office Manager American Nurses Association/California	October 1, 2019-September 30, 2021		
Kathy Hughes	Executive Director SEIU Nurse Alliance of California	October 1, 2019-September 30, 2021		
Saskia Kim	Regulations Policy Specialist California Nurses Association Union Representative	October 1, 2019-September 30, 2021		
Kim Tomasi, MSN, RN	CEO Association of California Nurse Leaders (ACNL) Workforce/Practice Stakeholder Rep	October 1, 2019-September 30, 2021		

California Board of Registered Nursing

MEMBER	TITLE/ORGANIZATION	Appointment Term	PHONE	EMAIL
Sandra Miller, MBA	Vice President Assessment Technologies Institute- Nursing Education-Public Representative	October 1, 2019-September 30, 2021		
Robyn Nelson, PhD, MS, RN	Dean, College of Nursing West Coast University Educator Rep: Private BSN - South	October 1, 2019-September 30, 2021		
Stephanie Robinson, PhD in HEA, RN	Director of Nursing Fresno City College Educator Rep: Public ADN - Central	October 1, 2019-September 30, 2021		
Anette Smith Dohring	Sutter Health Care Sierra Region Manager, Workforce Development- North	October 1, 2019-September 30, 2021		
Hazel Torres, MN, RN	Director, Regional Professional Development and Research Ambulatory Care Services Kaiser Permanente-South	October 1, 2019-September 30, 2021		
Peter Zografos, PhD, RN	Director, School of Nursing Mt. San Jacinto College Educator: Public ADN - South	October 1, 2019-September 30, 2021		
Ex-officio-non voting Board of Registered Nursing staff; BRN Survey contractor		Not Applicable (N/A)		
Joseph Morris, PhD, MSN, RN	Executive Officer (EO) Board of Registered Nursing Ex-Officio Representative	N/A		

California Board of Registered Nursing

MEMBER	TITLE/ORGANIZATION	Appointment Term	PHONE	EMAIL
Evon Lenerd, MBA	Assistant Executive Officer (AEO) Board of Registered Nursing	N/A		
Thelma Harris, MSN, RN	Chief of Legislation/Regulation Board of Registered Nursing	N/A		
Badrieh Caraway, MSN, M.Ed.D, RN	Supervising NEC-Southern California Regions California Board of Registered Nursing-Ex officio member	N/A		
Janette Wackerly, MBA, RN	Supervising NEC – Northern- Central CA Regions Board of Registered Nursing Ex-Officio Representative	N/A		
Katie Daugherty, MN, RN	Nursing Education Consultant Board of Registered Nursing NEWAC NEC staff liaison	N/A		
Joanne Spetz, Ph.D.	Professor, Philip R. Lee Institute for Health Policy Studies, Center for the Health Professions – UCSF BRN Survey Contractor/Annual School and RN Workforce Surveys	N/A		



October 2019

Dear _____

Thank you for your willingness to serve as a volunteer for the Board of Registered Nursing's (BRN) *Nursing Education and Workforce Advisory Committee (NEWAC)*.

It is anticipated your content expertise and regular participation in NEWAC's work will contribute greatly to NEWAC's purpose/charge and provide an important point of view on nursing education, nursing workforce and nursing practice matters consistent with the Board's mission and strategic plan.

Your appointment to the NEWAC committee commences effective October 1, 2019 and ends September 30, 2021 unless renewed for an additional two years term. Typically, NEWAC members are expected to attend two or three meetings in each yearly cycle (October and then most commonly again in a cycle between February-June) in addition to responding occasionally to other informational requests by email in any given yearly cycle.

Members may participate by attending the meeting face to face or by attending remotely via teleconference at one of the locations as listed at the top of each NEWAC meeting agenda. If you plan to attend remotely, your request for remote site telephone access must be pre-arranged with BRN support staff well in advance of the meeting dates so all teleconference locations can be listed on the posted meeting agenda at least 10 days prior to the meeting.

If you are not able to serve the NEWAC appointment term listed in this letter, please let the Board's Executive Officer know in writing as soon as possible.

Again, thank you for volunteering to assist the Board in fulfilling its mission and strategic planning goals/outcomes in relation to nursing education, and nursing workforce/practice matters.

Please don't hesitate to contact me or the NEWAC Nursing Education Consultant staff liaison, Katie Daugherty at katie.daugherty@dca.ca.gov if you have any additional questions.

Best Regards,

**Joseph Morris, PhD, RN
Executive Officer
California Board of Registered Nursing
Joseph.morris@dca.ca.gov**

BOARD OF REGISTERED NURSING
Nursing Education & Workforce Advisory Committee
Agenda Item Summary

AGENDA ITEM: 3.2
DATE: October 28, 2019

ACTION REQUESTED: Organizational and Governance Matters-Discussion and Possible Action Regarding Identification of NEWAC Strategic Initiatives for 2019-2021

REQUESTED BY: Joseph Morris, PhD, RN, BRN Executive Officer

BACKGROUND: The NEWAC advisory group continuously identifies other relevant and trending nursing education, nursing workforce and nursing practice issues and concerns for future NEWAC meeting agendas that are not already part of committee agenda matters members are currently considering.

Some possible issues informally identified by NEWAC members include:

- Trend to develop NP residencies in specialties;
- Song Brown funding;
- Understanding the Health and Well-being of the Nursing Workforce

NEXT STEPS: Identify any needed edits to the proposed 2019 attached documents and approve today with the any suggested edits.

PERSON(S) TO CONTACT: Joseph Morris, PhD, RN
BRN Executive Officer

BOARD OF REGISTERED NURSING
Nursing Education & Workforce Advisory Committee
Agenda Item Summary

AGENDA ITEM: 3.3
DATE: October 28, 2019

ACTION REQUESTED: Discussion and Possible Action Setting 2019-2020 NEWAC Meeting Dates

REQUESTED BY: Dr. Joseph Morris, PhD, RN, BRN Executive Officer

BACKGROUND: NEWAC Advisory Committee process are being updated to:

- Be consistent with the Board of Registered Nursing current 2018-2021 Strategic Planning document accessible as a link in the 2019 Purposes document;
- Reflect the most recent changes in the Board's business processes, including advisory committee processes;
- Reflect advisory committee membership and nursing experts consistent with the nursing education and nursing workforce charge and purposes of the NEWAC committee;
- More clearly describe in writing NEWAC alignment with the Open Meeting Act requirements;
- Formalize in writing meeting dates, and meeting agenda and materials submission dates in advance of NEWAC meetings.

Suggested possible meeting dates for remainder of the 2019-2020 cycle:

- Wednesday, April 29, 2020; meeting agenda items due Wednesday, 4/1/2020; agenda item related materials due Friday, 4/10/2020.
- Wednesday, October 28, 2020; meeting agenda items due Friday, 10/2/2020; agenda item related materials due Friday, 10/9/2020.

NEXT STEPS: Identify any needed edits to the proposed 2019-2020 meeting dates and submission deadlines and approve with the suggested edits included.

PERSON(S) TO CONTACT: Joseph Morris, PhD, RN
BRN Executive Officer

BOARD OF REGISTERED NURSING
Nursing Education & Workforce Advisory Committee
Agenda Item Summary

AGENDA ITEM: 4.0

DATE: October 28, 2019

ACTION REQUESTED: Information Only: Report on BRN Annual School Survey 2017-2018 Key Findings by Dr. Joanne Spetz, University of California, San Francisco

REQUESTED BY: Dr. Joseph Morris, PhD, RN, BRN Executive Officer

BACKGROUND: The Board of Registered Nursing contracts with UCSF Phillip R. Lee Institute for Health Policy Studies to conduct the BRN's online Annual School Survey of Board approved pre-licensure and post licensure nursing education programs in California.

The most recent pre-licensure annual school survey report results can be accessed at <https://www.rn.ca.gov/pdfs/education/prelicensure17-18.pdf>

Joanne Spetz, PhD, UCSF Professor and BRN contractor for the Annual School Survey and the RN Workforce Survey is summarizing the key findings from the 2017-2018 Annual School report today. This includes findings related to clinical and simulation use in this reporting period. In the 2017-2018, annual school survey period an increased number of simulation related questions were added and asked for the first time. Please refer to pages 34-40 for the clinical placement results and pages 47-60 for program simulation related report results.

NEXT STEPS: Consider/use the 2017-2018 annual school survey findings in discussion and voting on agenda items at the 10.28.19 NEWAC meeting and subsequent NEWAC meetings as pertinent.

PERSON(S) TO CONTACT: Joseph Morris, PhD, RN
BRN Executive Officer

BOARD OF REGISTERED NURSING
Nursing Education & Workforce Advisory Committee
Agenda Item Summary

AGENDA ITEM: 5.0
DATE: October 28, 2019

ACTION REQUESTED: Simulation: Discussion and Possible Action Regarding Finalizing Draft Simulation Guidelines and Draft Program Assessment Form Including Review of Part 1 of Simulation Proposal, the Information Related to OSHPD Pilot Projects Applicability/Title 22 Regulations, and NEWAC Members Written Feedback, and Recommendations to the Education Licensing Committee to Recommend to the Board Adoption of the Simulation Guidelines and Program Assessment Form

REQUESTED BY: Dr. Joseph Morris, PhD, RN, BRN Executive Officer

BACKGROUND: Since 2017 NEWAC has been the Board's primary advisory body of constituent stakeholders interested and supportive of exploring the pros and cons of a possible increase in simulation use by California approved pre-licensure nursing education programs beyond what is currently allowed by CCR 1420 (e) and 1426 (g)(2).

A number of stakeholder groups have suggested increasing the amount of allowable simulation in California could be an important solution to favorably address the existing clinical placement/displacement challenges experienced by a number of these education programs throughout California. It is also important to note, increasing the amount of allowable simulation was also a stated outcome of the seven Nursing Summits held in Fall 2018.

At the February 19, 2019 NEWAC meeting, Dr. KT Waxman, a recognized simulation expert and lead for the NEWAC simulation workgroup, provided the updated report related to the written Simulation Proposal Parts #1 and #2 that the NEWAC group has been discussing at its meetings from 2017 to the present time.

Because the use of simulation and state board regulations regarding the use of simulation vary across the United States, NEWAC continues to gather data/evidence to determine what is the minimum amount of direct patient care clinical hours that should be in all pre-licensure nursing programs and clinical courses and what amount of clinical hours spent in simulation ensures graduates of California nursing programs are prepared for safe competent entry in to practice as a newly licensed registered nurse.

Toward this end, in 2017-2018 the BRN annual school survey simulation questions were expanded to begin to capture additional simulation related information that may potentially support changes in California simulation regulations in the future. Some of the questions listed below are part of the annual school survey and others listed questions are being asked by NEWAC and others in an effort to amass sufficient data/evidence in order to pursue a justifiable, documented need to change existing simulation related simulation regulations. These include:

- What faculty, physical space, and other resources do pre-licensure nursing programs consistently have available to complement clinical direct patient care experiences with other non-direct patient care clinically related instructional modalities such as faculty-led skills labs, simulation labs, and clinical computer labs?
- How much simulation/clinical hours per CCR 1420 (e) and CCR 1426 ((g) (2) is actually be used by programs year over year; results to date indicate in the aggregate, programs are not using the amount allowable for a variety of reasons;
- Are schools/programs increasing use of simulation to that allowed by current regulations; if not why not?
- What evidence-based simulation standards/guidelines are being used by programs;
- Is there uniformity in the simulation standards being used? If not, why not? Are the proposed NEWAC Simulation Guidelines an effective strategy to establish some level of uniformity across all programs to ensure high quality simulation standards are used in all BRN regulated content required nursing clinical courses and by all schools?
- What consistent faculty development resources are available to ensure initial and continued faculty competence and program specific orientation in simulation-based learning is actually being reported by California programs;

Other simulation related questions also being discussed in a variety of stakeholder meetings including NEWAC are:

- How “real” do simulation-based learning experiences need to be in order to adequately complement the real direct patient care experiences planned, implemented and evaluated by the nursing program faculty?
- What should be the minimum number of direct patient care hours all approved pre-licensure programs must include, irrespective of the other instructional methods used?
- How do simulation experiences compare with direct patient care experiences in student acquisition and demonstration or transfer/application of learning, clinical reasoning and decision making?
- What actions can be taken by programs now to increase use of direct patient care non-acute, ambulatory, and community-based setting on a routine bases across the curriculum and clinical courses?
- It is not clear why nursing programs wishing to increase use simulation beyond what is allowed by content required for licensure regulations don’t develop or use “other degree” clinical courses and opportunities to increase simulation use via elective courses and other non-content required for licensure clinical experiences(meaning CCR 1420 (e) and 1426 (g)(2) regulations do not apply).
- If California promulgates different regulations related to simulation-based learning, what should be included in the regulations to ensure high quality simulation-based learning experiences are consistent delivered by all programs in every content required for licensure nursing course using simulation as one of the instructional methodologies?
- What regulations/regulatory changes need to be included in any future regulatory changes pertaining to simulation use to avoid possible over-reliance on simulation?
- To what degree are all California nursing program’s effectively using available direct patient care experiences across all levels of patient care in acute, ambulatory and community based clinical practice settings with real patients and families? If not using all of these direct patient care learning opportunities, why not and what can be done as quickly as possible to support programs doing so?

At the February 19, 2019 meeting, NEWAC members requested more time to review the Simulation related Proposal Part #1 and Part #2 written Comments document included in the meeting materials. More time was requested for purposes of providing very specific deliberative and thoughtful feedback in relation to both the Simulation Proposal Part #1 Pilot Projects/Increased Simulation issues and Part #2 Proposed Simulation Guidelines documents.

Report on Simulation Proposed Part #1 Follow up activities and outcome as of October 28, 2019

As a follow up to the February 2019 NEWAC meeting members request, Dr. Morris discussed the possibility of using the OSHPD Pilot Projects mechanism to conduct pilot projects with staff. It was discovered that the statutes enabling OSHPD's Pilot Project regulations provide that pilot projects are limited to the following:

- (1) Expanded role medical auxiliaries.
- (2) Expanded role nursing.
- (3) Expanded role dental assistants, dental hygienists, dental hygienists in alternative practice, or dental hygienists in extended functions.
- (4) Maternal child care personnel.
- (5) Pharmacy personnel.
- (6) Mental health personnel.
- (7) Other health care personnel including, but not limited to, veterinary personnel, chiropractic personnel, podiatric personnel, geriatric care personnel, therapy personnel, and health care technicians.

(Health & Safety Code, § 128160, subd. (a).)

The proposed simulation pilot projects are not related to expanding the nursing role but are for training nurses in their current role.

Currently the BRN does not have the authority to approve simulation pilot projects in California pre-licensure nursing schools that exceed the simulation amount authorized by California Code of Regulations, Title 16, Section § 1426(g)(2). Absent the requisite authority, the Board may not approve pilot projects that do not comply with § 1426(g)(2). This means the BRN would need to seek statutory or regulatory changes to authorize any pilot projects that use simulation in an amount greater than that allowed by § 1426(g)(2).

For Simulation Proposal Part #2 Please review NEWAC members individually submitted comments related to the proposed Simulation Guidelines and Program Simulation Use Assessment form

The NEWAC simulation workgroup lead KT Waxman has been working on revising the proposed simulation guidelines document based on the detailed Comments document provided at the February 19, 2019 meeting. A draft of the revised proposed Simulation Guidelines document and the Proposed fillable Program Simulation Use Assessment form was sent to NEWAC members for review and suggested edits in July/August 2019 following revision to reflect suggested edits as described in the February 19, 2019 Comments document.

Included in today's meeting packet are copies of the NEWAC members comments about the most recent version of the Simulation Proposal Part #2 documents-Simulation Guidelines and Program Simulation Use Assessment form. All original document sets have been provided. It is anticipated that NEWAC may decide today, 10.28.19, whether to vote to accept the two proposed Simulation Guideline documents with today's suggested edits from members or vote at an upcoming meeting (April 2020) when the committee is able to review a final revised version of both documents with today's suggested edits included in each of the documents.

Additionally, it is planned that today, NEWAC will identify potential dates to move the NEWAC Simulation Guidelines and Assessment form forward to the BRN ELC and Board as an information only item. Ideally, no later than May/June 2020. These suggested timelines will make it possible to send an e-blast request for voluntary adoption and use to Deans and Directors in July 2020 so prelicensure nursing programs could potentially voluntarily adopt the two documents and begin using in Fall 2020.

NEXT STEPS: Identify any necessary follow-up and determine next steps

PERSON(S) TO CONTACT: Joseph Morris, PhD, RN
BRN Executive Officer

Barclays Official
**CALIFORNIA
CODE OF
REGULATIONS**

Title 22. Social Security

Division 7. Health Planning and Facility Construction

Division 8. Nondiscrimination in State-Supported Programs and Activities

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(f) If for any reason the study is not completed after the consultant and the Office sign the contract for the study, no part of the deposit for use by the Office to pay the consultant shall be refundable to the applicant until after the applicant requests the Office in writing to stop the study and the consultant agrees that no additional fees are owed to the consultant.

(g) If, after the study is completed, the final cost of the study by the consultant is less than the amount deposited by the applicant with the Office for that purpose, the Office shall refund the balance to the applicant.

NOTE: Authority cited: Sections 129015 and 127010, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 129048 and 129049, Health and Safety Code.

HISTORY

1. New section filed 3-19-2001; operative 4-18-2001 (Register 2001, No. 12).

Article 3. California Health Facilities Construction Loan Insurance Program—State Plan

NOTE: Authority cited: Sections 436.3, 436.4, and 446.2, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 436.3 and 436.4, Health and Safety Code.

HISTORY

1. Repealer of Article 3 (Sections 91501-91511, not consecutive) and renumbering of Article 7 (Sections 91545 and 91547) to Article 3 (Sections 91545 and 91547) filed 12-18-81; effective thirtieth day thereafter (Register 81, No. 51). For prior history, see Register 79, No. 25.
2. Amendment filed 12-18-81; effective thirtieth day thereafter (Register 81, No. 51).
3. Order of Repeal of Article 3 (Sections 91545 and 91547) filed 6-3-85 by OAL pursuant to Government Code Section 11349.7; effective thirtieth day thereafter (Register 85, No. 26).

Article 4. Defaults

NOTE: Authority cited: Sections 436.3 and 436.13, Health and Safety Code. Reference: Sections 436.2 and 436.9, Health and Safety Code, Statutes of 1973.

HISTORY

1. Repealer of Article 4 (Sections 91513-91531, not consecutive) filed 12-18-81; effective thirtieth day thereafter (Register 81, No. 51). For prior history, see Register 79, No. 25.

Article 5. Termination of Insurance

NOTE: Authority cited: Sections 436.3 and 436.23, Health and Safety Code. Reference: Sections 436.2 and 436.9, Health and Safety Code, Statutes of 1973.

HISTORY

1. Repealer of Article 5 (Sections 91533-91537, not consecutive) filed 12-18-81; effective thirtieth day thereafter (Register 81, No. 51). For prior history, see Register 79, No. 25.

Article 6. Health Facility Construction Loan Insurance Fund

NOTE: Authority cited: Sections 436.3 and 436.26, Health and Safety Code. Reference: Sections 436.2 and 436.9, Health and Safety Code, Statutes of 1973.

HISTORY

1. Repealer of Article 6 (Sections 91539-91543, not consecutive) filed 12-18-81; effective thirtieth day thereafter (Register 81, No. 51). For prior history, see Register 79, No. 25.

Article 7. California Health Facilities Construction Loan Insurance Program—State Plan

NOTE: Authority cited: Sections 436.3 and 436.4, Health and Safety Code. Reference: Sections 436.2 and 436.9, Health and Safety Code, Statutes of 1973.

HISTORY

1. Renumbering of Article 7 (Sections 91545 and 91547) to Article 3 (Sections 91545 and 91547) filed 12-18-81; effective thirtieth day thereafter (Register 81, No. 51). For prior history, see Register 79, No. 25.

Chapter 6. Health Workforce Pilot Project Program

Article 1. Definitions

§ 92001. Deputy Director.

