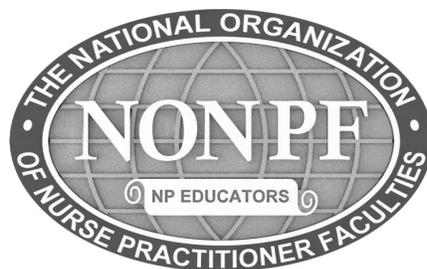


**Clinical Education Issues in Preparing Nurse Practitioner Students for
Independent Practice: An Ongoing Series of Papers**

National Organization of Nurse Practitioner Faculties

2010



National Organization of Nurse Practitioner Faculties, Washington, DC

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PREFACE

In keeping with the mission of the National Organization of Nurse Practitioner Faculties (NONPF) to be the leader in education preparing a quality nurse practitioner workforce, this collection of papers is to meet a need identified by the NONPF membership for defining information about clinical education issues for nurse practitioners. The papers herein describe and differentiate the types of clinical educational experiences that are part of nurse practitioner education and provide NONPF's recommendations. Topics addressed in the collection include, but are not limited to, clinical practice hours, simulation for education, and universal terminology to describe clinical practice. Since varied terms and approaches to clinical education exist in nurse practitioner curricula, NONPF members identified a need to describe and define the optimal types of clinical educational experiences in nurse practitioner curricula. The NONPF Board envisions this collection as part of an ongoing series of papers to be produced based on the emergent needs of the NONPF membership.

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Introduction

Nurse practitioners (NPs) have become a vital part of the United States health care system, focusing on health promotion and care of acute and chronic illnesses and injuries. NPs are independent practitioners providing care in a variety of settings, including public health, primary care, long-term care and acute care. Consequently, NP education must include a strong clinical base to prepare NPs for independent practice.

The concept of “ independent practice” is multidimensional, including legal aspects (Weiland, 2008), clinical practice realities related to the level of autonomy in actual practice (Cajulis & Fitzpatrick, 2007; Deshefy-Longhi, Swartz, & Grey, 2008), actual or perceived attainment of competencies (Hart & Macnee, 2007), political dimensions (Mullinix & Bucholtz, 2009), and interprofessional issues such as perceptions of others, e.g., physicians, on independence, perceptions of autonomy and scope of practice (Fletcher, Baker, Copeland, Reeves, & Lowery, 2007). Although legal independence is a fact, real practice independence in the pragmatic sense is contingent upon reimbursement (Weiland, 2008). In addition to the multiple dimensions regarding independent clinical practice described in the literature, anecdotally, when asked, most NPs have commented that practicing independently relates directly to the level of autonomy they experience in their clinical setting (Dumas, 2008, discussion with the American College of Physicians, July 11, 2008).

The DNP degree for NP students includes additional competencies that are to be combined with the existing *Domains and Core Competencies of Nurse Practitioner Practice* (NONPF 2006). The existing NP core competencies have guided educational programs in preparing the highly skilled nurse practitioner to implement full scope of practice as a licensed independent practitioner. The competencies are essential behaviors of all nurse practitioners that are demonstrated upon graduation regardless of the specialty focus of program. Nurse Practitioner graduates of a practice doctorate program have knowledge, skills, and abilities that are important to clinical practice including complex decision-making; refined communication; scientific foundations; mentored patient care experience with emphasis on independent and interprofessional practice; analytic skills for evaluating and providing evidence-based, patient care across settings; and advanced knowledge of the health care delivery system.

Strong curricula and strong clinical practica experiences are the foundation for preparing highly qualified independent nurse practitioners to meet the needs of the nation's health. This series of papers provides NONPF's position regarding clinical education for independent practice. The papers in this series describe and define terms related to the optimal types of clinical educational experiences in nurse practitioner programs. As more evidence-based knowledge is generated from educational research on learning outcomes of clinical experiences, recommendations will be revisited, updated and revised.

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NATIONAL ORGANIZATION OF NURSE PRACTITIONER FACULTIES

**Position on Clinical Hours for
Nurse Practitioner Preparation in
Doctor of Nursing Practice Programs**

August 2008

The National Organization of Nurse Practitioner Faculties (NONPF) membership requested guidance on the issue of how clinical hours should be determined for nurse practitioner (NP) preparation at the doctoral level, especially for those programs focusing on post-baccalaureate students. In response to increasing inquiries from members, the NONPF Board of Directors charged the Curricular Leadership Committee with addressing this issue for NP students in Doctor of Nursing Practice (DNP) programs. The position presented in this paper is the outcome of extensive work begun by the Clinical Hours Subcommittee, a subgroup of NONPF members serving on the Curricular Leadership Committee. This subcommittee developed an initial draft of a document describing current issues in clinical education of NPs and making recommendations regarding required number of clinical hours. The draft developed by the Clinical Hours Subcommittee then went on to the Review Subcommittee, another subgroup of NONPF members serving in the Curricular Leadership Committee that has the charge of reviewing the overall readability of documents prepared by the Curricular Leadership Committee. The NONPF Board of Directors, based on member input at the annual meeting in 2008 and the recommendations from both the Clinical Hours and Review Subcommittees, developed the final version of the report. *Since this is a time of transition from master's education to DNP education for NPs and keeping with NONPFs emphasis on competency-based education, this document is meant to be interpreted as a guide during this time of transition.*