Deputy Director means the Deputy Director of the Healthcare Workforce and Community Development Division of the Office of Statewide Health Planning and Development.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. New Chapter 6 (Articles 1-7, Sections 92001-92604, not consecutive) filed 2-13-80; effective thirtieth day thereafter (Register 80, No. 7).
2. Repealer and new section filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
3. Change without regulatory effect amending chapter heading, section heading, section and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92002. Clinical Phase.

"Clinical Phase" means instructor supervised experience with patient during which the trainee applies knowledge presented by an instructor.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Repealer and new section filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92003. Didactic Phase.

"Didactic Phase" means an organized body of knowledge presented by an instructor.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Repealer and new section filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92004. Employment/Utilization Phase.

"Employment/Utilization Phase" means ongoing application of didactic and clinical knowledge and skills in an employment setting under the supervision of the supervisor.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128180, Health and Safety Code.

HISTORY

1. Amendment of NOTE filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92005. Employment/Utilization Site.

"Employment/Utilization Site" means health facility or any clinical setting where health care services are provided.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128135 and 128180, Health and Safety Code.

HISTORY

1. Amendment of NOTE filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).

2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92006. Instructor.

"Instructor" means a person certified or licensed in California to practice or teach the knowledge or skills, or both, the trainee is to learn.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92007. Program.

"Program" means the Health Workforce Pilot Project Program administered by the Office of Statewide Health Planning and Development.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending section and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92008. Program Staff.

"Program Staff" means the staff of the Office of Statewide Health Planning and Development with responsibility for the Health Workforce Pilot Projects.

NOTE: Authority cited: Sections 127010 and 128165, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128165, Health and Safety Code.

HISTORY

1. Repealer and new section filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending section and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92009. Project.

"Project" means a Health Workforce Pilot Project approved by the Director.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Repealer and new section filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending section and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92010. Project Director.

"Project Director" means the individual designated by the sponsor to have responsibilities for the conduct of the project staff, instructors, supervisors, and trainees.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Repealer and new section filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92011. Sponsor.

"Sponsor" means a community hospital or clinic, nonprofit educational institution, or governmental agency engaged in health or educational activities.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128135, Health and Safety Code.

HISTORY

1. Repealer and new section filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending section filed 11-16-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 47).
3. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92012. Training Program.

"Training Program" means an organized educational program that includes at least a didactic phase, clinical phase, and usually an employment/utilization phase. All or portions of the didactic and clinical phases may be concurrent.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Repealer and new section filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92013. Training Program.

NOTE: Authority cited: Section 429.76, Health and Safety Code. Reference: Section 429.71, Health and Safety Code.

HISTORY

1. Repealer filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).

Article 2. Minimum Standards

§ 92101. Minimum Standards.

Each pilot project shall:

- (a) Provide for patient safety.
- (b) Provide qualified instructors to prepare trainees.
- (c) Assure that trainees have achieved a minimal level of competence before they entered the employment/utilization phase.
- (d) Inform trainees that there is no assurance of a future change in law or regulations to legalize their role.
- (e) Demonstrate that the project has sufficient staff to monitor trainee performance and to monitor trainee supervision during the employment/utilization phase.
- (f) Possess the potential for developing new or alternative roles for health care personnel or for developing a reallocation of health care tasks, which would improve the effectiveness of health care delivery systems.
- (g) Demonstrate the feasibility of achieving the project objectives.
- (h) Comply with the requirements of the Health Workforce Pilot Projects statute and regulations.

(i) Comply with at least one of the eligibility criteria provided in Sections 128130, 128135, and 128160 of Article 1, Chapter 3, Part 3, Division 107, of the Health and Safety Code.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128165, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending subsections (h) and (i) and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

Article 3. Application Procedure

§ 92201. Application Forms.

(a) The application forms and a copy of the Health Workforce Pilot Project statute and regulations shall be obtained from program staff. The forms shall be filled out completely.

- (b) The sponsor and project director shall certify in writing that they:
 - (1) Will not discriminate on the basis of age, sex, creed, disability, race, or ethnic origin.
 - (2) Will comply with the requirements of the Health Workforce Pilot Project statute and regulations.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending subsections (a) and (b)(2) and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92202. Application Instructions.

The application instructions shall include, but not be limited to, the following:

- (a) Number of copies of completed applications to be submitted to the program.
- (b) Name, address and telephone number of person to whom the completed applications are to be submitted.
- (c) The time period for submission, when applicable.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Amendment of NOTE filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

Article 4. Content of Application

§ 92301. Abstract.

An abstract shall be submitted with each application. This provides a brief description of the information included in the proposal's narrative.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Amendment of NOTE filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92302. Purpose and Objectives.

These brief statements describe:

- (a) The purpose(s) of the project.
- (b) The objectives to meet the purpose(s).
- (c) The time plan for accomplishing the objectives.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Amendment of NOTE filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92303. Background Information.

Background information shall include, but not be limited to the following:

- (a) Documentation of the need for this project.
- (b) A description of the types of patients or clients likely to be seen or treated.
- (c) A description of the skills trainees are to learn.
- (d) An identification of existing laws or regulations, or both, that, in the absence of Health Workforce Pilot Project statute Section 128125, et seq., of the Health and Safety Code, would prevent the preparation and utilization of trainees as proposed in this project.
- (e) A description of employment opportunities for trainees after the project terminates.
- (f) An identification of other educational programs or groups conducting similar projects.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128165, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending subsection (d) and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92304. Sponsor Information.

Sponsor information shall include, but not be limited to the following:

- (a) A description of the sponsor, including a copy of an organizational chart that identifies the project's relationship to the sponsor.
- (b) A copy of a document verifying the sponsor's status as a community hospital or clinic, or non-profit educational institution.
- (c) A description of functions of the project director, instructors and other project staff.
- (d) A description of funding source(s) for the project.
- (e) A description of sponsor's previous experience in preparing health care workers.

(f) A description of the composition and functions of an advisory group if one currently exists or will be developed to advise the project.

(g) An identification of collaborative arrangements with other educational institutions and/or health care facilities, or both.

(h) A description and location of facilities used in the didactic and clinical phases. This shall include the availability of support services such as library, equipment, etc.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128135 and 128155, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending subsection (b) and NOTE filed 11-16-92 pursuant to section 100, title 1, California Code of Regulations (Register 92, No. 47).
3. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92305. Participant Selection Information.

Participant selection information shall include at least the following:

- (a) Trainee Information.
 - (1) Criteria used to select trainees.
 - (2) Plan to inform trainees of their responsibilities and limitations under the Health Workforce Pilot Project statute and regulation.
 - (3) Number of proposed trainees.
- (b) Supervisor Information.
 - (1) Criteria used to select supervisors.
 - (2) Plan to orient supervisors to their roles and responsibilities.
 - (3) Number of proposed supervisors.
- (c) Employment/Utilization Site Information.
 - (1) Criteria used to select an employment/utilization site.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128180, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending subsection (a)(2) and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92306. Curriculum.

The curriculum plan shall include, but not be limited to the following:

- (a) A description of the minimum level of competence the trainee shall achieve before entering the employment/utilization phase of the project.
- (b) A description of the content required to meet this minimal competency.
- (c) A description of the methodology utilized in the didactic and clinical phases.
- (d) A description of the evaluation process used to determine when trainees have achieved the minimum level of competence.

(e) An identification in hours and months of the time required to complete the didactic and clinical phases.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128180, Health and Safety Code.

HISTORY

1. Amendment of NOTE filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92307. Evaluation.

The evaluation plan shall include, but not be limited to the following:

(a) A description of the baseline data and information collected about the availability or provision of health care delivery, or both, prior to utilization of trainee. The actual baseline data shall be collected and submitted in writing to the program within six (6) months after the project is initially approved.

(b) A description of baseline data and information to be collected about trainee performance, acceptance, and cost effectiveness.

(c) A description of the methodology to be used in collecting and analyzing the data about trainee performance, acceptance, and cost effectiveness.

(d) The data required in (b) and (c) shall be submitted in writing to the program at least annually or as requested by program staff.

(e) The evaluation plan shall include provision for reviewing and modifying the project's objectives and methodology at least annually. Results of this evaluation and project modification shall be reported to program staff in writing.

(f) The evaluation plan shall include provision for retaining for two (2) years after completion of the pilot project all raw data about trainees and the implementation of the project.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128165, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92308. Monitoring.

The monitoring plan shall include, but not be limited to the following:

(a) A description of the provisions for protecting patients' safety.

(b) A description of the methodology used by the project director and project staff to provide at least quarterly monitoring of the following:

- (1) Trainee competency.
- (2) Supervisor fulfillment of role and responsibilities.
- (3) Employment/utilization site compliance with selection criteria.

(c) Acknowledgement that project staff or their designee shall visit each employment/utilization site at least semi-annually.

(d) The monitoring plan shall also identify a methodology for reporting information to program staff.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128180, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92309. Informed Consent.

The plan used to obtain prior informed consent from patients to be treated by trainees or those legally able to give informed consent for the patients shall be described. It shall include, but not be limited to the following:

(a) A description of the content of the informed consent.

(1) Explanation of the role and status of the trainee, including the ready availability of the trainee's supervisor for consultation.

(2) Assurance that the patient can refuse care from a trainee without penalty for such a request.

(3) Identification that consenting to treatment by a trainee does not constitute assumption of risk by the patient.

(b) Provision that the content of the informed consent, either written or oral, shall be provided in a language in which the patient is fluent.

(c) Documentation in the patient record that informed consent has been obtained prior to providing care to the patient.

(d) Provision for obtaining witnesses to informed consent. Written informed consent must be witnessed. Oral informed consent obtained by the trainee shall have a third party document in writing that he/she has witnessed the oral consent.

(e) Informed consent need be obtained only for those tasks, services, or functions to be provided as a pilot project trainee.

(f) A copy of the language of the informed consent shall be included in the application.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128150 and 128155, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92310. Costs.

A plan for determining estimated or projected costs shall include, but not be limited to the following:

(a) An identification of the average cost of preparing a trainee. This shall include cost information related to instruction, instructional materials and equipment, space for conducting didactic and clinical phases, and other pertinent costs.

(b) An identification of the average cost per patient visit for similar care rendered by a current provider of care.

(c) An identification of predicted average cost per patient visit for the care rendered by a trainee.

(d) Specific information relative to these estimated or projected costs shall be provided to program staff at the time of annual renewal or as otherwise requested.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128165, Health and Safety Code.

HISTORY

1. Amendment of NOTE filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92311. Trainee Information.

A plan to provide information to program staff regarding trainees in the employment/utilization phase shall be described. It shall include, but not be limited to the following:

(a) Name, work address and telephone number of the trainee.

(b) Name, work address and telephone number and license number of the supervisor.

(c) This information shall be submitted in writing to program staff within five (5) days of the date trainee enters the employment/utilization phase.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128180, Health and Safety Code.

HISTORY

1. Amendment of NOTE filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92312. Modifications.

Any modifications or additions to an approved project shall be submitted in writing to program staff. Modifications include, but are not limited to the following:

(a) Changes in the scope or nature of the project.

(b) Changes in selection criteria for trainees, supervisors, or employment/utilization sites.

(c) Changes in project staff or instructors.

(1) This change will not require prior approval by program staff, but shall be reported to program staff within two (2) weeks after the change occurs.

(2) Curriculum vitae are required on all project staff and instructors.

(d) All other modifications require program staff approval prior to implementation.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92313. Legal Liability.

Sponsors and other participants are advised to ascertain the legal liability they assume when participating in a pilot project.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128145 and 128155, Health and Safety Code.

HISTORY

1. Amendment of NOTE filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

Article 5. Application Review Process

§ 92401. Review Process for New Applications.

The review process of a completed application shall include, but not be limited to the following:

(a) An initial review conducted by program staff to determine the appropriateness and completeness of the application.

(b) Review and comment by technical consultant(s) selected by program staff for review and comment within forty-five (45) calendar days from the date on which the application was distributed for review.

(c) Review and comment by appropriate Healing Arts Boards and professional associations within forty-five (45) calendar days from the date on which the application was distributed for review.

(d) An abstract of the application shall be made available to any interested party upon request.

(e) A complete application shall be available for review in program offices during normal working hours.

(f) A public meeting shall be scheduled on a date that is no sooner than forty-five (45) calendar days from the date on which the applications were distributed for review to discuss the application and comments of consultants, reviewers, healing arts boards, professional associations, and other interested parties with the applicant.

(g) Review for state agency applications shall be as noted in this section with the additional procedure of Section 128175 of the Health and Safety Code.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128135, 128155 and 128175, Health and Safety Code.

HISTORY

1. Amendment filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending subsection (g) and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92402. Review for State Agency Application.

NOTE: Authority cited: Section 429.76, Health and Safety Code. Reference: Section 429.80, Health and Safety Code.

HISTORY

1. Repealer filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).

Article 6. Project Approval

§ 92501. Initial Approval.

(a) The Director has the exclusive authority to grant approval or deny approval to a pilot project applicant.

(b) Approval may be for one year or less or until the project is completed, whichever is sooner.

(c) The Director's decision shall be transmitted in writing to the applicant with copies to interested parties.

(d) A sponsor whose project has been denied may resubmit a modified application after a sixty (60) day waiting period.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128135, Health and Safety Code.

HISTORY

1. Repealer of Article 6 (Sections 92501-92504) and new Article 6 (Section 92501) filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

Article 7. Program Responsibilities

§ 92601. Records.

The program shall maintain the following records:

(a) A copy of the application, related documents and evaluation data on all projects for a minimum of three (3) years after termination of a project. These shall be available for public review in the program office during regular working hours.

(b) A list of all trainees who are in the employment/utilization phase. This shall be updated at least semi-annually by the sponsors except as provided for in Section 92311(c).

(c) Information about project applications, approved projects and the status of trainees who are in the employment/utilization phase shall be provided to appropriate State regulatory bodies.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128165, Health and Safety Code.

HISTORY

1. Repealer of Article 7 (Sections 92601-92604) and new Article 7 (Sections 92601-92604) filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92602. Project Evaluation.

The evaluation of approved projects shall include, but not be limited to, the following:

(a) Written information shall be requested periodically by program staff to ascertain the progress of the project in meeting its stated objectives and in complying with program statutes and regulations.

(b) Periodic site visits shall be conducted to project offices, locations, or both, where trainees are being prepared or utilized as noted in Section 128165.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128125 and 128165, Health and Safety Code.

HISTORY

1. Change without regulatory effect amending subsection (b) and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92603. Site Visits.

Site visits shall include at least the following:

(a) Determination that adequate patient safeguards are being utilized.

(b) Validation that the project is complying with the approved or amended application.

(c) Interviews with project participants and recipients of care.

(d) An interdisciplinary team composed of representatives of the healing arts boards, professional organizations, and other State regulatory bo-

dies shall be invited to participate in a site visit. They will receive at least fourteen (14) calendar days written notice.

(e) Written notification of the date, purpose, and principal members of the site visit team shall be sent to the project director at least fourteen (14) calendar days prior to the date of the site visit.

(f) Plans to interview trainees, supervisors and patients or to review patient records shall be made in advance through the project director.

(g) Site visits by program staff may be scheduled, after consultation with the project sponsor or director, on less than twenty-four (24) hours notice when questions of patient or trainee safety necessitate.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128125 and 128165, Health and Safety Code.

HISTORY

1. Editorial correction of Reference cite (Register 95, No. 25).
2. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92604. Continuing Approval.

(a) Continuing approval shall be contingent upon review of written information submitted by the project of the project's progress in meeting stated objectives and its compliance with plans described in the approval or amended application.

(b) Approval may be granted for periods of time up to one year as determined by the Director.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128155 and 128180, Health and Safety Code.

HISTORY

1. Change without regulatory effect amending NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

Article 8. Project Completion/Termination

§ 92701. Completion of Project.

(a) An approved project shall indicate its intention in writing to discontinue its status as a Health Workforce Pilot Project.

(b) A closing report shall be submitted. This report shall include at least the following:

- (1) The reasons for discontinuation as a pilot project.
- (2) A summary of pilot project activities including the number of persons who entered the employment/utilization phase.
- (3) A description of the plan to inform trainees of the project's discontinuation, and that they are precluded from performing the skills authorized under the pilot project after discontinuation unless the role has been legalized.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Section 128155, Health and Safety Code.

HISTORY

1. New Article 8 (Sections 92701 and 92702) filed 7-29-83; effective thirtieth day thereafter (Register 83, No. 31).
2. Change without regulatory effect amending subsection (a) and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

§ 92702. Termination of Project.

A pilot project may be terminated during the term of approval in the following way:

(a) In the event of a general or non-critical failure to comply with the program's statute, regulations or conditions of the approved application, a written notice of intent to terminate, stating with specificity the reasons for the intended termination, shall be served on the project director and sponsor thirty (30) calendar days before the termination is to become effective.

(1) If a project director or sponsor desires to protest the termination, that director or sponsor shall, within seven (7) calendar days after service of notice of intent to terminate, serve upon the program, written notice

requesting that an informal conference be scheduled to review the matter with the Deputy Director.

(2) The Deputy Director, or designee, shall hold, within fourteen (14) calendar days from the service of the request, an informal conference.

(A) The project director or sponsor shall have the right to be represented by legal counsel and to present oral or written evidence or other information in its behalf at the informal conference.

(B) The representatives of the program shall attend the conference and present evidence or information, oral or written, in substantiation of the recommended termination.

1. The conference shall be a simple, informal proceeding and shall not be conducted in the manner of a judicial hearing or as a hearing under the Administrative Procedure Act (Chapter 5, commencing with Section 11500 of Part 1 of Division 3 of the Government Code), and need not be conducted according to technical rules relating to evidence and witnesses.

2. Neither the project director, sponsor, nor the program, shall have the right to subpoena any witnesses to attend the conference, or to formally cross-examine any person testifying at the conference. However, the project director or sponsor and the program may present any witnesses on their behalf at the conference.

(C) Within three (3) calendar days of the conclusion of the informal conference the Deputy Director shall either recommend the termination or withdraw the notice of intent to terminate. The Deputy Director shall state the decision in writing and shall immediately transmit a copy of the decision to the project director or sponsor.

(D) If the project director or sponsor desires to contest the decision made after the informal conference, that director or sponsor shall serve written notice on the Deputy Director within seven (7) calendar days after service of the decision of the informal conference.

(E) If the project director or sponsor fails to notify the Deputy Director of the intention to contest the decision of the informal conference within the specified time, the decision by the Deputy Director shall be deemed a final order of the Director and shall not be subject to further administrative review.

(F) Upon notifying the Deputy Director, in writing, of the intention to contest the decision of the informal conference the project director or sponsor shall, within seven (7) calendar days of the service of the decision of informal conference, serve upon the Director and the program a memorandum or brief which sets forth, with particularity, the specific grounds for contesting the decision and the support for these grounds.

(G) Within seven (7) calendar days of the service of the project director's or sponsor's memorandum or brief, the program may serve a memorandum or brief containing its arguments in support of the decision of the informal conference on the Director and the project director or sponsor.

(H) Within seven (7) calendar days from the service of the program's arguments, the project director or sponsor may serve a reply memorandum or brief containing its arguments to the program's position of the Director and the program. The project director or sponsor shall notify the Director in writing within seven (7) calendar days from the service of the program's memorandum or brief, if no reply will be filed.

(I) The Director shall, within seven (7) calendar days from the service of the project director's or sponsor's counter arguments, or within seven (7) calendar days from the service of the notice that no reply brief will be filed, render a decision to either terminate the project or to withdraw the notice of intent to terminate. The decision shall be in writing and shall state the reasons for the decision. The decision shall be immediately transmitted to the project director or sponsor. This decision shall be deemed a final order of the Director and shall not be subject to further administrative review.

(b) In the event of non-compliance with the program's statute, regulations, or conditions of the approved application, which constitute a threat to patient health or safety, project approval shall be immediately suspended. Notice of suspension, together with a notice of intent to terminate project approval, shall be provided the project director or sponsor. Notice of the suspension and of the intent to terminate may be given in

writing and must state, with particularity, the reasons for the suspension and the intended termination; or notice may be given orally, but must be followed within seven (7) calendar days, by a written notice which states, with particularity, the reasons for the suspension and the intended termination. A threat to patient health or safety occurs when the physical or mental well-being of a patient is in jeopardy from continued performance by the pilot project trainee(s).

(1) If the project director or sponsor desires to protest the suspension or intended termination, that director or sponsor shall, within seven (7) calendar days after service of the written notice, serve upon the program written notice requesting that an informal conference be scheduled to review the matter with the Deputy Director.

(2) The Deputy Director, or designee, shall hold an informal conference within fourteen (14) calendar days after service of the project director's or sponsor's request.

(3) The conference and appeals procedure shall be identical to the procedure established in Subsections 92702(a)(2)(A) through (I) of Title 22, of the California Administrative Code, except that these provisions shall also apply:

(A) If the decision of the informal conference is that there is no basis for the termination of the project approval, the Deputy Director's written decision shall contain, in addition to the reasons for the decision, an order lifting the suspension of project approval and withdrawing the notice of intent to terminate project approval.

(B) If the decision of the Director is that there is no basis for the termination of project approval, the Director's written decision shall contain, in addition to the reasons for the decision, an order lifting the suspension of project approval and withdrawing the notice of intent to terminate project approval.

(C) If the project director or sponsor fails to protest, in writing, the suspension or the intended termination within seven (7) calendar days after service of the written notice of suspension or intended termination, the Deputy Director shall order the termination of the project approval and shall serve upon the director or sponsor a notice stating that project approval has been terminated and stating the reasons for the termination. The decision by the Deputy Director shall be deemed a final order of the Director and shall not be subject to further administrative review.

(D) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination on the merits provided. However, the temporary suspension shall be deemed vacated if the Director fails to make a final determination on the merits within seventy (70) days after the original hearing has been completed.

(c) All appropriate regulatory bodies shall be immediately informed in writing when procedure to terminate has been instituted by program staff.

(d) Program staff shall notify the project's trainees and trainee's supervising professional(s), in writing, of the suspension of the project and the outcome of any hearing relative to that suspension.

(e) Trainees are precluded from performing the skills authorized under the pilot project when a project is suspended or terminated.

NOTE: Authority cited: Sections 127010 and 128155, Health and Safety Code; and Section 11152, Government Code. Reference: Sections 128125, 128140 and 128155, Health and Safety Code.

HISTORY

1. Editorial correction of subsection (b)(3) filed 9-23-83 (Register 83, No. 39).
2. Change without regulatory effect amending section and NOTE filed 2-28-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 9).

Chapter 7. Seismic Structural Safety Standards

Article 1. General Provisions

§ 94001. Purpose.

NOTE: Authority cited: Sections 446.3 and 15020, Health and Safety Code. Reference: Sections 15000-15023, Division 12.5, Health and Safety Code.

HISTORY

1. New Chapter 7 (Sections 94001-94134, not consecutive) filed 10-11-79; effective thirtieth day thereafter (Register 79, No. 41).
2. Change without regulatory effect repealing chapter 7 (articles 1-16, sections 94001-94602), article 1 (sections 94001-94009) and section, filed 4-8-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 15).

§ 94003. Scope.

NOTE: Authority cited: Sections 446.3 and 15020, Health and Safety Code. Reference: Sections 15000-15023, Division 12.5, Health and Safety Code.

HISTORY

1. Change without regulatory effect repealing section, filed 4-8-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 15).

§ 94005. Authority.

NOTE: Authority cited: Sections 446.3 and 15020, Health and Safety Code. Reference: Sections 15000-15023, Division 12.5, Health and Safety Code.

HISTORY

1. Change without regulatory effect repealing section, filed 4-8-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 15).

§ 94007. Interpretation.

NOTE: Authority cited: Sections 446.3 and 15020, Health and Safety Code. Reference: Sections 15000-15023, Division 12.5, Health and Safety Code.

HISTORY

1. Change without regulatory effect repealing section, filed 4-8-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 15).

§ 94009. Application of Regulations.

NOTE: Authority cited: Sections 446.3 and 15020, Health and Safety Code. Reference: Sections 15000-15023, Division 12.5, Health and Safety Code.

HISTORY

1. Change without regulatory effect repealing section, filed 4-8-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 15).

Article 2. Definitions

§ 94011. Approved Drawings and Specifications.

NOTE: Authority cited: Sections 446.3 and 15020, Health and Safety Code. Reference: Sections 15000-15023, Division 12.5, Health and Safety Code.

HISTORY

1. Change without regulatory effect repealing article 2 (sections 94011-94033) and section, filed 4-8-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 15).

§ 94013. Building.

NOTE: Authority cited: Sections 446.3 and 15020, Health and Safety Code. Reference: Sections 15000-15023, Division 12.5, Health and Safety Code.

HISTORY

1. Change without regulatory effect repealing section, filed 4-8-96 pursuant to section 100, title 1, California Code of Regulations (Register 96, No. 15).

§ 94015. Building Safety Board.

NOTE: Authority cited: Sections 446.3 and 15020, Health and Safety Code. Reference: Sections 15000-15023, Division 12.5, Health and Safety Code.

NEWAC Simulation Workgroup’s response to the February 2019 SEIU and CNA letters distributed at the February 2019 NEWAC meeting

Service Employees International Union (SEIU) Issues	Response from the NEWAC Simulation Workgroup Review
<p>They (pre-licensure programs) don’t use_25% now is due to lack of funding to provide the space, qualified faculty and equipment needed.</p>	<p>Simulation does not have to involve expensive equipment. Simulation modalities include:</p> <ul style="list-style-type: none"> • Skills labs • Low-fidelity simulation (such as, but not limited to, task-trainers, mid-level mannequins, role play) • High-fidelity simulation (such as, but not limited to, high-fidelity simulators, standardized participants)
<p>We also believe that the fact that private schools can and do offer financial incentives to hospitals to gain clinical placement favor needs to be addressed</p>	<p>This is outside the scope of NEWAC Simulation Work Group.</p>
<p>Additionally, not having a true path from ADN to BSN education and nursing programs is problematic when hospitals favor one over another when deciding which programs they offer clinical rotations to.</p>	<p>This is outside the scope of NEWAC Simulation Work Group.</p>
<p>There is no affordable or timely avenue for nurses in an ADN program or nurses with a current ADN degree to achieve a BSN when they are often working full-time and may have families or other priorities that impedes them from continuing their education. Looking at dual enrollment opportunities or other ways colleges and universities coordinate programs for a more seamless transition from ADN to BSN needs to be a priority.</p>	<p>This is outside the scope of NEWAC Simulation Work Group.</p>
<p>Having guidelines for simulation that all schools follow is another priority for us, especially when schools are proposing to increase the amount of simulation/in-direct patient care allowed. If there are not universal guidelines in place, that are enforceable by the BRN, it will be difficult to ensure that our nursing students are still receiving the training and education needed to be safe when out in the field and provide competent care upon graduation when going into independent nursing practice.</p>	<p>Agree that guidelines are needed. In the 2/19/19 NEWAC Committee, the proposed CSA/NCSBN Simulation Guidelines were accepted and will be forwarded to the Education and Licensing Committee.</p>

NEWAC Simulation Workgroup’s response to the February 2019 SEIU and CNA letters distributed at the February 2019 NEWAC meeting

<p>California Nurses Association (CNA) and National Nurses United (NNU) Issues</p>	<p>Response from the NEWAC</p>
<p>CNA believes it is important that NEWAC members and the Board of Registered Nursing (BRN) be made aware that the California Simulation Alliance-which has put forth the Report's two recommendations to be considered by NEWAC and which has also endorsed increasing the use of simulation to 50%-has promoted the use of kick-backs from the simulation industry to support its program and recommends this questionable practice to other simulation alliances.</p> <p>Furthermore, the Report contains a link to the website of the International Nursing Association for Clinical Simulation and Learning (INACSL) and its map identifying those states that allow 50% simulation in nursing education. It is worth nothing that INACSL identifies two businesses as its sponsors---one that sells simulation equipment and the other that sells Virtual Clinical Scenarios?</p>	<p>This is an incorrect characterization of the relationship. The relationship with the simulation industry vendors is to help support our educational programs and are not kick-backs.</p> <p>The legal definition of a kickback, according to Cornell Law School is, “a term used to refer to a misappropriation of funds that enriches a person of power or influence who uses the power or influence to make a different individual, organization, or company richer. Often, kickbacks result from a corrupt bidding scheme. Through corrupt bidding, the official can award the contract to a company, even though the company did not place the lowest bid. The company profits by having been awarded the bid and getting to perform the contract. In exchange for this corrupt practice, the company pays the official a portion of the profits. This portion is the “kickback.”</p> <p>Such a practice falls within a sphere of practices often referred to as “anti-competitive practices.” Organized crime has been traced using kickbacks for many years. Some also consider kickbacks to be a type of bribery.” https://www.law.cornell.edu/wex/kickbacks</p>
<p>CNA is opposed to the substitution of <i>clinical/earning with actual patients</i> for learning in a high-fidelity simulation laboratory beyond what is currently allowed.</p> <p>The most sophisticated mannequin cannot replicate the human response to nursing care or indicate the subtle changes that can occur during the course of an illness. It cannot replace mentored, experiential time with patients in the actual environment of care. Students should be educated with skills and critical thinking ability rather than simply trained in tasks. The observations made and knowledge acquired during clinical training is the beginning of a vast amount of experiential learning that is going to be</p>	<p>Agree that the mannequin cannot replicate all responses.</p> <p>Simulation methodology, which is a form of experiential learning, does teach learners the practice of nursing. Skills such as communication, problem-solving and critical thinking can be taught in a safe environment where mistakes can be made, and students can learn from. Much of the learning occurs in debriefing where the students reflect on their actions and performance in a non-threatening, safe environment. Tasks are primarily taught in skills lab. Protection of the public</p>

NEWAC Simulation Workgroup’s response to the February 2019 SEIU and CNA letters distributed at the February 2019 NEWAC meeting

<p>needed to provide safe and effective direct care to patients in hospitals, clinics, and in community settings. Protection of the public requires direct patient care experience.</p>	<p>includes allowing students to make mistakes on a mannequin rather than a human being.</p>
<p>California Nurses Association (CNA) and National Nurses United (NNU) Issues</p>	<p>Response from the NEWAC</p>
<p>Also, as proposed, the report before NEWAC to utilize an out-of-state school for a simulation study in order to gather data beyond the National Council of State Boards of Nursing (NCSBN) study would suffer limitations similar to those of the NCSBN.</p>	<p>Any research study has strengths and limitations. Just because a study has limitations does not necessarily negate the validity of the study. Replication studies are time consuming and resource intensive. Therefore, we do not recommend replicating the study but rather accept the study results as they are presented in a peer-review publication in light of the limitations.</p>
<p>Not unlike the bias that is suggested in the NCSBN study, the BRN is also faced with a proposal supported by NEW AC members whose bias in favor of replacing direct care clinical learning with simulation mannequins is apparent as noted above. Simulation training certainly reduces the number of clinical educators that will be required since clinical supervision and education of nursing student is the most labor-intensive part of nursing education. You can crowd 60 students in a classroom for didactic instruction and supplement it with online learning for an unlimited number of students. However, clinical education in direct care requires a safe ratio of faculty clinical instructors to nursing students.</p>	<p>Simulation training does not reduce the number of clinical educators that will be required; in fact, simulation has been known to increase jobs for educators (American Nurse Today, 2018). https://www.americannursetoday.com/nursing-specialties-on-the-cutting-edge/</p> <p>The guidelines will help support safe ratios in simulation as they are based on the International Nursing Association for Clinical Simulation and Learning (INACSL) Standards.</p>
<p>CNA also has concerns with the costs of simulation programs which can be steep and even cost prohibitive, particularly for public nursing programs. One high fidelity mannequin, Sim Man 3G, costs roughly \$27,000, but can cost up to \$60,000 with additional accessories and programs available for download onto the mannequin.⁴ That does not even take into consideration the ongoing labor costs associated with maintenance and trouble-shooting of the simulation lab mannequins or the cost of educating faculty on the use of the simulation technology. An INACSL member of the board of directors proudly touts her school's newly opened 13,000 square foot high tech simulation center in the new \$50 million state-of-the-art nursing school.⁵ The choice between funding</p>	<p>Simulation does not have to involve expensive equipment. Simulation modalities include e.g.,:</p> <ul style="list-style-type: none"> • Skills labs • Low-fidelity simulation (such as, but not limited to, task trainers, mid-level mannequins, role play) • High-fidelity simulation (such as, but not limited to, high-fidelity simulators and standardized participants) <p>Maintenance costs can be off-set by hiring a qualified simulation technician to assist faculty/educators.</p>

NEWAC Simulation Workgroup’s response to the February 2019 SEIU and CNA letters distributed at the February 2019 NEWAC meeting

<p>the public education of nursing students and the funding of high technology teaching tools is one that schools must make but the <i>substitution of high technology simulation for clinical time providing direct care</i> is a public policy decision.</p>	<p>How educational organizations find funding for their programs is outside the scope of NEWAC.</p> <p>Simulation is already granted through regulation and so the public policy decision has already been made.</p>
<p>CNA firmly believes that clinical faculty involvement in direct patient care clinical learning for nursing students cannot be replaced by technology. It does not matter whether you are a student in an associate degree program, baccalaureate program, or an entry level masters program, the minimum clinical experience required by the BRN is the same. <i>The BRN standards for patient care clinical learning should not be altered.</i> There is nothing that prevents a school from increasing the time its students have with simulation mannequins if the school believes the time spent has value for its nursing students. But, the replacement of minimum clinical hours with patients with increased simulation time is an action that threatens safe patient care by increasing the risk of decreased competency and is one that CNA will vigorously oppose.</p>	<p>There is no evidence to suggest that simulation has a negative effect or poses a risk to public safety.</p>
<p>Finally, we would be remiss in not noting for the record the objections CNA has made to the private meetings of the NEWAC Simulation Work Group despite the clear instruction from Department of Consumer Affairs Legal Counsel and the BRN’s Executive Officer that the Work Group’s meetings should be open and publicly noticed.</p>	<p>This has been addressed by NEWAC.</p>



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Featured Article

Regulation of Simulation Use in United States Prelicensure Nursing Programs

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KEYWORDS

simulation;
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regulation

Abstract

Background: Simulation usage has proliferated throughout nursing education. Although nursing programs have sought integration of simulation to substitute traditional clinical learning hours, the variability of regulations between states raises questions about consistency of learner outcomes.

Methods: The Boards of Nursing (BONs) of the United States and the District of Columbia were queried by internet, phone, and email to discover regulations and guidelines for the use of simulation in nursing education.

Results: More than half of the BONs reported regulations for simulation use, but they varied greatly. Some had regulations defining a percentage of traditional clinical hours that could be replaced with simulation. A few BONs specified an equivalent ratio of hours between simulation and clinical, but most did not. Some BONs described requirements for simulation instructors, but few provided specific criteria.

Conclusions: This search revealed great variability in how BONs are defining and regulating the use of simulation in prelicensure nursing education including the amount of traditional clinical hours that can be replaced with simulation. Because a description of measured learning that occurs during traditional clinical learning hours is lacking, inconsistency in regulation will persist.

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Simulation is advancing as an integral component of the preparation of nursing professionals and has been used increasingly as an alternative teaching-learning method to traditional clinical experiences. Clinical situations can be replicated in a controlled environment using manikins,

Key Points

- Simulation use has increased in nursing education programs, yet consistent regulatory guidelines are lacking.
- The individuality of state board of nursing regulation of traditional clinical education contributes to the variability of regulation of simulation within the United States.
- A description of measured learning in traditional clinical environments is needed if simulation is considered an equivalent replacement.

standardized patients, or virtual means, to allow participants to apply knowledge and skills without risk to patient safety. Within the United States, each state Board of Nursing (BON) is enacting legislation and rules to regulate the use of simulation in prelicensure nursing education. Because of the rapid rise of simulation usage, the International Nursing Association for Clinical Simulation and Learning (INACSL) Board of Directors formed a committee charged with compiling national and international regulations and making it accessible online. This article describes the purpose, process, and findings of a search for simulation regulations within the United States.

NCSBN is to protect the public by ensuring that nurses possess necessary knowledge and skills before entering practice through each state BON licensure processes. For graduates to be eligible to obtain nursing licensure, the program must be approved by the state BON and may require accreditation by a recognized accrediting body (NCSBN, 2018). A chief difference in purpose between the BON and an accreditor is that the mission of the BON is to protect the public, whereas the mission of an accreditor is to ensure continuous quality program improvement (Spector et al., 2018). Currently, there are two accreditors recognized by the USDE: The Accreditation Commission for Education in Nursing (ACEN, 2017) and the Commission on Collegiate Nursing Education (CCNE, 2017), whereas the National League for Nursing Commission for Nursing Education Accreditation (NLN CNEA, 2017) is a third organization currently seeking USDE recognition.

Regulatory System of the State Boards of Nursing

The 10th Amendment of the U.S. Constitution stipulates that all forms of licensure are governed by a state-based regulatory system which allows for “individual state jurisdiction with its inevitable variations and uniqueness” (Poe, 2008, p. 268). As such, each BON is a unique governmental agency that enacts the state Nurse Practice Act and regulates the initial approval and ongoing regulation of nursing education programs. In the pursuit of ensuring public safety, each BON maintains jurisdiction to determine state-specific regulations for nursing programs to ensure that nurses demonstrate minimum competence for licensure to practice within an authorized scope (NCSBN, 2018). Because of each state’s individual jurisdiction, the legislative and governing process of enforcing the Nurse Practice Act and regulating nursing education programs varies between the BONs.

Each BON develops state-specific regulations for nursing programs that monitor the preparation of nurses who are competent to practice. Owing to the clinical nature of the nursing profession, these regulations include criteria for required clinical learning experiences, clinical instructor preparation, and student-to-faculty ratios in patient-care environments (Spector et al., 2018). The state BONs specify the settings in which these clinical learning experiences can take place including prehospital, inpatient, community centers and long-term care facilities. However, sites for appropriate learning opportunities are becoming increasingly limited across the nation because of escalating health care system constraints, staffing models, patient safety requirements, and a growing faculty shortage (Hayden, Smiley, & Gross, 2014b; Jeffries, Dreifuerst, Kardong-Edgren, & Hayden, 2015). Despite these limitations, each nursing program is required to provide clinical learning opportunities to ensure students are prepared for practice and remain compliant with the state regulations. One solution to meet this challenge is the use of simulation.

Background

Governance of Nursing Education Programs

Higher education within the United States is governed through a triad approach consisting of the U.S. Department of Education (USDE), state authorizing agencies, and accrediting organizations (United States Department of Education, 2019). It is the role of the USDE to ensure compliance with federal aid, collect higher education data, and enforce educational laws of privacy and civil rights. State authorizing agencies, which are state BONs, approve the initial operation of a degree-granting program and monitor adherence to state educational requirements (Spector, Hooper, Silvestre, & Qian, 2018). Accrediting organizations oversee the quality of programs within higher education by establishing criteria for standards that must be met to demonstrate excellence.

The National Council of State Boards of Nursing (NCSBN), governed by a board of directors and the Delegate Assembly, advocates from a national level for the implementation of regulations that promote patient safety across the nation (NCSBN, 2018). A focus of the

Simulation as an Alternative Clinical Teaching-Learning Method

Simulation is one alternative method used increasingly for providing direct patient-care learning experiences across nursing education (Smiley, 2019). Simulation immerses learners in clinical situations that replicate reality, then a trained debriefer facilitates a reflective dialogue to help learners make meaning of the experience, acquire new knowledge, and apply this knowledge to future clinical situations (Adamson, 2015). Debriefing is the component of simulation that has been found to be most significant to learning (Shinnick, Woo, Horwich, & Steadman, 2011) because it facilitates the development of clinical reasoning (Dreifuerst, 2012; Forneris et al., 2015; Mariani, Cantrell, Meakim, Prieto, & Dreifuerst, 2013;) and improves teamwork, situational awareness, and skills necessary for nursing practice (Levett-Jones & Lapkin, 2014). However, as programs of nursing have sought to increase simulation use because of documented positive learning outcomes (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014a; Adamson, 2015; Boling & Hardin-Pierce, 2016; Dreifuerst, 2012), each BON is confronted with developing specific guidelines that safeguard the integrity of this emerging alternative clinical learning environment as a replacement for traditional experiences (Spector et al., 2018).

As simulation usage has proliferated throughout nursing education, scrutiny of its use as an alternative learning experience has concurrently increased. This is further complicated by the individuality of state BON regulations. Although nursing programs have sought curricular integration of simulation to both supplement and substitute traditional clinical learning hours (Jeffries et al., 2015; Woda, Dreifuerst, & Garnier-Villarreal, 2019), the variability of permitted use within and between states (Bailey & Mixer, 2018) raises questions about the consistency of outcomes that learners can achieve. To that end, in 2009, the INACSL Board of Directors determined that standards of best practice for the use of simulation were necessary. Since the original seven Standards of Best Practice, SimulationSM, were published in 2011, the standards have been updated twice using a review process based on new evidence, extensive literature reviews, and feedback from external reviewers (Sittner, 2016). There are currently eight Standards of Best Practice, SimulationSM (INACSL, 2016), which serve to guide best practice in the design, implementation, and evaluation of simulation activities. Although educators are seeking to align simulation curricula with the standards, there is little evidence describing programs' adherence because the standards are not regulations, but represent evidence-based practice.

The INACSL Standards of Best Practice: SimulationSM provide programs with a framework for implementing simulation pedagogy, yet faculty and administrators look to the BONs for clear regulatory guidance on the use of simulation as a form of clinical education. To understand the impact of simulation on new nursing graduates' readiness for practice,

the NCSBN conducted a landmark multisite longitudinal study, the National Simulation Study (NSS), which demonstrated that up to 50% of simulation can be effectively substituted for traditional clinical experiences in prelicensure programs with similar or better readiness for practice than new graduates who were prepared with traditional clinical experiences (Hayden et al., 2014a). After the dissemination of the NSS findings, an expert panel was convened by the NCSBN to develop national guidelines to assist state BONs in developing regulations for the use of simulation in prelicensure programs (Alexander et al., 2015). These guidelines specified that to effectively substitute simulation for traditional clinical experiences, the NSS methodology must be replicated which included high-quality scenarios facilitated by faculty formally trained in simulation and debriefing (Alexander et al., 2015; Jeffries, et al., 2015).

Because of the positive NSS findings (Hayden et al., 2014a), many programs of nursing sought to integrate more simulation within their curriculum, although not all used the standardized NSS approach. Since the NCSBN established simulation guidelines (Alexander et al., 2015), nursing programs held the expectation that BONs would establish consistent regulations for the use of simulation. However, the broad NCSBN recommendations (Alexander et al., 2015) did not have these results nor dispel the confusion about simulation integration because of the individuality and variability between the BONs.

Regulation of Supervised Clinical Experiences

The NCSBN defines supervised clinical experiences as practical learning activities designed for students to apply nursing knowledge and skills in the direct care of patients under the supervision of an instructor who has met BON requirements (NCSBN, 2005). Because nurses are licensed to practice in all patient settings, programs must comply with BON requirements for providing both course content and clinical hours spent in supervised practical learning experiences in a variety of patient settings (Spector et al., 2018). However, the NCSBN acknowledges that while there is evidence of the quality, there is little evidence of the quantity of hours of clinical learning experiences necessary for preparing competent nurses (Benner et al., 2010; Spector et al., 2018). Consequently, the NCSBN does not suggest a required number of hours, but merely states that "the number of hours should be comparable to clinical hours in similar programs" (Spector et al., 2018, p. 24). In an NCSBN survey (Smiley, 2019), the range of clinical hours across baccalaureate programs in 2017 was reported between 432 and 960 ($n = 279$), whereas the hours in associate degree programs ranged from 270 to 855 ($n = 294$). The NCSBN recognizes the legal jurisdiction of each state BON to determine minimum requirements for clinical hours. Yet, this wide variability of the acceptable number of hours is incongruent with "evidence-based regulatory excellence for patient safety and public protection" (NCSBN, 2019).

Simulation Hours Substituted for Traditional Clinical Hours

With the increasing use of simulation, questions remain regarding how simulation hours are counted proportionately to traditional clinical hours. Specifically, as simulation use has accelerated, the unremitting question has been how many clinical hours each BON allows to be replaced with simulation (Hayden et al., 2014a; Smiley, 2019). Inherent in this question is the presumption that one hour of time in traditional clinical settings is equivalent to one hour in simulation despite little supporting evidence beyond the NSS (Hayden et al., 2014a). However, now there is also emerging evidence to support a ratio of two hours of time in traditional clinical settings as equivalent to one hour in simulation (Sullivan et al., 2019). Historically, 16 state BONs approved the use of simulation as a replacement for clinical hours in 2006 (Nehring, 2008). Twenty-two BONs allowed unspecified amounts of clinical replacement with simulation, whereas four states (CA, FL, VT, and VA) allowed up to 25% of traditional clinical hours to be replaced with simulation. At the same time, 21 BONs did not address the use of simulation (Hayden, Smiley, & Gross, 2014b). In the most recent NCSBN survey that assessed simulation usage in nursing education, 60.9% of respondents in RN programs ($n = 852$) reported substituting some number of simulation hours for traditional clinical hours (Smiley, 2019), an increase from 48.5% in 2010 ($n = 878$) (Hayden, Smiley, & Gross, 2014b). Moreover, Breymier, Rutherford-Hemming, Horsley, Smith, and Connor (2015) reported that 32% of the respondents in a survey of simulation usage indicated that their program used an equal ratio of simulation to clinical hours, which is consistent with the NSS 1-to-1 ratio. Just over half (55%) of the respondents indicated not using an equal ratio of simulation as a substitution, using 2-to-1 or 3-to-1 instead (Breymier et al., 2015). Yet, in the NCSBN survey, 82.9% of respondents reported using a 1-to-1 ratio (Smiley, 2019), demonstrating confusion and inconsistency in reporting.

Nursing education has valued clinical learning experiences as an essential element for learning nursing practice, a tradition that was established decades ago as an apprenticeship-style of training. These practical experiences later evolved to university-based learning that remains the undisputed gold standard of achieving nursing competence (Ironside & McNelis, 2010). Practical clinical experiences are grounded on the assumption that the patient-care environment is the best platform for applying concepts learned in the classroom, thereby lessening the theory-practice gap (Hatzenbuehler & Klein, 2019; Ironside, McNelis, & Ebright, 2014), yet there is little evidence that supports this assumption. Moreover, there is little documentation describing the learner outcomes that occur during each hour of traditional clinical experiences, or the value of varying length of a clinical day (6, 8, 10, or 12 hours). Although the focus of the NSS was to investigate outcomes associated with varying percentages

of simulation use, further examination of specific learning experiences in traditional clinical settings is needed if simulation continues to be substituted for it (McNelis et al., 2014). The absence of this description prevents efforts to define how to best measure substitution with any alternative teaching-learning method (Bowling, Cooper, Kellish, Kubin, & Smith, 2018; Ironside & McNelis, 2010).

Questions regarding substitution of required traditional clinical hours persist despite the lack of a description of what those hours should or do entail. Given the variety of simulation use that is prevalent in prelicensure nursing programs, there is a need to focus the attention of nurse educators, academic leaders, and BON members on the status of regulation and guidance for simulation. Therefore, the purpose of this article is to report the findings of a search of the U.S. BONs for regulatory guidelines of simulation usage and to offer recommendations for future regulatory efforts.

Method

The BONs of the United States and the District of Columbia (DC) were queried by internet, phone, and email to discover documented regulations and guidelines for the use of simulation in nursing education. Initial inquiry began with an internet search of the website of each BON. If no documented regulations were readily available online, direct contact was made with the BON via phone or email. In addition, phone or email communication occurred with individuals identified as having a role in simulation education within that state.

Data collected included the following for each state: date of established simulation regulation; percent of clinical hours allowed to be replaced with simulation; ratio of simulation to clinical hours; definition of simulation; and simulation educator requirements. Only data that was documented and publicly accessible were collected and compiled into an excel spreadsheet using the exact BON wording to preserve data integrity. No anecdotal reports or survey data were collected.

Results

State Boards of Nursing with Established Simulation Regulations

Of the 50 states in the United States and the DC, 30 BONs had documented regulations for the use of simulation in a nursing program, whereas 21 BONs had no simulation regulations that could be located or officially verified (Table 1). Simulation was described and defined by 23 of the BONs with regulations, although seven BONs (AL, CA, FL, IL, KY, SD, and VA) did not provide a description of what qualifies as simulation although there were established regulations for its use in nursing programs.

Table 1 State Boards of Nursing Simulation Regulations

State	Established Simulation Regulations	Up to 50% Sub	Up to 30% Sub	Up to 25% Sub	Other Sub	No Defined Sub	Ratio of Simulation to Clinical	Definition of Simulation	Educator Requirements
AL	X					X			X
AK									
AZ	X					X		X	X
AR									
CA	X			X					
CO	X				X		1:1 or 1:2	X	X
CT									
DE									
DC	X		X					X	X
FL	X	X							
GA	X					X		X	
HI									
ID									
IL	X			X					
IN	X			X				X	
IA	X	X						X	
KS									
KY	X	X							X
LA	X	X						X	
ME									
MD									
MA									
MI	X				X			X	X
MN	X	X						X	X
MS	X			X			1:1	X	X

(continued on next page)

Table 1 (continued)

State	Established Simulation Regulations	Up to 50% Sub	Up to 30% Sub	Up to 25% Sub	Other Sub	No Defined Sub	Ratio of Simulation to Clinical	Definition of Simulation	Educator Requirements
MO	X					X		X	X
MT									
NE									
NV	X			X				X	X
NH	X	X						X	
NJ									
NM	X	X						X	X
NY									
NC	X				X			X	X
ND									
OH	X				X			X	X
OK	X		X				1:1	X	X
OR									
PA									
RI									
SC	X	X						X	X
SD	X	X							
TN	X	X						X	X
TX	X	X						X	X
UT									
VT	X			X				X	
VA	X			X			1:1		X
WA	X	X						X	X
WI	X	X						X	X
WV									
WY									

The highlighted states have no regulations.

Clinical Hour Replacement with Simulation

Twenty-five BONs had documented regulations defining a percentage of clinical hours that could be replaced with simulation. Of these, 13 BONs allow up to 50% of the clinical hours to be replaced with simulation (FL, IA, KY, LA, MN, NH, NM, SC, SD, TN, TX, WA, and WI). Other state BONs allow for smaller percentages of replacement of clinical hours with simulation including 30% replacement ($n = 2$; DC and OK), and 25% replacement ($n = 7$; CA, IL, IN, MS, NV, VT, and VA). Four BONs identified regulations for the use of simulation but did not specify an exact allowable percentage of replacement (AL, GA, MO, and RI).

Three BONs specified a percentage range or other allowance for clinical hour replacement. The Colorado BON allows up to 50% replacement of traditional clinical hours with simulation if the program is accredited and up to 25% if the program is not. North Carolina allows no more than 25% in focused client care and no more than 50% in any other clinical experience; all simulation is limited to no more than 25% if a program is not accredited. Ohio allows up to 50% replacement with mid- or high-fidelity simulation in pediatrics and obstetrics only. The Michigan BON allows no more than 50% replacement for RN programs and up to 100% replacement with simulation in practical nursing programs for pediatrics and obstetrics courses only.

Ratio of Simulation Hours to Clinical Hours

The search for simulation regulations included an investigation of the ratio of hours of simulation that are considered equivalent to hours of traditional clinical time. Three BONs specified that one hour in simulation should be counted as equal to one hour in the clinical environment (MS, OK, and VA). One BON allowed one hour of simulation to be counted as either one or two hours of clinical time, if the nursing program was nationally accredited (CO). The remaining 25 BONs of the 30 with identified regulations did not define an equivalence ratio between simulation and clinical hours.

Requirements for Simulation Educators

Twenty BONs described requirements for instructors who participate in simulation, whereas ten BONs did not. The requirements for preparing educators to facilitate simulation varied widely. Although some BONs referred to the INACSL Standards of Best Practice, SimulationSM, or the NCSBN guidelines as the criteria for preparing educators, many broadly stated that faculty need to be trained in the use of simulation. Common language was used across the BONs, including the need for documented and focused training, maintaining competencies in simulation and debriefing, and participating in ongoing professional development. Arizona identified the need for educators to be prepared to respond to “the psychological impact of simulation on students.” Overall, the BONs with

requirements for preparing educators in simulation pedagogy broadly identified that educators must be adequately prepared and trained to use simulation. However, few states provided specific criteria for achieving or measuring this.

Discussion

Given the individual state-based regulation of nursing licensure, the lack of consistency in guiding the use of simulation in nursing education is not surprising. The first challenge for nursing programs seeking guidance is accessing the BON regulations for their respective state. Anecdotal reports from educators were not always consistent with the data made publicly accessible by the BONs. Although some BONs had information readily available on their website, other websites were arduous to navigate, requiring reading meeting minutes to discern the consensus of the BON. Still other states' BON regulations were included on state licensure websites that included all licensures for that state. In addition, communication of new or updated regulations to nursing program administrators and faculty varied greatly between states. It was not clear how this communication was occurring and if there were clear processes in place for programs to verify regulatory changes. In fact, during this review process, a change in one state's regulations was inadvertently found on the state nursing association's website and not directly from an official BON source. In another case, a change in regulations was denied by the BON representative when in fact it had been published in their records for over a year.

The findings of this search revealed great variability in the percentage of simulation hours that BONs approve for replacing traditional clinical hours. In fact, only 12 states require a minimum number of traditional clinical hours (NCSBN, 2019). This was not surprising, given that the number of required clinical hours also varies considerably by state. For regulatory bodies, this is perhaps the most common query with the most inconsistent response. Yet, this question is not easily answered because regulations often specify a percentage or a number of hours of clinical time can be substituted when in fact the state BONs must carefully consider several factors that impact such a decision, including the quality of the clinical experiences.

One factor that state BONs must consider in determining guidelines for clinical replacement is the number of traditional clinical hours required by each state BON. Each of the NSS sites required a minimum of 600 hours of traditional clinical experiences to be eligible to participate in the study (Alexander et al., 2015). Because the reported range of clinical hours in prelicensure nursing programs is as low as 270 and as high as 960 (Smiley, 2019), the vast difference between 50% of 270 hours and 50% of 960 hours is an important consideration. This also further complicates the concept of defining the substitution of simulation to clinical in ratios of hours of 1-to-1, 1-to-2, or 1-to-more.

Another aspect is that while the NSS demonstrated that up to 50% of clinical hours could be replaced with

simulation, an often-overlooked contributing element to the positive outcomes achieved is the prescriptive methodology that was used. To anticipate similar results in education practice, the same methodology must be fully replicated, which includes the use of vetted scenarios, high-quality simulation, and a theory-based debriefing method (Alexander et al., 2015; Hayden et al., 2014a).

A third consideration is the necessary preparation of educators to facilitate simulation and debriefing. Training faculty to competently engage in simulation and debriefing was an important aspect of the NSS design that must be addressed to promote similar outcomes (Jeffries et al., 2015). Yet, the BONs did not consistently address requirements for training faculty in the pedagogy of simulation, and those that did were vague. Defining the type and dose of faculty training is critical to ensuring consistent learning outcomes (Bradley, 2019). Faculty who participated in the NSS not only received consistent and repeated training in implementing scenarios and facilitating debriefing but also they demonstrated competency before inclusion in the NSS and at regular intervals throughout the duration of the study. Competence assessment after training is indeed recommended in the literature that informed the INACSL Standards of Best Practice: SimulationSM (Bradley, 2019; Bradley & Dreifuerst, 2016). However, articulation of what that training should entail, valid instruments to assess competence, and a description of a competent level in simulation and debriefing skills are gravely lacking (Bradley & Dreifuerst, 2016). However, BONs have few resources to inform these types of regulatory decisions. Therefore, if BONs allow substitution of traditional clinical time with simulation, there is a risk that faculty in nursing programs are not prepared to translate the NSS methodology into simulation (Jeffries et al., 2015).

A fourth factor for the state BONs to consider is whether substitution should be based on an hour-by-hour calculation. There is no evidence that describes what an hour of traditional clinical time should entail, much less that time spent in traditional clinical learning environments provides the most effective learning to prepare a future nurse (Ironside et al., 2014). In fact, research has demonstrated that during a traditional eight- or twelve-hour clinical experience, most students, if not all, had many missed learning opportunities and considerable downtime while they waited for the clinical instructor or the patient. This downtime occurred so often that neither faculty nor students were surprised by it (Ironside & McNelis, 2010; McNelis et al., 2014). Alternatively, in high-quality simulation, there is little downtime or missed opportunities. Intense learning is compressed into compacted timeframes with purposeful debriefing and articulated outcomes. This must be deliberated cautiously as state BONs address substitution percentages and ratios of time. With no evidence demonstrating the learning outcomes expected from one hour in traditional clinical settings, it is challenging to benchmark against it. Breymier et al (2015) noted that 14% of nursing programs surveyed relied on their BON to determine this hour

substitution ratio, yet currently, most BONs with established simulation regulations fail to do so.

A final, yet overarching, issue that requires deep contemplation is a description of measured learning that occurs during traditional clinical learning hours within nursing education. If state BONs allow any amount of replacement of traditional clinical hours in nursing programs, it seems intuitive that they would be replaced with learning experiences that are equivalent in both quantity and quality. Clearly, the measurement of clinical experiences in hours is done for convenience and consistency, yet hours vary widely across nursing programs. This results in tension over the number of hours that can be considered equivalent. Furthermore, it is impossible to determine what qualifies as an equivalent learning experience when the literature lacks a description of traditional clinical time tied to specific, measured learning outcomes. In fact, there are few reports outlining the learning that occurs in traditional clinical experiences. The few documented descriptions of traditional clinical learning focus on finishing course assignments and completing assigned total patient care. This is a sharp contrast with outcomes related to decision-making, clinical reasoning, patient-care issues, delegation, or leadership skills (McNelis et al., 2014), which can be achieved in simulation (Hayden et al., 2014a). In the limited literature describing traditional clinical learning experiences, task completion of care routinely delegated to unlicensed staff in practice remains both a priority and a measure of progression for student nurses (Henderson, Cooke, Creedy, & Walker, 2012; McNelis et al., 2014). Other clinical outcomes include the number of hours spent in clinical practice environments and improved student-faculty ratios, neither of which describe student learning outcomes (Ironside, McNelis, & Ebright, 2014). It is also important to note that although the difference was not statistically significant, the NSS control group of students who received no more than 10% of simulation scored lower on all standardized knowledge assessments through the duration of the study than the group receiving 50% of their clinical time in simulation (Hayden et al., 2014a).

Conclusions

Clearly, the replacement of traditional clinical hours with simulation is accelerating across nursing education; inconsistent and unclear regulations are currently part of the landscape. To advance the science, a revisioning of what constitutes clinical learning is needed, to overcome the tension of comparing simulation and traditional experiences. Then, the discipline can embrace the value of clinical learning in all settings and focus on outcomes and quality experiences instead of hours. Further research is needed to determine how to best measure clinical learning to inform regulation and expand the evidence supporting teaching and learning in all settings, including simulation, to ensure nurses are well prepared to provide safe and quality care in a complex and dynamic health care environment.

Acknowledgment

The authors acknowledge members of the INACSL Regulatory Initiatives Committee and INACSL Board of Directors.

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From: Zinzun, Eloisa
Sent: Friday, July 19, 2019 9:11 AM
Subject: comments
Attachments: NEWAC Sim Use Assessment Form.Final7.19.docx; NEWAC.BRN.Sim.Recommendations-Final 7.19).docx

Importance: High

Greetings NEWAC Member,
Please see the attached documents for your review and comments. Once your comments have been received, the documents will be updated and presented at the next NEWAC meeting. Please email your responses by 7/22/2019 to Eloisa.Zinzun and cc: Katie.Daugherty

Best regards,

Dr. Joseph Morris
Executive Officer, CA Board of Registered Nursing



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Eloisa Zinzun
Administration Services Analyst

CONFIDENTIALITY NOTICE: This communication with its contents may contain confidential and/or legally privileged information. It is solely for the use of the intended recipient(s). Unauthorized interception, review, use or disclosure is prohibited and may violate applicable laws, including

From: Zinzun, Eloisa
Sent: Monday, July 22, 2019 10:30 AM
Subject: Simulation guideline comments

Hello All,
Based on the number of emails received requesting to extend the deadline for comments on the proposed simulation guidelines, we will adjust the deadline to August 12th. No late responses please. The staff will need ample time to review the comments and compile the data accordingly. Thank you in advance.

Regards,

Dr. Joseph Morris
Executive Officer

Eloisa Zinzun
Administration Services Analyst
CA Board of Pesticides

CONFIDENTIALITY NOTICE: This communication with its contents may contain confidential and/or legally privileged information. It is solely for the use of the intended recipient(s). Unauthorized interception, review, use or disclosure is prohibited and may violate applicable laws, including the Electronic Communications Privacy Act. If you are not the intended recipient, please contact the sender and destroy all copies of the communication.

Simulation Guidelines (SG)

Recommended by the California Board of Registered Nursing's Nursing Education and Workforce Advisory Committee (NEWAC)

** NEWAC is committed to the promotion and achievement of excellence in nursing education, workforce planning and nursing practice in California. (Fall 2019)*

NEWAC is requesting California Pre-Licensure Nursing Education Programs voluntarily adopt/use these guidelines and the standardized Simulation Assessment form beginning in Fall 2019

The Simulation Guidelines (SG) listed below were developed by the NEWAC Simulation workgroup to promote simulation use and establish a broad, realistic and uniform set of simulation guidelines/standards that support statewide commitment and consensus related to implementation of high quality simulation-based learning experiences in California pre-licensure nursing education programs.

These guidelines have been developed based on findings from the NCSBN National Simulation Study (Hayden, Smiley, Alexander, Kardong-Edgren, & Jefferies, 2014), the International Nursing Association for Clinical Simulation and Learning Standards of Best Practice: SimulationSM, the Society for Simulation in Healthcare CORE Accreditation Standards, and the Society for Simulation in Healthcare TEACHING/EDUCATION Accreditation Standards and *NCSBN Model Rules (2017)*.

The Resources and References sections of this document provide access to the more detailed specific evidence-based national simulation standards for the SG categories and subcategories listed below.

A standardized Simulation Guidelines (SG) Assessment form has also been included. Voluntary use of the attached standardized SG Assessment form is to promote more uniform routine simulation guideline assessment across all schools as a part of a school's total program evaluation processes.

Definitions

"Simulation" is a technique that creates a situation or environment to allow a person to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions (Society for Simulation in Healthcare Dictionary, 2016).

"Debriefing" means an activity that follows a simulation experience, is led by an approved program faculty member/facilitator, encourages participant's reflective thinking, and provides feedback regarding the participant's performance. (Society for Simulation in Healthcare Dictionary, 2016).

Standard - The nursing program is committed to providing high-quality simulation educational activities. The program can demonstrate these activities through the criteria listed below.

1. Evidence of Compliance

- a. A program shall provide evidence to the board of nursing that these standards have been met.

2. Organization and Management

- a. The program shall have a framework that provides adequate resources (fiscal, human, and material) to support the simulation activities.

- b. Simulation activities shall be managed by an individual who is academically and experientially qualified. The individual shall demonstrate continued expertise and competence in the use of simulation while managing the program.
 - c. The budget will sustain simulation activities and education and training of the faculty.
- 3. Facilities and Resources**
- a. The program shall have appropriate facilities for conducting simulation.
 - b. The program has personnel with expertise designing simulation educational activities.
 - c. The program has adequate equipment and supplies to create a realistic patient care environment.
- 4. Faculty Preparation**
- a. The program has a process to assure faculty utilizing simulation are formally trained in simulation pedagogy.
 - b. The program has a process to assure initial and ongoing development and competence of simulation educators.
- 5. Curriculum**
- a. The program shall demonstrate that simulation activities are linked to programmatic outcomes.
 - b. The program uses appropriate simulation related planning, implementation and evaluation processes, and clinical practice learning activities that comply with the state board of nursing regulatory requirements.
 - c. The program uses simulation educational activities that are evidence-based, engaging, and effective.
- 6. Policies and Procedures**
- a. The program shall have written policies and procedures in place to ensure quality, consistent simulation experiences for the students throughout the curriculum. This includes the following:
 - I. Short-term and long-term plans for integrating simulation into the curriculum
 - II. Method of debriefing each simulated activity
 - III. Plan for orienting faculty to simulation
 - IV. Clearly defined roles and responsibilities for simulation faculty members/facilitators
- 7. Evaluation**
- The program has mechanisms in place to evaluate educational activities, including:
- a. Criteria to evaluate the simulation activities.
 - b. Faculty ensure all simulation-based experiences require participant evaluation.
- 8. Annual Report**
- a. Include information about use of simulation in its annual school survey to the board of nursing.

Resources available

Standards

INASCL Standards <https://www.inacsl.org/i4a/pages/index.cfm?pageID=3407>

Hayden, J. K., Smiley, R. A., Alexander, M., Kardong-Edgren, S., & Jefferies, P. R. (2014). The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education. *Journal of Nursing Regulations*, 5(2), S3-S64. [https://www.journalofnursingregulation.com/article/S2155-8256\(15\)30062-4/pdf](https://www.journalofnursingregulation.com/article/S2155-8256(15)30062-4/pdf)

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSM Debriefing. *Clinical Simulation in Nursing*, 12(S), S21-S25.
<http://dx.doi.org/10.1016/j.ecns.2016.09.008>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSM Facilitation. *Clinical Simulation in Nursing*, 12(S), S16-S20.
<http://dx.doi.org/10.1016/j.ecns.2016.09.007>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSM Simulation glossary. *Clinical Simulation in Nursing*, 12(S), S39-S47.
<http://dx.doi.org/10.1016/j.ecns.2016.09.012>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL Standards of Best Practice: SimulationSM Outcomes and objectives. *Clinical Simulation in Nursing*, 12(S), S13-S15.
<http://dx.doi.org/10.1016/j.ecns.2016.09.006>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSM Participant evaluation. *Clinical Simulation in Nursing*, 12(S), S26-S29.
<http://dx.doi.org/10.1016/j.ecns.2016.09.009>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSM Professional integrity. *Clinical Simulation in Nursing*, 12(S), S30-S33.
<http://dx.doi.org/10.1016/j.ecns.2016.09.010>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL Standards of Best Practice: SimulationSM Simulation-enhanced interprofessional education (sim-IPE). *Clinical Simulation in Nursing*, 12(S), S34-S38. <http://dx.doi.org/10.1016/j.ecns.2016.09.011>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSMSimulation design. *Clinical Simulation in Nursing*, 12(S), S5-S12. <http://dx.doi.org/10.1016/j.ecns.2016.09.005>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

National Council of State Boards of Nursing Model Act Simulation Rules (2017):

<https://www.ncsbn.org/search.htm?q=model+rules+simulation>

Society For Simulation in Healthcare. (2016, May). *CORE Standards and Measurement Criteria*. Retrieved from <http://www.ssih.org/Accreditation/Full-Accreditation>:

<http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Core%20Standards%20and%20Criteria.pdf>

Society for Simulation in Healthcare. (2016, May). *TEACHING/EDUCATION Standards and Measurement Criteria*. Retrieved from <http://www.ssih.org/Accreditation/Full-Accreditation>:

<http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Teaching-Education%20Standards%20and%20Criteria.pdf>

Certifications

Certification as Healthcare Simulation Educator (CHSE):

<http://www.ssih.org/Certification/CHSE>

Certification as Healthcare Simulation Operations Specialist (CHSOS)

<http://www.ssih.org/Certification/CHSOS>

Educational Courses

California Simulation Alliance Education Courses, Mentor Program, and Apprentice Program:

<https://www.californiasimulationalliance.org/education/>

National League for Nursing (NLN): www.nln.org/professional-development-programs/teaching-resources/aging/unfolding-cases

Quality and Safety Education for Nurses (QSEN): http://qsen.org/teaching-strategies/strategy-search/advanced-search-results/?strat_type=Simulation%20Exercises

Simulation Innovation Resource Center (SIRC): <http://sirc.nln.org/mod/page/view.php?id=842>

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DRAFT

Simulation Guidelines Use/Implementation Assessment Form

School Name: Proposed fillable PDF once approved by
NEWAC _____

Program(s) Reviewed (A.D.N, B.S.N, E.L.M): _____

Reviewer Name: _____

Assessment Date: _____

Title: _____

Standard- The Nursing Program is committed to providing high-quality simulation educational activities. The program can demonstrate/document the criteria listed below each academic year.

Ratings: 3 = Fully Evident	2 = Partially Evident	1 = Little or no Evidence	3	2	1
Evidence of Compliance					
a. A program shall provide evidence to the Board of Nursing that these standards have been met.			X		
Organization and Management					
a. The program shall have a framework that provides adequate resources (fiscal, human and material) to support the simulation activities.					
b. Simulation activities shall be managed by an individual who is academically and experientially qualified, the individual shall demonstrate continued expertise and competence in the use of simulation while managing the program.					
c. The budget will sustain simulation activities and education and training of the faculty.					
Facilities and Resources					
a. The program shall have appropriate facilities for conducting simulation.					
b. The program has personnel with expertise designing simulation and educational activities.					
c. The program has adequate equipment and supplies to create a realistic patient care environment.					
Faculty Preparation					
a. The program has a process to assure faculty utilizing simulation are formally trained in simulation pedagogy.					
b. The program has the process to assure initial and ongoing development and competence of simulation educators.					
Curriculum					
a. The program shall demonstrate that simulation activities are linked to programmatic outcomes.					
b. The program uses appropriate simulation related planning, implementation and evaluation processes, and clinical practice learning activities that comply with the state board of nursing regulatory requirements.					
c. The program uses simulation educational activities that are evidence based, engaging, and effective.					
Policies and Procedures					
a. The program shall have written policies and procedures in place to ensure quality consistent simulation experiences for the students throughout the curriculum. This includes the following:					
I. Short-term and long-term plans for integrating simulation into the curriculum.					
II. Method of debriefing each simulated activity					
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IV. Clearly defined roles and responsibilities for simulation faculty members/facilitators.					
Evaluation					
a. Criteria to evaluate the simulation activities.					
b. Faculty to ensure all simulation-based experiences require participant evaluation.					
Annual Report					
a. Include information about simulation in its annual school report to the board of nursing.					

Planned Actions to Enhance or Improve use/evidence:

Attachments:

Thanks for the invitation to review. Attached are the two documents with "comments" inserted; note "TA" added to document title. Overall they both look good with my main concern being frequency of submission to the BRN and amount of supporting documentation required. I would there to be discussion about whether this needs to be used if the school is nationally certified for simulation.

.../Tanya



SACRAMENTO
STATE

Tanya K. Altmann PhD, RN

Intuition is the source of

From: Zinzun, Eloisa
Sent: Friday, July 19, 2019 9:11 AM
Subject: comments
Importance: High

Greetings NEWAC Member,

Please see the attached documents for your review and comments. Once your comments have been received, the documents will be updated and presented at the next NEWAC meeting. Please email your responses by 7/22/2019 to Eloisa.Zinzun and cc: Katie.Daugherty

Best regards,

Simulation Guidelines (SG)

Recommended by the California Board of Registered Nursing's Nursing Education and Workforce Advisory Committee (NEWAC)

** NEWAC is committed to the promotion and achievement of excellence in nursing education, workforce planning and nursing practice in California. (Fall 2019)*

NEWAC is requesting California Pre-Licensure Nursing Education Programs voluntarily adopt/use these guidelines and the standardized Simulation Assessment form beginning in Fall 2019

Commented [TKA1]: Is there a consequence for not adopting/using? What if a school is a certified simulation center?

The Simulation Guidelines (SG) listed below were developed by the NEWAC Simulation workgroup to promote simulation use and establish a broad, realistic and uniform set of simulation guidelines/standards that support statewide commitment and consensus related to implementation of high quality simulation-based learning experiences in California pre-licensure nursing education programs.

These guidelines have been developed based on findings from the NCSBN National Simulation Study (Hayden, Smiley, Alexander, Kardong-Edgren, & Jefferies, 2014), the International Nursing Association for Clinical Simulation and Learning Standards of Best Practice: SimulationSM, the Society for Simulation in Healthcare CORE Accreditation Standards, and the Society for Simulation in Healthcare TEACHING/EDUCATION Accreditation Standards and *NCSBN Model Rules (2017)*.

The Resources and References sections of this document provide access to the more detailed specific evidence-based national simulation standards for the SG categories and subcategories listed below.

A standardized Simulation Guidelines (SG) Assessment form has also been included. Voluntary use of the attached standardized SG Assessment form is to promote more uniform routine simulation guideline assessment across all schools as a part of a school's total program evaluation processes.

Definitions

"Simulation" is a technique that creates a situation or environment to allow a person to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions (Society for Simulation in Healthcare Dictionary, 2016).

"Debriefing" means an activity that follows a simulation experience, is led by an approved program faculty member/facilitator, encourages participant's reflective thinking, and provides feedback regarding the participant's performance. (Society for Simulation in Healthcare Dictionary, 2016).

Standard - The nursing program is committed to providing high-quality simulation educational activities. The program can demonstrate these activities through the criteria listed below.

1. Evidence of Compliance

- a. A program shall provide evidence to the board of nursing that these standards have been met.

Commented [TKA2]: Is the assessment form sufficient evidence? What is required here?

2. Organization and Management

- a. The program shall have a framework that provides adequate resources (fiscal, human, and material) to support the simulation activities.

- b. Simulation activities shall be managed by an individual who is academically and experientially qualified. The individual shall demonstrate continued expertise and competence in the use of simulation while managing the program.
- c. The budget will sustain simulation activities and education and training of the faculty.

3. Facilities and Resources

- a. The program shall have appropriate facilities for conducting simulation.
- b. The program has personnel with expertise designing simulation educational activities.
- c. The program has adequate equipment and supplies to create a realistic patient care environment.

4. Faculty Preparation

- a. The program has a process to assure faculty utilizing simulation are formally trained in simulation pedagogy.
- b. The program has a process to assure initial and ongoing development and competence of simulation educators.

5. Curriculum

- a. The program shall demonstrate that simulation activities are linked to programmatic outcomes.
- b. The program uses appropriate simulation related planning, implementation and evaluation processes, and clinical practice learning activities that comply with the state board of nursing regulatory requirements.
- c. The program uses simulation educational activities that are evidence-based, engaging, and effective.

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- a. The program shall have written policies and procedures in place to ensure quality, consistent simulation experiences for the students throughout the curriculum. This includes the following:
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7. Evaluation

The program has mechanisms in place to evaluate educational activities, including:

- a. Criteria to evaluate the simulation activities.
- b. Faculty ensure all simulation-based experiences require participant evaluation.

8. Annual Report

- a. Include information about use of simulation in its annual school survey to the board of nursing.

Resources available

Standards

INASCL Standards <https://www.inacsl.org/i4a/pages/index.cfm?pageID=3407>

Hayden, J. K., Smiley, R. A., Alexander, M., Kardong-Edgren, S., & Jefferies, P. R. (2014). The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education. *Journal of Nursing Regulations*, 5(2), S3-S64. [https://www.journalofnursingregulation.com/article/S2155-8256\(15\)30062-4/pdf](https://www.journalofnursingregulation.com/article/S2155-8256(15)30062-4/pdf)

Commented [TKA4]: To which specific requirements does this refer?

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSM Debriefing. *Clinical Simulation in Nursing*, 12(S), S21-S25.
<http://dx.doi.org/10.1016/j.ecns.2016.09.008>.

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<http://dx.doi.org/10.1016/j.ecns.2016.09.010>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL Standards of Best Practice: SimulationSMSimulation-enhanced interprofessional education (sim-IPE). *Clinical Simulation in Nursing*, 12(S), S34-S38. <http://dx.doi.org/10.1016/j.ecns.2016.09.011>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSMSimulation design. *Clinical Simulation in Nursing*, 12(S), S5-S12. <http://dx.doi.org/10.1016/j.ecns.2016.09.005>.

<https://www.inacsl.org/INACSL/document-server/?cftp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

National Council of State Boards of Nursing Model Act Simulation Rules (2017):

<https://www.ncsbn.org/search.htm?q=model+rules+simulation>

Society For Simulation in Healthcare. (2016, May). *CORE Standards and Measurement Criteria*. Retrieved from <http://www.ssih.org/Accreditation/Full-Accreditation>:

<http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Core%20Standards%20and%20Criteria.pdf>

Society for Simulation in Healthcare. (2016, May). *TEACHING/EDUCATION Standards and Measurement Criteria*. Retrieved from <http://www.ssih.org/Accreditation/Full-Accreditation>:

<http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Teaching-Education%20Standards%20and%20Criteria.pdf>

Certifications

Certification as Healthcare Simulation Educator (CHSE):

<http://www.ssih.org/Certification/CHSE>

Certification as Healthcare Simulation Operations Specialist (CHSOS)

<http://www.ssih.org/Certification/CHSOS>

Educational Courses

California Simulation Alliance Education Courses, Mentor Program, and Apprentice Program:

<https://www.californiasimulationalliance.org/education/>

National League for Nursing (NLN): www.nln.org/professional-development-programs/teaching-resources/aging/unfolding-cases

Quality and Safety Education for Nurses (QSEN): http://qsen.org/teaching-strategies/strategy-search/advanced-search-results/?strat_type=Simulation%20Exercises

Simulation Innovation Resource Center (SIRC): <http://sirc.nln.org/mod/page/view.php?id=842>

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Alexander, M., Durham, C. F., Hooper, J. I., Jeffries, P. R., Goldman, N., Kardong-Edgren, S., . . . Radtke, T. C. NCSBN Simulation Guidelines for Prelicensure Nursing Programs. *Journal of Nursing Regulation*, 2015; 39-41. https://www.ncsbn.org/16_Simulation_Guidelines.pdf

Benner P, Sutphen M, Leonard V, Day L. *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass; 2010.

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Forneris SG, Fey M. *Critical conversations: The NLN guide for teaching thinking*. Washington, D.C.: National League for Nursing; 2018.

Forneris SG, Neal DO, Tiffany J, et al. Enhancing clinical reasoning through simulation debriefing: A multisite study. *Nursing Education Perspectives*. 2015;36(5):304-310. doi: 10.5480/15-1672

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Ironside PM, McNelis AM, Ebright P. Clinical education in nursing: rethinking learning in practice settings. *Nursing Outlook*. 2014;62(3):185-191.

Jeffries PR. A framework for designing, implementing and evaluating simulations used as teaching strategies in nursing. *Nursing Education Perspectives*. 2005;26(2):96.

Jeffries PR. *The NLN Jeffries Simulation Theory*. Washington, DC: National League for Nursing; 2015. ISBN/ISSN:9781934758243.

Marshall LC, *Mastering patient and family education: A healthcare handbook for success*. Indianapolis, IN. Sigma Theta Tau International: 2015.

National League for Nursing. (2015). Debriefing across the curriculum. Retrieved from [http://www.nln.org/docs/default-source/about/nln-vision-series-\(position-statements\)/nln-vision-debriefing-across-the-curriculum.pdf?sfvrsn=0](http://www.nln.org/docs/default-source/about/nln-vision-series-(position-statements)/nln-vision-debriefing-across-the-curriculum.pdf?sfvrsn=0)

The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education. *Journal of Nursing Regulations*. 2014;5(Supplement):S3–S40. doi: [10.1016/S2155-8256\(15\)30062-4](https://doi.org/10.1016/S2155-8256(15)30062-4).

Palaganas, J.C., Maxworthy, J.C., Epps, C. A., Mancini, M.E. (2015). Defining Excellence in Simulation Programs, SSH.

Rudolph J, Simon R, Dufresne RL, Raemer DB. There's no such thing as "nonjudgmental" debriefing: A theory and method for debriefing with good judgement. *Simulation in Healthcare*. 2006;1(1):49-55.

Rizzolo MA, Kardong-Edgren S, Oermann MH, Jeffries PR. The National League for Nursing project to explore the use of simulation for high stakes assessment: Process, outcomes and recommendations. *Nursing Education Perspectives*. 2015;36:299-303. doi: [10.5480/15-1639](https://doi.org/10.5480/15-1639).

White C. A socio-cultural approach to learning in the practice setting. *Nurse Education Today*. 2010;30(8):794–797. doi: 10.1016/j.nedt.2010.02.002.

DRAFT

Simulation Guidelines Use/Implementation Assessment Form

School Name: **Proposed fillable PDF once approved by NEWAC**

Program(s) Reviewed (A.D.N, B.S.N, E.L.M): _____

Reviewer Name: _____

Assessment Date: _____

Title: _____

Standard- The Nursing Program is committed to providing high-quality simulation educational activities. The program can demonstrate/document the criteria listed below each academic year.

Ratings: 3 = Fully Evident	2 = Partially Evident	1 = Little or no Evidence	3	2	1
Evidence of Compliance					
a. A program shall provide evidence to the Board of Nursing that these standards have been met. <input checked="" type="checkbox"/>					
Organization and Management					
a. The program shall have a framework that provides adequate resources (fiscal, human and material) to support the simulation activities.					
b. Simulation activities shall be managed by an individual who is academically and experientially qualified, the individual shall demonstrate continued expertise and competence in the use of simulation while managing the program.					
c. The budget will sustain simulation activities and education and training of the faculty.					
Facilities and Resources					
a. The program shall have appropriate facilities for conducting simulation.					
b. The program has personnel with expertise designing simulation and educational activities.					
c. The program has adequate equipment and supplies to create a realistic patient care environment.					
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a. The program has a process to assure faculty utilizing simulation are formally trained in simulation pedagogy.					
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a. The program shall demonstrate that simulation activities are linked to programmatic outcomes.					
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I. Short-term and long-term plans for integrating simulation into the curriculum.					
II. Method of debriefing each simulated activity					
III. Plan for orienting faculty to simulation					
IV. Clearly defined roles and responsibilities for simulation faculty members/facilitators.					
Evaluation					
a. Criteria to evaluate the simulation activities.					
b. Faculty to ensure all simulation-based experiences require participant evaluation.					
Annual Report					
a. Include information about simulation in its annual school report to the board of nursing.					
Planned Actions to Enhance or Improve use/evidence:					

Commented [TKA1]: Is the reviewer the BRN representative or the School rep?

Commented [TKA2]: Is the expectation that it is submitted and reviewed annually? Are there other annual reports such as this? Seems over-regulating.

Commented [TKA3]: Who is rating this? If it is the school, it is more of a direction than an assessment. If it is the BRN, what forms of evidence are required to be submitted with the assessment?

Commented [TKA4]: Is there an idea of how many faculty are needed? Is it enough for the person in charge to be CHSE certified or is it expected that at least some faculty also have this certification?

Commented [TKA5]: Missing end bracket

Commented [TKA6]: This needs better defining. Many faculty would consider practice with simulation as ongoing development.

Commented [TKA7]: spelling

Commented [TKA8]: This does not belong as part of an assessment.

Simulation Guidelines Use/Implementation Assessment Form

[EXTERNAL]: Barbara.Barney-Knox

No edits from me. Looks good. When is the next meeting?

Barbara Barney-Knox, MBA, MA, BSN, RN
Chief Nurse Executive

Greetings NEWAC Member,
Please see the attached documents for your review and comments. Once your comments have been received, the documents will be updated and presented at the next NEWAC meeting. Please email your responses by 7/22/2019 to Eloisa.Zinzun and cc: Katie.Daugherty

Best regards,

Dr. Joseph Morris



Zinzun, Eloisa

From: Cathy Deckers <Cathy.Deckers@csulb.edu>
Sent: Sunday, July 21, 2019 6:42 PM
To: Zinzun, Eloisa
Cc: Daugherty, Katie
Subject: Fw: comments /forward
Attachments: CSULB feedback NEWAC.BRN.Sim.Recommendations-Final 7.19).docx

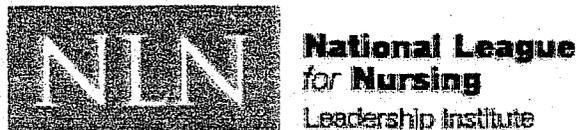
[EXTERNAL]: Cathy.Deckers

Greetings all (trying this again) ,

Attached is the requested feedback from CSULB School of Nursing. What a great job the committee did on this to provide standardization and guidelines for the state of California! Just a couple of ideas that might come in handy based on my experience with working on SSH Accreditation and INACSL Standards.

1. Consider creating a companion document or some document that provides a few examples of how the standards can be met. This really helps the site as well as the reviewers understand how a general standard can be met in a less prescriptive way. That said, if the standards are prescriptive, please identify the minimum requirements (example: SSH Accreditation standards require that there be a .5 FTE directing the simulation program at a bare minimum.
2. Consider adding the [University of Washington Simulation education modules](#) to the training resources. These were developed with a grant and I believe Suzi Kardong-Edgren was instrumental in this education. Best part is that they are FREE where as the other resources you have cited have fees.

Best Regards,
Cathleen M. Deckers, EdD, RN, MSN, CHSE
Assistant Professor. School of Nursing



From: Cathy Deckers
Sent: Sunday, July 21, 2019 5:55 PM
To: Eloisa.Zinzun

Greetings all,

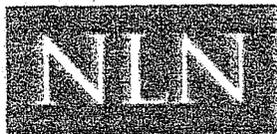
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Best Regards,

Cathleen M. Deckers, EdD, RN, MSN, CHSE

INTL. FAX: (562) 985-7581



**National League
for Nursing**
Leadership Institute



July 19, 2019

Dear Cathy:

Greetings from Prescott, Arizona!

I just received the attached guidelines and measurements related to the adoption and the use of simulation in CA BRN approved schools of nursing. They are asking for input from the schools. Since you are the most knowledgeable person on simulation in our school, can you provide me with your feedback.

I read it and it is very comprehensive. This was prepared by a special Task force on simulation by the BRN. It specifies as being voluntary, however, it is asking for annual written report.

They gave a very short time frame to respond, which is July 22.

If you have the time, I would appreciate your input.

Simulation Guidelines (SG)

Recommended by the California Board of Registered Nursing's Nursing Education and Workforce Advisory Committee (NEWAC)

** NEWAC is committed to the promotion and achievement of excellence in nursing education, workforce planning and nursing practice in California. (Fall 2019)*

NEWAC is requesting California Pre-Licensure Nursing Education Programs voluntarily adopt/use these guidelines and the standardized Simulation Assessment form beginning in Fall 2019

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Commented [TD1]: Will there be BRN guidelines provided to define what adequate resources are?

- b. Simulation activities shall be managed by an individual who is academically and experientially qualified. The individual shall demonstrate continued expertise and competence in the use of simulation while managing the program.
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<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSMProfessional integrity. *Clinical Simulation in Nursing*, 12(S), S30-S33.
<http://dx.doi.org/10.1016/j.ecns.2016.09.010>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL Standards of Best Practice: SimulationSMSimulation-enhanced interprofessional education (sim-IPE). *Clinical Simulation in Nursing*, 12(S), S34-S38. <http://dx.doi.org/10.1016/j.ecns.2016.09.011>.

<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>

INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSMSimulation design. *Clinical Simulation in Nursing*, 12(S), S5-S12. <http://dx.doi.org/10.1016/j.ecns.2016.09.005>.

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<http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Core%20Standards%20and%20Criteria.pdf>

Society for Simulation in Healthcare. (2016, May). *TEACHING/EDUCATION Standards and Measurement Criteria*. Retrieved from <http://www.ssih.org/Accreditation/Full-Accreditation>:

<http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Teaching-Education%20Standards%20and%20Criteria.pdf>

Certifications

Certification as Healthcare Simulation Educator (CHSE):

<http://www.ssih.org/Certification/CHSE>

Certification as Healthcare Simulation Operations Specialist (CHSOS)

<http://www.ssih.org/Certification/CHSOS>

Educational Courses

California Simulation Alliance Education Courses, Mentor Program, and Apprentice Program:

<https://www.californiasimulationalliance.org/education/>

National League for Nursing (NLN): www.nln.org/professional-development-programs/teaching-resources/aging/unfolding-cases

Quality and Safety Education for Nurses (QSEN): http://qsen.org/teaching-strategies/strategy-search/advanced-search-results/?strat_type=Simulation%20Exercises

Simulation Innovation Resource Center (SIRC): <http://sirc.nln.org/mod/page/view.php?id=842>

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Alexander, M., Durham, C. F., Hooper, J. I., Jeffries, P. R., Goldman, N., Kardong-Edgren, S., . . . Radtke, T. C. NCSBN Simulation Guidelines for Prelicensure Nursing Programs. *Journal of Nursing Regulation*, 2015; 39-41. https://www.ncsbn.org/16_Simulation_Guidelines.pdf

Commented [TD2]: Might I suggest the University of Washington FREE modules be added here. <https://collaborate.uw.edu/resources-and-training/online-training-and-toolkits/simulation/>

Benner P, Sutphen M, Leonard V, Day L. *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass; 2010.

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Ironside PM, McNelis AM, Ebright P. Clinical education in nursing: rethinking learning in practice settings. *Nursing Outlook*. 2014;62(3):185-191.

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Marshall LC, *Mastering patient and family education: A healthcare handbook for success*. Indianapolis, IN. Sigma Theta Tau International: 2015.

National League for Nursing. (2015). Debriefing across the curriculum. Retrieved from [http://www.nln.org/docs/default-source/about/nln-vision-series-\(position-statements\)/nln-vision-debriefing-across-the-curriculum.pdf?sfvrsn=0](http://www.nln.org/docs/default-source/about/nln-vision-series-(position-statements)/nln-vision-debriefing-across-the-curriculum.pdf?sfvrsn=0)

The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education. *Journal of Nursing Regulations*. 2014;5(Supplement):S3-S40. doi: [10.1016/S2155-8256\(15\)30062-4](https://doi.org/10.1016/S2155-8256(15)30062-4).

Palaganas, J.C., Maxworthy, J.C., Epps, C. A., Mancini, M.E. (2015). Defining Excellence in Simulation Programs, SSH.

Rudolph J, Simon R, Dufresne RL, Raemer DB. There's no such thing as "nonjudgmental" debriefing: A theory and method for debriefing with good judgement. *Simulation in Healthcare*. 2006;1(1):49-55.

Rizzolo MA, Kardong-Edgren S, Oermann MH, Jeffries PR. The National League for Nursing project to explore the use of simulation for high stakes assessment: Process, outcomes and recommendations. *Nursing Education Perspectives*. 2015;36:299-303. doi: [10.5480/15-1639](https://doi.org/10.5480/15-1639).

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DRAFT

From: Robyn Nelson
Sent: Friday, July 19, 2019 6:10 PM
To: Daugherty, Katie
Subject: RE: NEWAC Sim Recommendations
Attachments: NEWAC Sim Use Assessment Form.Final7.19.docx

Hi Katei – Here you go...Obviously formatting could use some help.

Robyn Nelson, PhD, MS, RN
Dean, College of Nursing and Professor



Robyn, thanks for the feedback and phone follow up of today. Will look forward to receiving the suggested edits as you envision being included on the documents. Have a nice weekend! Katie

From: Robyn Nelson
Sent: Friday, July 19, 2019 4:43 PM
To: Zinzun, Eloisa
Cc: Daugherty, Katie
Subject: NEWAC Sim Recommendations

Good Afternoon – Thank you for the opportunity to provide feedback on the sim recommendations. I would recommend adding Society for Simulation in Healthcare (SSH) accreditation. Many of the areas of assessment have been confirmed by accreditation and may expedite the review process. Thank you.

Robyn Nelson, PhD, MS, RN
Dean, College of Nursing and Professor



This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed.

Simulation Guidelines Use/Implementation Assessment Form

School Name: **Proposed fillable PDF once approved by NEWAC** _____

Program(s) Reviewed (A.D.N, B.S.N, E.L.M): _____

Reviewer Name: _____

Assessment Date: _____

Title: _____

SSH Accredited Yes Full Provisional
Date _____ No

Standard- The Nursing Program is committed to providing high-quality simulation educational activities. The program can demonstrate/document the criteria listed below each academic year.

Ratings: 3 = Fully Evident	2 = Partially Evident	1 = Little or no Evidence	3	2	1
Evidence of Compliance					
a. A program shall provide evidence to the Board of Nursing that these standards have been met.			X		
Organization and Management					
a. The program shall have a framework that provides adequate resources (fiscal, human and material) to support the simulation activities.					
b. Simulation activities shall be managed by an individual who is academically and experientially qualified, the individual shall demonstrate continued expertise and competence in the use of simulation while managing the program.					
c. The budget will sustain simulation activities and education and training of the faculty.					
Facilities and Resources					
a. The program shall have appropriate facilities for conducting simulation.					
b. The program has personnel with expertise designing simulation and educational activities.					
c. The program has adequate equipment and supplies to create a realistic patient care environment.					
Faculty Preparation					
a. The program has a process to assure faculty utilizing simulation are formally trained in simulation pedagogy.					
b. The program has the process to assure initial and ongoing development and competence of simulation educators.					
Curriculum					
a. The program shall demonstrate that simulation activities are linked to programmatic outcomes.					
b. The program uses appropriate simulation related planning, implementation and evaluation processes, and clinical practice learning activities that comply with the state board of nursing regulatory requirements.					
c. The program uses simulation educational activities that are evidence based, engaging, and effective.					
Policies and Procedures					
a. The program shall have written policies and procedures in place to ensure quality consistent simulation experiences for the students throughout the curriculum. This includes the following:					
I. Short-term and long-term plans for integrating simulation into the curriculum.					
II. Method of debriefing each simulated activity					
III. Plan for orienting faculty to simulation					
IV. Clearly defined roles and responsibilities for simulation faculty members/facilitators.					
Evaluation					
a. Criteria to evaluate the simulation activities.					
b. Faculty to ensure all simulation-based experiences require participant evaluation.					
Annual Report					
a. Include information about simulation in its annual school report to the board of nursing.					
Planned Actions to Enhance or Improve use/evidence:					

Simulation Guidelines Use/Implementation Assessment Form

Zinzun, Eloisa

From: Saskia Kim <
Sent: Wednesday, July 24, 2019 3:18 PM
To: Morris, Joseph
Subject: Simulation guidelines follow up
Attachments: Resources-and-References-Chart-CNA-Comments .docx

Hi - thanks again for the helpful information this afternoon. Per our conversation, here's the chart I mentioned indicating which reference documents we had trouble accessing. Please let me know if you have any questions. Thanks ~

Saskia

Zinzun, Eloisa

From: Saskia Kim
Sent: Monday, August 12, 2019 4:14 PM
To: Morris, Joseph
Subject: NEWAC Simulation Guidelines
Attachments: CNA Comments NEWAC Simulation Guidelines (8-12-19).pdf

Hi – hope you are both well. Please see attached comments on the proposed simulation guidelines. Please let me know if you have any questions. Thank you ~
Saskia

Saskia Kim, Regulatory Policy Specialist
California Nurses Association/National Nurses United

ATTACHMENT I

<u>Standards</u>	<i>Comment</i>
INACSL Standards https://www.inacsl.org/i4a/pages/index.cfm?pageID=3407	Link not functioning. Document cannot be found
Hayden, J. K., Smiley, R. A., Alexander, M., Kardong-Edgren, S., & Jefferies, P. R. (2014). The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education. <i>Journal of Nursing Regulations</i> , 5(2), S3-S64. https://www.journalofnursingregulation.com/article/S2155-8256(15)30062-4/pdf	Duplicate document in references. This is not really a standard .
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Debriefing. <i>Clinical Simulation in Nursing</i> , 12(S), S21-S25. http://dx.doi.org/10.1016/j.ecns.2016.09.008 . https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBP_EnglishCombo.pdf	All 8 of the INACSL Standards are contained within one link that is repeated 8 times resulting in unnecessary duplication and padding of the standards section.
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Facilitation. <i>Clinical Simulation in Nursing</i> , 12(S), S16-S20. http://dx.doi.org/10.1016/j.ecns.2016.09.007 .	Duplicative
INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSMSimulation glossary. <i>Clinical Simulation in Nursing</i> , 12(S), S39-S47. http://dx.doi.org/10.1016/j.ecns.2016.09.012 .	Duplicative
INACSL Standards Committee (2016, December). INACSL Standards of Best Practice: Simulation SM Outcomes and objectives. <i>Clinical Simulation in Nursing</i> , 12(S), S13-S15. http://dx.doi.org/10.1016/j.ecns.2016.09.006 .	Duplicative
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Participant evaluation. <i>Clinical Simulation in Nursing</i> , 12(S), S26-S29. http://dx.doi.org/10.1016/j.ecns.2016.09.009 .	Duplicative
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Professional integrity. <i>Clinical Simulation in Nursing</i> , 12(S), S30-S33. http://dx.doi.org/10.1016/j.ecns.2016.09.010 .	Duplicative
INACSL Standards Committee (2016, December). INACSL Standards of Best Practice: Simulation SM	Duplicative

ATTACHMENT I

Simulation-enhanced interprofessional education (sim-IPE). <i>Clinical Simulation in Nursing</i> , 12(S),S34-S38. http://dx.doi.org/10.1016/j.ecns.2016.09.011 .	
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Simulation design. <i>Clinical Simulation in Nursing</i> , 12(S), S5-S12. http://dx.doi.org/10.1016/j.ecns.2016.09.005 .	Duplicative
<u>National Council of State Boards of Nursing Model Act Simulation Rules (2017):</u> https://www.ncsbn.org/search.htm?q=model+rules+simulation <u>on</u>	Link is to Aug 2016 NCSBN Annual Meeting where <i>partial model act presented</i> . Complete Simulation Guidelines incorrectly placed in references.
Society For Simulation in Healthcare. (2016, May). <i>CORE Standards and Measurement Criteria</i> . Retrieved from http://www.ssih.org/Accreditation/Full-Accreditation: http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Core%20Standards%20and%20Criteria.pdf	No comment
Society for Simulation in Healthcare. (2016, May). <i>TEACHING/EDUCATION Standards and Measurement Criteria</i> . Retrieved from http://www.ssih.org/Accreditation/Full-Accreditation: http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Teaching-Education%20Standards%20and%20Criteria.pdf	No comment
<u>Certifications</u>	<i>Comment</i>
Certification as Healthcare Simulation Educator (CHSE): http://www.ssih.org/Certification/CHSE	No comment
<u>Certification as Healthcare Simulation Operations Specialist (CHSOS)</u> http://www.ssih.org/Certification/CHSOS	Non-functioning link in draft for CHSOS.
<u>Educational Courses</u>	<i>Comment</i>
California Simulation Alliance Education Courses, Mentor Program, and Apprentice Program: https://www.californiasimulationalliance.org/education/	No Comment

ATTACHMENT I

<i>Educational Courses (continued)</i>	<i>Comment</i>
National League for Nursing http://www.nln.org/professional-development-programs/teaching-resources/ace-s/unfolding-cases	No comment
Quality and Safety Education for Nurses (QSEN): http://qsen.org/teaching-strategies/strategy-search/advanced-search-results/?strat_type=Simulation%20Exercises	No comment
Simulation Innovation Resource Center (SIRC): http://sirc.nln.org/mod/page/view.php?id=842	SIRC is part of NLN educational resources
<i>References</i>	<i>Comment</i>
Abersold, M, Tschannenm D. Simulation in nursing practice: The impact on patient care. <i>The Online Journal of Issues in Nursing</i> . 2013;18(2):Manuscript 6. doi: 10.3912/OJIN.Vol18No02Man06.	This article is specific to licensed practicing RNs in the patient care setting. It is not relevant to prelicensure students.
Alexander, M., Durham, C. F., Hooper, J. I., Jeffries, P. R., Goldman, N., Kardong-Edgren, S., . . . Radtke, T. C. NCSBN Simulation Guidelines for Prelicensure Nursing Programs. <i>Journal of Nursing Regulation</i> ,2015; 39-41. https://www.ncsbn.org/16_Simulation_Guidelines.pdf	Incorrectly placed in references when these are actually standards/guidelines
Benner P, Sutphen M, Leonard V, Day L. <i>Educating nurses: A call for radical transformation</i> . San Francisco, CA: Jossey-Bass; 2010.	Dated Material with old and outdated information on nursing workforce.
Dreifuerst KT. Using debriefing for meaningful learning to foster development of clinical reasoning in simulation. <i>Journal of Nursing Education</i> . 2012;51(6), 326-333. doi:10.3928/01484834-20120409-02.	Not Open Access Unable to Review and Comment
Eppich W, Cheng A. Promoting excellence and reflective learning in simulation (PEARLS): Development and rationale for a blended approach to health care simulation debriefing. <i>Simulation in Healthcare</i> . 2015;10(2):106-115. doi: 10.1097/SIH.0000000000000072.	No comment
Forneris SG, Fey M. <i>Critical conversations: The NLN guide for teaching thinking</i> . Washington, D.C.: National League for Nursing; 2018.	Not Open Access Unable to Review and Comment
Forneris SG, Neal DO, Tiffany J, et al. Enhancing clinical reasoning through simulation debriefing: A multisite study. <i>Nursing Education Perspectives</i> . 2015;36(5):304-310. doi: 10.5480/15-1672	No comment
INACSL. Simulation regulation map. https://www.inacsl.org/simulation-regulations/ Retrieved: March 31, 2019	Map not relevant to standards development

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Ironsides PM, McNelis AM, Ebright P. Clinical education in nursing: rethinking learning in practice settings. <i>Nursing Outlook</i> . 2014;62(3):185-191.	Not Open Access Unable to Review and Comment
Jeffries PR. A framework for designing, implementing and evaluating simulations used as teaching strategies in nursing. <i>Nursing Education Perspectives</i> . 2005;26(2):96.	Not Open Access Unable to Review and Comment
Jeffries PR. <i>The NLN Jeffries Simulation Theory</i> . Washington, DC: National League for Nursing; 2015. ISBN/ISSN:9781934758243.	Not Open Access Unable to Review and Comment
Marshall LC, <i>Mastering patient and family education: A healthcare handbook for success</i> . Indianapolis, IN. Sigma Theta Tau International: 2015.	Not Open Access Unable to Review and Comment
National League for Nursing. (2015). Debriefing across the curriculum. Retrieved from http://www.nln.org/docs/default-source/about/nln-vision-series-(position-statements)/nln-vision-debriefing-across-the-curriculum.pdf?sfvrsn=0	Link does not work
The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education. <i>Journal of Nursing Regulations</i> . 2014;5(Supplement): S3–S40. doi: 10.1016/S2155-8256(15)30062-4 .	Refer to CNA comments on 10/2018 Draft.
Palaganas, J.C., Maxworthy, J.C., Epps, C. A., Mancini, M.E. (2015). Defining Excellence in Simulation Programs, SSH.	Not Open Access Unable to Review and Comment
Rudolph J, Simon R, Dufresne RL, Raemer DB. There's no such thing as "nonjudgmental" debriefing: A theory and method for debriefing with good judgement. <i>Simulation in Healthcare</i> . 2006;1(1):49-55.	Link not provided to article. Orange County/Long Beach Consortium has article on website. Old article but useful information on debriefing with good judgment.
Rizzolo MA, Kardong-Edgren S, Oermann MH, Jeffries PR. The National League for Nursing project to explore the use of simulation for high stakes assessment: Process, outcomes and recommendations. <i>Nursing Education Perspectives</i> . 2015;36:299-303. doi: 10.5480/15-1639 .	Not Open Access Unable to Review and Comment
White C. A socio-cultural approach to learning in the practice setting. <i>Nurse Education Today</i> . 2010;30(8):794–797. doi: 10.1016/j.nedt.2010.02.002 .	Not Open Access Unable to Review and Comment



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August 12, 2019

Dr. Joseph Morris, PhD, MSN, RN, Executive Officer
Katie Daugherty, MN, RN, Nursing Education Consultant
California Board of Registered Nursing
1747 Market Blvd. Suite 150
Sacramento, CA 95834

VIA ELECTRONIC MAIL TO: joseph.morris@dca.ca.gov; katie.daugherty@dca.ca.gov

RE: Simulation Guidelines Revisions: Nursing Education and Workforce Advisory Committee (NEWAC)

Dear Dr. Morris and Ms. Daugherty:

The California Nurses Association/National Nurses United (CNA), representing over 100,000 registered nurses in the state, appreciates the opportunity to comment on the revisions of the *Simulation Guidelines* from October 2018 (SG18). Our comments regarding the 2019 revised *Simulation Guidelines* (SG19) and the new, proposed *Simulation Guidelines Use/Implementation Assessment Form* (SG Form) are below.

As an initial matter, we would like to briefly address an issue that arose at the last NEWAC meeting when there seemed to be a misunderstanding about the focus of CNA's concern and opposition to the *Report of the NEWAC Simulation Work Group*.¹ CNA has concerns about the substitution of clinical learning with actual patients for learning in a simulation laboratory and is especially opposed to increasing simulation beyond what is currently allowed. The use of educational technology including, but not limited to, high fidelity mannequins and computer-based simulation under the guidance of qualified nursing educators may benefit students as a complement to clinical learning experiences with real patients. Approved nursing programs should have the freedom to utilize these tools to the extent needed to provide high quality nursing education for students and to prepare them to provide safe patient care in the prelicensure program and following licensure. However, what is clear to CNA is that the quest by the NEWAC simulation workgroup to push through SG19 or any future simulation guideline (SG) iteration, is to ultimately create a pathway to reduce the proportion of direct patient care clinical hours from the minimum seventy-five percent of a nursing course as currently required.²

¹ October 5, 2018.

² 16 CCR §1426(g)(2).

- **NCSBN National Simulation Study's Highest Attrition Rate Found in 50% Simulation Group and Among Minority Students and Military Medical Corps**

The SG18 and SG19 have been developed, in part, based on the findings of the NCSBN National Simulation Study (NCSBN Study).³ CNA's previous comments addressed some significant flaws in the NCSBN Study.⁴ However, an additional concern for California is that students who dropped out of the NCSBN study were, disproportionately, students from minority groups and returning veterans.⁵ Black/African American student study attrition rate was 33.3% (24/72 students), Asian student study attrition rate was 33.9% (20/59 students), male attrition rate was 27.2% (31/144 students) and medical corps veterans had a study attrition rate of 50% (4/8 students).⁶ In comparison, the white students had an attrition rate of 18% (124/690) and female students had a study attrition rate of 19.5% (138/708).⁷

The NCSBN study had three groups with varying exposure to simulation. The control group had less than 10% simulation in clinical hours, another group had 25% of their clinical hours replaced by simulation and a third group had 50% of clinical hours replaced by simulation.⁸ The group that had 50% clinical hours replaced by simulation had the highest rate of study drop out (19.2%).⁹ The Control Group with less than 10% simulation had the lowest rate of drop out at 9.3% and the 25% simulation group had a rate of 12.0%.¹⁰ The difference between groups was considered statistically significant.¹¹ We are not aware of any study that replicates the findings of the NCSBN Study so it remains a one-off research project until replicated.

In short, not only does the study have significant limitations, as noted in our previous letter, but the negative impact on minority students, veterans students, and those students in the 50% simulation group should give the NEWAC Simulation Workgroup pause when identifying the NCSBN Study findings as the basis for SG19 or for any future iteration that may be recommended by NEWAC as a SG.

³ SG19 at 1.

⁴ See CNA Letter to Dr. Joseph Morris from Saskia Kim dated 1/22/2019 at 2-3.

⁵ Hayden, J. K., Smiley, R. A., Alexander, M., Kardong-Edgren, S., & Jefferies, P. R., *The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education*, *Journal of Nursing Regulations*, 2014, 5(2), Table 3 at S13.

⁶ *Id.* at Table 3 at S13.

⁷ *Id.* at Table 3 at S13.

⁸ *Id.* at S3-S64, at S3.

⁹ *Id.* at Table 3 at S13.

¹⁰ *Id.* at S13.

¹¹ *Id.* at S14.

- **SG19 Introduces A New Definition of Simulation**

The SG18 definition of simulation mirrored the NCSBN Model Rules on the Use of Simulation in a Prelicensure Nursing Education Program with the addition of “and includes all modalities of simulation”:

“Simulation” means a technique to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner (Gaba, 2004) and includes all modalities of simulation.¹²

The new definition placed in SG19 has been taken from the Society for Simulation in Healthcare Dictionary from among several other definitions for simulation in the same resource.¹³ The publication itself notes that the document is not perfect, nor complete and that terms and definitions will change.¹⁴

“Simulation” is a technique that creates a situation or environment to allow a person to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding (sic) of systems or human actions.

SG19 refers to simulation as a “technique” whereas 16 CCR §1420 (p) defines equipment, tools and devices that support the teaching and learning of the nursing program’s board-approved curriculum as “technology.” CNA recommends using already existing language found in BRN statutes and Administrative Procedure Act (APA)-approved regulations whenever possible.

It is noteworthy and relevant to a definition of simulation that the BRN Annual School Report has collected extensive data on nursing programs’ use of simulation in the 2017-2018 report based upon a definition of simulation that differs from that in SG19. The definition of clinical simulation used when collecting data from nursing programs speaks to the specific role of

¹² Maryann Alexander, PhD, RN, FAAN, et. al, NCSBN Simulation Guidelines for Prelicensure Nursing Programs, 2016 at 10 and SG 18 at second page (no pagination on document).

¹³ Healthcare Simulation Dictionary, 1st Edition, June 2016, at 33.

Simulation:

- A technique that creates a situation or environment to allow persons to experience a representation of a real event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions.
- An educational technique that replaces or amplifies real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner (Gaba Future Vision Qual Saf Health Care 2004).
- A pedagogy using one or more typologies to promote, improve, or validate a participant’s progression from novice to expert (INACSL, 2013).
- The application of a simulator to training and/or assessment (SSH).
- A method for implementing a model over time.

¹⁴ Healthcare Simulation Dictionary, 1st Edition, June 2016, at 3.

simulation in nursing programs for use with student nurses in clinical practice.

“Clinical Simulation” provides a simulated nursing care scenario that allows students to integrate, apply, and refine specific skills and abilities that are based on theoretical concepts and scientific knowledge. It may include videotaping, de-briefing and dialogue as part of the learning process. Simulation can include experiences with standardized patients, mannequins, role-playing, computer simulation, or other activities.¹⁵

Arguably, there may be a benefit to a standard definition of simulation for use in California nursing programs. More importantly, we believe that the definition currently used by UCSF to gather data provides more consistency in the collection of data for future Annual Schools Reports. Additionally, the UCSF definition clearly indicates what activities are included under the rubric of clinical simulation for *nursing students*. The broader definition may be more inclusive of the use of the technology in healthcare, but CNA recommends keeping the focus on the use of simulation technology in prelicensure programs in California.

The word “simulation” is only found once in the Nursing Practice Act in 16 CCR §1420(e) “Clinical Practice,” but it is not defined. A word search of the healing arts statutes and regulations reveals that the Dental Board provides a definition:

“Simulated clinical instruction” means instruction in which *students* receive supervised experience performing procedures using simulated patient heads mounted in appropriate position and accommodating an articulated typodont in an enclosed intraoral environment or mounted on a dental chair in a dental operatory. Clinical simulation spaces shall be sufficient to permit one simulation space for each 2 students at any one time.¹⁶

Other than the Dental Board, most of the other healing arts boards use the term as part of continuing education approval standards.¹⁷ The term is only used in the healing arts chapters of the Business and Professions Code by Respiratory Therapy and it refers to a “Clinical Simulation Examination.” Simulation is not defined in that chapter, however.

We conclude that if NEWAC were to advise the use of a standard definition for simulation, debriefing, or any other term, it is important for California to create and utilize language that makes specific reference to nursing care and nursing students in order to distinguish the use of this teaching modality in prelicensure programs from its use in other areas of healthcare.

¹⁵ Lisel Blash, MPA, Joanne Spetz, PhD, California BRN 2017-18 Annual School Report, February 8, 2019, at 81.

¹⁶ 16 CCR § 1070.1 (f) (emphasis added).

¹⁷ There are a total of 16 regulatory code sections that use of the term simulation, including the BRN. Only the Dental Board defines the term in regulation.

The definition of “debriefing” appears to come from the NCSBN Proposed Rules on the Use of Simulation in a Prelicensure Nursing Education Program, Chapter 2. Definitions (k) rather than the Society for Simulation Healthcare Dictionary and needs to be correctly attributed to that source.¹⁸

“Debriefing” means an activity that follows a simulation experience, is led by a facilitator, encourages participant’s reflective thinking, and provides feedback regarding the participant’s performance.¹⁹

A word search of Title 16 of the California Code of Regulations and of the Business and Professions Code finds no use of the term “debriefing.”

- **SG19 Deletes Reference To Course Outcomes**

SG18 stated under the “Curriculum” standards:

- a. The program shall demonstrate that simulation activities are linked *to course and programmatic outcomes*.²⁰

However, SG19 deletes reference to course outcomes:

- a. The program shall demonstrate that simulation activities are linked to programmatic outcomes.²¹

First, it is not clear why this change was made. It would be helpful to understand the rationale for the revision. But, more importantly, we believe that programmatic outcomes and course outcomes are inextricably linked. 16 CCR §1426(b) describes the outcomes of a successful

¹⁸ Healthcare Simulation Dictionary, 1st Edition, Society For Simulation in Healthcare, June 2016, at 8.

Debriefing

- *(noun)* A formal, collaborative, reflective process within the simulation learning activity.
- An activity that follows a simulation experience and led by a facilitator.
- *(verb)* To conduct a session after a simulation event where educators/instructors/facilitators and learners re-examine the simulation experience for the purpose of moving toward assimilation and accommodation of learning to future situations (Johnson-Russell & Bailey, 2010; NLN-SIRC, 2013); debriefing should foster the development of clinical judgment and critical thinking skills (Johnson-Russell & Bailey, 2010).
 - To encourage participants’ reflective thinking and provide feedback about their performance while various aspects of the completed simulation are discussed.
 - To explore with participants their emotions and to question, reflect, and provide feedback to one another (i.e., *guided reflection*).

¹⁹ Maryann Alexander, PhD, RN, FAAN, et. al, NCSBN Simulation Guidelines for Prelicensure Nursing Education Programs, NCSBN, 2016, at 10.

²⁰ KT Waxman, Report of the NEWAC Simulation Work Group, *Proposed Simulation Program Guidelines, “Curriculum”* October 5, 2018 (no pagination in document) (emphasis added).

²¹ SG19, “Curriculum” (no pagination in document).

nursing program as one that is "... designed so that a student who completes the program will have the knowledge, skills, and abilities necessary to function in accordance with the registered nurse scope of practice as defined in code section 2725 and to meet minimum competency standards of a registered nurse." The building blocks of a successful nursing program are dependent upon each course of study providing both theory and clinical practice for students so that students may acquire the necessary knowledge and skills in each nursing area. 16 CCR §1420(e) states:

"Clinical practice" means the planned learning experiences designed for students to apply nursing knowledge and skills to meet *course objectives* in a variety of board-approved clinical settings. Clinical practice includes *learning experiences* provided in various health care agencies as well as nursing skills labs, simulation labs, and computer labs. (emphasis added)

Simulation technology is clearly a complementary subcategory of clinical practice that contributes to learning experiences. 16 CCR §1420(k) states:

(k) "Learning experience" means those activities planned for students by the faculty that are *designed to meet the objectives of the required course of instruction*, including the basic standards of competent performance in section 1443.5. (emphasis added)

In effect, the proposed language change in SG19 completely removes the link between simulation in clinical practice and specific course outcomes. We are very concerned that this broad reference to only "programmatic outcomes" clouds the existing requirement that only 25% of the clinical hours *in each course* (except in an initial nursing course) can be outside of a board approved clinical setting providing direct patient care.²² Simulation activities should be linked to *both* course and programmatic outcomes.

Furthermore, recent legislative activity that would allow certain nursing programs to reduce direct patient care from 75% of the clinical hours *in a course* to 50% of the *total clinical hours* only serves to support our belief that a desire exists for rapid and unregulated increases in school enrollment by taking advantage of the expanded use of expensive simulation technology to replace direct patient care.

- **Resources and References Cannot be Completely Reviewed**

CNA has reviewed the resources and references that are part of the SG19 document to the extent that they are available. As we have discussed, we were unable to review a number of the documents because they are not open access or the links to the references are not functioning properly. We have prepared a chart (See Attachment I) with comments and recommendations.

²² 16 CCR 1426(g)(2).

- **SG Form for Voluntary Use in Assessment of Compliance with Standards**

The SG Form provided for the voluntary use of nursing programs is a puzzling addition to an SG that is already voluntary. The NECs cannot use the form to evaluate nursing programs or programs applying for approval until an SG and an SG form has been adopted by the Board (assuming the board would choose to do so) and approved through the APA process. It would seem to be a reasonable assumption that programs that voluntarily agree to utilize the SG might also voluntarily agree to self-assess using the SG Form.

However, it seems unlikely that a program that is unable or unwilling to adopt the SGs or that believes that their own guidelines meet their specific needs, would volunteer to participate in the process at all, much less volunteer to self-assess using the SG Form. This makes it unlikely that “routine simulation guideline assessment across all schools as a part of a school’s total program evaluation processes” would be a likely outcome.²³ The document provides a place to fill in the Reviewer Name, but it is not clear who the Reviewer is since it is not a document that NECs, would be able to use. Are these self-assessment forms that are to be filled out by a faculty reviewer? If so, is the form meant to be for internal use only?

- **Annual Report Added To SG19**

Since 99% of nursing programs already report on the use of simulation in their annual school survey to the BRN, this provision would seem to be a superfluous addition to SG19.²⁴

- **Nursing Programs With Sufficient Clinical Placements For Students In Direct Patient Care Eschew Maximum Use of Simulation**

The 2017-2018 Annual School Report indicates that the majority of nursing programs that use less than 25% non-direct patient care in their clinical courses choose to do so because they have enough clinical placement/direct patient care opportunities available.²⁵ This suggests that many schools that have adequate clinical placement for their students do not see simulation as a technology that is *necessary* for student success.

In sum, CNA believes the BRN should neither encourage nor discourage the use of simulation technology and that schools should continue to demonstrate compliance with BRN standards during regular program reviews by NECs at least every five years, as required, or sooner if the program fails to meet NCLEX pass rates or other regulatory standards.

²³ SG19 at 1.

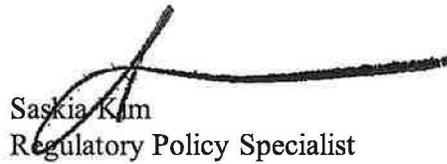
²⁴ Lisel Blash, MPA, Joanne Spetz, PhD, California BRN 2017-18 Annual School Report, February 8, 2019 at 46.

²⁵ *Id.* at 48.

Thank you for the opportunity to comment on the SG19, the revised version of the October 5, 2018 simulation guidelines proposed by the NEWAC Simulation Work Group, and the SG Assessment Form. Please let me know if you have any questions.

Sincerely,

CALIFORNIA NURSES ASSOCIATION/
NATIONAL NURSES UNITED



Saskia Kim
Regulatory Policy Specialist

Attachment

ATTACHMENT I

<u>Standards</u>	<u>Comment</u>	<u>Recommendation</u>
INACSL Standards https://www.inacsl.org/i4a/pages/index.cfm?pageID=3407	Link not functioning. Document cannot be found	Delete
Hayden, J. K., Smiley, R. A., Alexander, M., Kardong-Edgren, S., & Jefferies, P. R. (2014). The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education. <i>Journal of Nursing Regulations</i> , 5(2), S3-S64. https://www.journalofnursingregulation.com/article/S2155-8256(15)30062-4/pdf	Duplicate document in references. This is not really a standard .	Delete from “Standards” and leave in “References”
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Debriefing. <i>Clinical Simulation in Nursing</i> , 12(S), S21-S25. http://dx.doi.org/10.1016/j.ecns.2016.09.008 . https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBP EnglishCombo.pdf	All 8 of the INACSL Standards are contained within one link that is repeated 8 times resulting in unnecessary duplication and padding of the standards section.	Re-format as one link and label “INACSL Standards Committee (2016, December) INACSL Standards of Best Practice Simulation”
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Facilitation. <i>Clinical Simulation in Nursing</i> , 12(S), S16-S20. http://dx.doi.org/10.1016/j.ecns.2016.09.007 .	Duplicative	Delete
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Simulation glossary. <i>Clinical Simulation in Nursing</i> , 12(S), S39-S47. http://dx.doi.org/10.1016/j.ecns.2016.09.012 .	Duplicative	Delete
INACSL Standards Committee (2016, December). INACSL Standards of Best Practice: Simulation SM Outcomes and objectives. <i>Clinical Simulation in Nursing</i> , 12(S), S13-S15. http://dx.doi.org/10.1016/j.ecns.2016.09.006 .	Duplicative	Delete
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Participant evaluation. <i>Clinical Simulation in Nursing</i> , 12(S), S26-S29. http://dx.doi.org/10.1016/j.ecns.2016.09.009 .	Duplicative	Delete
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Professional integrity. <i>Clinical Simulation in Nursing</i> , 12(S), S30-S33. http://dx.doi.org/10.1016/j.ecns.2016.09.010 .	Duplicative	Delete
INACSL Standards Committee (2016, December). INACSL Standards of Best Practice: Simulation SM	Duplicative	Delete

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Simulation-enhanced interprofessional education (sim-IPE). <i>Clinical Simulation in Nursing</i> , 12(S),S34-S38. http://dx.doi.org/10.1016/j.ecns.2016.09.011 .		
INACSL Standards Committee (2016, December). INACSL standards of best practice: Simulation SM Simulation design. <i>Clinical Simulation in Nursing</i> , 12(S), S5-S12. http://dx.doi.org/10.1016/j.ecns.2016.09.005 .	Duplicative	Delete
<u>National Council of State Boards of Nursing Model Act Simulation Rules (2017):</u> https://www.ncsbn.org/search.htm?q=model+rules+simulation	Link is to Aug 2016 NCSBN Annual Meeting where <i>partial model act presented</i> . Complete Simulation Guidelines incorrectly placed in references.	Delete and replace with link/citation in reference section
Society For Simulation in Healthcare. (2016, May). <i>CORE Standards and Measurement Criteria</i> . Retrieved from http://www.ssih.org/Accreditation/Full-Accreditation: http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Core%20Standards%20and%20Criteria.pdf	No comment	
Society for Simulation in Healthcare. (2016, May). <i>TEACHING/EDUCATION Standards and Measurement Criteria</i> . Retrieved from http://www.ssih.org/Accreditation/Full-Accreditation: http://www.ssih.org/Portals/48/Accreditation/2016%20Standards%20and%20Docs/Teaching-Education%20Standards%20and%20Criteria.pdf	No comment	
<u>Certifications</u>	<i>Comment</i>	<i>Recommendation</i>
Certification as Healthcare Simulation Educator (CHSE): http://www.ssih.org/Certification/CHSE	No comment	
<u>Certification as Healthcare Simulation Operations Specialist (CHSOS)</u> http://www.ssih.org/Certification/CHSOS	Non-functioning link in draft for CHSOS.	Use link: https://www.ssih.org/Credentialing/Certification/CHSOS
<u>Educational Courses</u>	<i>Comment</i>	<i>Recommendation</i>
California Simulation Alliance Education Courses, Mentor Program, and Apprentice Program: https://www.californiasimulationalliance.org/education/	No Comment	

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<i>Educational Courses (continued)</i>	<i>Comment</i>	<i>Recommendation</i>
National League for Nursing http://www.nln.org/professional-development-programs/teaching-resources/ace-s/unfolding-cases	No comment	
Quality and Safety Education for Nurses (QSEN): http://qsen.org/teaching-strategies/strategy-search/advanced-search-results/?strat_type=Simulation%20Exercises	No comment	
Simulation Innovation Resource Center (SIRC): http://sirc.nln.org/mod/page/view.php?id=842	SIRC is part of NLN educational resources	Add: NLN to title:
<i>References</i>	<i>Comment</i>	<i>Recommendation</i>
Abersold, M, Tschannenm D. Simulation in nursing practice: The impact on patient care. <i>The Online Journal of Issues in Nursing</i> . 2013;18(2):Manuscript 6. doi: 10.3912/OJIN.Vol18No02Man06.	This article is specific to licensed practicing RNs in the patient care setting. It is not relevant to prelicensure students.	Delete
Alexander, M., Durham, C. F., Hooper, J. I., Jeffries, P. R., Goldman, N., Kardong-Edgren, S., . . . Radtke, T. C. NCSBN Simulation Guidelines for Prelicensure Nursing Programs. <i>Journal of Nursing Regulation</i> , 2015; 39-41. https://www.ncsbn.org/16_Simulation_Guidelines.pdf	Incorrectly placed in references when these are actually standards/guidelines	Move to standards to replace incomplete Simulation Guidelines from Aug 2016 NCSBN Annual Meeting Presentation
Benner P, Sutphen M, Leonard V, Day L. <i>Educating nurses: A call for radical transformation</i> . San Francisco, CA: Jossey-Bass; 2010.	Dated Material with old and outdated information on nursing workforce.	Delete
Dreifuerst KT. Using debriefing for meaningful learning to foster development of clinical reasoning in simulation. <i>Journal of Nursing Education</i> . 2012;51(6), 326-333. doi:10.3928/01484834-20120409-02.	Not Open Access Unable to Review and Comment	Make available for review or delete.
Eppich W, Cheng A. Promoting excellence and reflective learning in simulation (PEARLS): Development and rationale for a blended approach to health care simulation debriefing. <i>Simulation in Healthcare</i> . 2015;10(2):106-115. doi: 10.1097/SIH.0000000000000072.	No comment	
Forneris SG, Fey M. <i>Critical conversations: The NLN guide for teaching thinking</i> . Washington, D.C.: National League for Nursing; 2018.	Not Open Access	Make available for review or delete
Forneris SG, Neal DO, Tiffany J, et al. Enhancing clinical reasoning through simulation debriefing: A multisite study. <i>Nursing Education Perspectives</i> . 2015;36(5):304-310. doi: 10.5480/15-1672	No comment	

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<p>INACSL. Simulation regulation map. https://www.inacsl.org/simulation-regulations/ Retrieved: March 31, 2019</p>	<p>Map not relevant to standards development</p>	<p>Delete</p>
<p>Ironside PM, McNelis AM, Ebright P. Clinical education in nursing: rethinking learning in practice settings. <i>Nursing Outlook</i>. 2014;62(3):185-191.</p>	<p>Not Open Access Unable to Review and Comment</p>	<p>Make available for review or delete.</p>
<p>Jeffries PR. A framework for designing, implementing and evaluating simulations used as teaching strategies in nursing. <i>Nursing Education Perspectives</i>. 2005;26(2):96.</p>	<p>Not Open Access Unable to Review and Comment</p>	<p>Make available for review or delete.</p>
<p>Jeffries PR. <i>The NLN Jeffries Simulation Theory</i>. Washington, DC: National League for Nursing; 2015. ISBN/ISSN:9781934758243.</p>	<p>Not Open Access Unable to Review and Comment</p>	<p>Make available for review or delete.</p>
<p>Marshall LC, <i>Mastering patient and family education: A healthcare handbook for success</i>. Indianapolis, IN. Sigma Theta Tau International: 2015.</p>	<p>Not Open Access Unable to Review and Comment</p>	<p>Make available for review or delete.</p>
<p>National League for Nursing. (2015). Debriefing across the curriculum. Retrieved from http://www.nln.org/docs/default-source/about/nln-vision-series-(position-statements)/nln-vision-debriefing-across-the-curriculum.pdf?sfvrsn=0</p>	<p>Link does not work</p>	<p>Insert correct link: http://www.nln.org/docs/default-source/about/nln-vision-series-%28position-statements%29/nln-vision-debriefing-across-the-curriculum.pdf?sfvrsn=0</p>
<p>The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education. <i>Journal of Nursing Regulations</i>. 2014;5(Supplement): S3–S40. doi: 10.1016/S2155-8256(15)30062-4.</p>	<p>Refer to CNA comments on 10/2018 Draft.</p>	<p>Refer to CNA comments on 10/2018 Draft</p>
<p>Palaganas, J.C., Maxworthy, J.C., Epps, C. A., Mancini, M.E. (2015). Defining Excellence in Simulation Programs, SSH.</p>	<p>Not Open Access Unable to Review and Comment</p>	<p>Make available for review or delete.</p>
<p>Rudolph J, Simon R, Dufresne RL, Raemer DB. There’s no such thing as “nonjudgmental” debriefing: A theory and method for debriefing with good judgement. <i>Simulation in Healthcare</i>. 2006;1(1):49-55.</p>	<p>Link not provided to article. Orange County/Long Beach Consortium has article on website. Old article but useful information on debriefing with good judgment.</p>	<p>Add link: http://www.oclbcp.org/Documents/Simulation%20article%20with%20good%20judgment.pdf</p>
<p>Rizzolo MA, Kardong-Edgren S, Oermann MH, Jeffries PR. The National League for Nursing project to explore the use of simulation for high stakes assessment: Process,</p>	<p>Not Open Access Unable to Review and Comment</p>	<p>Make available for review or delete.</p>

ATTACHMENT I

<p>outcomes and recommendations. <i>Nursing Education Perspectives</i>. 2015;36:299-303. doi: 10.5480/15-1639.</p>		
<p>White C. A socio-cultural approach to learning in the practice setting. <i>Nurse Education Today</i>. 2010;30(8):794–797. doi: 10.1016/j.nedt.2010.02.002.</p>	<p>“This paper examines the changes which have occurred within the pre-registration nursing curriculum in the Republic of Ireland with the transition from the apprenticeship system to the graduate programme, and the resulting reduction in clinical learning hours.” [from abstract] Ireland has a different nursing education structure than California/USA.</p> <p>Not Open Access.</p>	<p>Delete</p>

Simulation Guidelines (SG)

Recommended by the Nursing Education and Workforce Advisory Committee (NEWAC) *
NEWAC is requesting California Pre-Licensure Nursing Education Programs voluntarily adopt/use
these guidelines and the standardized Simulation Assessment form beginning in Fall 2019

**** NEWAC is committed to the promotion and achievement of excellence in nursing education, workforce planning and nursing practice in California. (Fall 2019)***

The SG listed below were developed by the NEWAC Simulation workgroup to promote simulation use and establish a broad, realistic and uniform set of simulation guidelines/standards that support statewide commitment and consensus related to implementation of high quality simulation-based learning experiences in California pre-licensure nursing education programs.

These guidelines have been developed based on findings from the NCSBN National Simulation Study (Hayden, Smiley, Alexander, Kardong-Edgren, & Jefferies, 2014), the International Nursing Association for Clinical Simulation and Learning Standards of Best Practice: SimulationSM, the Society for Simulation in Healthcare CORE Accreditation Standards, and the Society for Simulation in Healthcare TEACHING/EDUCATION Accreditation Standards and *NCSBN Model Rules (2017)*

The Resources and References sections of this document provide access to the more detailed specific evidence-based national simulation standards for the SG categories and subcategories listed below. (KT please check hyperlinks for reference accuracy and workability)

A standardized Simulation Guidelines (SG) Assessment form has also been included. Voluntary use of the attached standardized SG Assessment form is to promote more uniform routine simulation guideline assessment across all schools as a part of a school's total program evaluation processes.

Definitions

"Simulation" means a technique to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner (Gaba, 2004), and includes all modalities of simulation.

"Debriefing" means an activity that follows a simulation experience, is led by an approved program faculty member/facilitator, encourages participant's reflective thinking, and provides feedback regarding the participant's performance.

Standard - The nursing program is committed to providing high-quality simulation educational activities. The program can demonstrate the criteria listed below.

Evidence of Compliance

- a. A program shall provide evidence to the board of nursing that these standards have been met.

Organization and Management

- a. The program shall have a framework that provides adequate resources (fiscal, human, and material) to support the simulation activities.

- b. Simulation activities shall be managed by an individual who is academically and experientially qualified. The individual shall demonstrate continued expertise and competence in the use of simulation while managing the program.
- c. The budget will sustain simulation activities and education and training of the faculty.

Facilities and Resources

- a. The program shall have appropriate facilities for conducting simulation.
- b. The program has personnel with expertise designing simulation educational activities.
- c. The program has adequate equipment and supplies to create a realistic patient care environment. (took out the period after patient care)

Faculty Preparation

- a. The program has a process to assure faculty utilizing simulation are formally trained in simulation pedagogy.
- b. The program has a process to assure initial and ongoing development and competence of simulation educators.

Curriculum

- a. The program shall demonstrate that simulation activities are linked to programmatic outcomes.
- b. The program uses appropriate simulation related planning, implementation and evaluation processes, and clinical practice learning activities that comply with the state board of nursing regulatory requirements.
- c. The program uses simulation educational activities that are evidence based, engaging, and effective.

Policies and Procedures

- a. The program shall have written policies and procedures in place (removed the word “are”) to ensure quality consistent simulation experiences for the students throughout the curriculum. This includes the following:
 - I. short-term and long-term plans for integrating simulation into the curriculum
 - II. method of debriefing each simulated activity
 - III. plan for orienting faculty to simulation
 - IV. Clearly defined roles and responsibilities for simulation faculty members/facilitators

Evaluation

The program has mechanisms in place to evaluate educational activities, including:

- a. Criteria to evaluate the simulation activities.
- b. Faculty ensure all simulation-based experiences require participant evaluation.

Annual Report

- a. Include information about use of simulation in its annual school survey to the board of nursing.

Resources available

CHSE Certification: <http://www.ssih.org/Certification/CHSE>

California Simulation Alliance Education Courses, Mentor Program, and Apprentice Program: <https://www.californiasimulationalliance.org/education/>

Need clarification if this is the correct title or should it be Online Graduate Program in Healthcare Simulation> Three-Step Program at Boise State: this links to Boise State ut not simulation specific reference https://hs.boisestate.edu/nursing/sgcp/ This link does take one to Online Graduate Program in Healthcare Simulation

<https://www.boisestate.edu/nursing/sgcp/>

INASCL Standards <https://www.inacsl.org/i4a/pages/index.cfm?pageID=3407>

Massachusetts Nursing Initiative: <http://www.mass.edu/currentinit/Nursing/Sim/Scenarios.asp>

Montgomery College—Maryland: <http://cms.montgomerycollege.edu/nursingsims/>

National League for Nursing (NLN): www.nln.org/professional-development-programs/teaching-resources/aging/unfolding-cases

National Council of State Boards of Nursing Model Act Simulation Rules (2017): http://www.ncsbn.org/Model_Rules_0917.pdf KT please check/modify as needed

Quality and Safety Education for Nurses (QSEN): http://qsen.org/teaching-strategies/strategy-search/advanced-search-results/?strat_type=Simulation%20Exercises

Simulation Innovation Resource Center (SIRC): <http://sirc.nln.org/mod/page/view.php?id=842>

University of South Dakota: **broken** www.usd.edu/health-sciences/nursing/simulation-scenarios

Unable to find simulation scenarios refereced at <https://www.usd.edu/health-sciences/nursing/simulation-center>

University of Washington: **broken** <http://collaborate.uw.edu/educators-toolkit/stroke.html-0>

Here is the link to University of Washington but was not able to find this reference for stroke <https://collaborate.uw.edu/resources-and-training/online-training-and-toolkits/>

Textbooks:

Jeffries (2007) Simulations in Nursing Education: From Conceptualization to Evaluation;

Jeffries (2013) Clinical Simulations: Advanced Concepts, Trends, and Possibilities;

Palaganas, J.C., Maxworthy, J.C., Epps, C. A., Mancini, M.E. (2015). Defining Excellence in Simulation Programs

<http://nl.lww.com/Simulation-in-Nursing-Education/p/9781934758151>
<http://nl.lww.com/Clinical-Simulations-in-Nursing-Education/p/9781934758199>

DRAFT

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https://www.ncsbn.org/16_Simulation_Guidelines.pdf
- Hayden, J. K., Smiley, R. A., Alexander, M., Kardong-Edgren, S., & Jefferies, P. R. (2014). The NCSBN national simulation study: A longitudinal, randomized, controlled study replacing clinical hours with simulation in pre-licensure nursing education. *Journal of Nursing Regulations, 5(2)*, S3-S64. [https://www.journalofnursingregulation.com/article/S2155-8256\(15\)30062-4/pdf](https://www.journalofnursingregulation.com/article/S2155-8256(15)30062-4/pdf)
- INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSM Debriefing. *Clinical Simulation in Nursing, 12(S)*, S21-S25.
<http://dx.doi.org/10.1016/j.ecns.2016.09.008>.
<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>
- INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSM Facilitation. *Clinical Simulation in Nursing, 12(S)*, S16-S20.
<http://dx.doi.org/10.1016/j.ecns.2016.09.007>.
<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>
- INACSL Standards Committee (2016, December). INACSL standards of best practice: SimulationSM Simulation glossary. *Clinical Simulation in Nursing, 12(S)*, S39-S47.
<http://dx.doi.org/10.1016/j.ecns.2016.09.012>.
<https://www.inacsl.org/INACSL/document-server/?cfp=INACSL/assets/File/public/standards/SOBPEnglishCombo.pdf>
- INACSL Standards Committee (2016, December). INACSL Standards of Best Practice: SimulationSM Outcomes and objectives. *Clinical Simulation in Nursing, 12(S)*, S13-S15.
<http://dx.doi.org/10.1016/j.ecns.2016.09.006>.
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BOARD OF REGISTERED NURSING
Nursing Education & Workforce Advisory Committee
Agenda Item Summary

AGENDA ITEM: 6.0
Date: October 28, 2019

ACTION REQUESTED: Nursing Workforce Issues-Information Only-Public Health Nursing Update

REQUESTED BY: Dr. Joseph Morris, PhD, RN, BRN Executive Officer

BACKGROUND: At the February 19, 2019 NEWAC meeting, NEWAC member Jose Escobar, provided a PowerPoint presentation related to Public Health Nursing entitled: *Enhancing the Education and Preparation of the future Public Health Nursing Workforce in California.*

The presentation included recommendations for the California Directors of Public Health Nursing including use of the recognized public health definitions, appropriate public health practice settings, educational and regulatory requirements, identified gaps in faculty qualifications, and clearly defining appropriate public health settings and experiences, along with the need to embed the core principles/ANA Standards of Public Health Nursing in the nursing education program curriculum.

Three main presentation key points related to the Robert Wood Johnson Foundation Culture of Health Framework. This framework calls for a strong collaboration between academia, practice and the Board of Registered Nursing to:

- Assure nursing students receive instruction from qualified faculty with experience in public health nursing;
- Clearly define appropriate public health settings and experiences for clinical rotations;
- Embed the ANA core principles of PHN Scope and Standards of Practice in the nursing programs curriculum.

Today's agenda item is to further discuss barriers to achieve these outcomes and identify ways nursing education curriculum can be further enhanced/changed to accomplish the outcomes listed above.

NEXT STEPS: To be determined by NEWAC membership

PERSON(S) TO CONTACT: Joseph Morris, PhD, RN
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