Introduction

Health care disciplines, including nursing, have been moving toward competency based education as evidence of achievement of outcomes from educational programs. For over 18 years, NP curricula have been guided by the domains and core competencies developed by NONPF and based on the 1989 seminal research by Dr. Karen Brykczynski into the clinical practice of experienced nurse practitioners. In more recent years, NP curricula have been shaped further by the availability of NP population-focused competencies developed through a national consensus process led by NONPF. In 2006, NONPF also released the NP

competencies for the DNP. Despite the availability of national competencies for entry-level NP practice, NP student evaluation is not based solely on attainment of competencies. National standards, such as those outlined in the *Criteria for Evaluation of Nurse Practitioner Programs*, are applied across all NP programs and include requirements that are not directly learner-defined. Most notable of these standards is the minimum requirement of 500 clinical hours for masters NP education. This requirement was determined following review of the data obtained in 1995 from the NONPF Ad Hoc Task Force on Education, led by Dr. Doreen Harper. The Task Force on Education collected data from the 217 NP programs in existence at that time and found that the mean number of clinical hours reported by the NP programs included in the study were 500. An outcome of the study was to recommend to new and existing programs that a minimum of 500 clinical hours should be required by all NP students. It should be noted that the completion of the Ad Hoc Committee's work in 1995 represented data obtained from NP programs that were opened and graduating students during the period of data collection. Although the study did not assess achievement of individual competencies, the recommendations of a 500 clinical hours requirement was determined from both the NP program data available and collective wisdom at the time. Despite having only minimal evidence to support it, this number has historically served as a reasonable baseline for successful achievement on national NP certification examinations. Similarly, the recommendation of a minimum 1000 hours for post-baccalaureate DNP preparation proposed by the American Association of Colleges of Nursing (AACN) in their *Essentials for Doctoral Education* is not based on evidence. It is unclear as to whether these 1000 hours are intended to be totally clinical hours (face-to-face patient contact) or based on the additional content and competencies within the DNP preparation. Clearly, more evidence is needed to establish a national standard for the number of clinical hours required. More importantly, NP education needs to move towards a competency-based approach to assessment in which the number of clinical hours is of less importance than attainment of national NP competencies. However, as we work towards defining and clarifying terms and strategies related to measurement of competencies, this position statement is intended to give guidance to NP educators who are currently developing DNP programs for nurse practitioners.

Background

Practice doctorates in many health professions (i.e., medicine, audiology, dentistry, chiropractic medicine, optometry, pharmacy, physical therapy, podiatric medicine) are designed to prepare the beginning practitioner to enter practice. Specialty preparation for these professions is usually obtained after the practice doctorate and achieved in non-degree granting internships and residencies.

Nursing has chosen to pursue a different curricular pathway. The DNP is built upon the entry level professional preparation programs and is designed to prepare advanced practitioners in a variety of practice areas. Basic professional nursing education is the foundation for the DNP and encompasses achieving the competencies necessary to enter specialty practice. Therefore, there is little way to compare the clinical hour requirements of other practice doctorates with the new practice doctorate in nursing. The curricular models and the desired outcomes of these different practice doctorate programs are not comparable.

Nurse practitioner educational programs have a long and rich history of preparing highly competent graduates that have advanced the health of the people of this nation and abroad. These programs have evolved over the past quarter century from initial certificate programs to lengthy masters level programs. The core competencies for all NP graduates, as well as the population-focused competencies, have guided NP program development. In preparing for future practice, additional competencies beyond the master's have been identified for the practice doctorate. These include general competencies for all practice doctorates in nursing as well as unique competencies for NP graduates.

Although 500 hours is required in the *Criteria for Evaluation of Nurse Practitioner Programs*, NP programs at the master's level report that students spend on average 650 clock hours of supervised clinical time to achieve beginning level competencies¹. Although strong evidence is not available, anecdotally, this suggests that with this number of clinical hours graduates are able to successfully complete national board certification and enter beginning practice as a nurse practitioner. Achievement of the additional competencies for the DNP is expected to require additional practicum hours. **(See Table 1 for the NONPF DNP Competencies.)** The additional practicum hours will include clinical hours as well as other faculty guided and supervised experiences.

Defining Clinical Practice

Whereas the *AACN Doctoral Essentials* and other resource documents may tend to be vague on the definition of clinical practice, NONPF has a long-standing record of defining *clinical practice hours* as the hours in which direct clinical care is provided to individuals, families and populations in *population-focused areas* of NP practice. *Clinical hours* do not include skill laboratory hours, physical assessment practice sessions, or a community project, unless these include provision of direct care. Clinical experiences and time spent should be varied and distributed in a way that prepares the student to provide care to the populations served. For example, a FNP student should receive experiences with individuals/families across the life span.

Conclusions

Faculty supervised clinical experiences providing direct patient care will remain central to NP preparation for students seeking practice doctorates. However, clinical hours, as previously defined, is too narrow a definition of practicum hours to assess the achievement of the additional nurse practitioner competencies for the practice doctorate. As indicated within the NP DNP competencies, the NP with a practice doctorate must be able to provide leadership to foster intra-professional and inter-professional collaboration, demonstrate skills in peer review that promote a culture of evidence, apply clinical investigative skills to evaluate health outcomes, and be able to influence health policy. These and other additional competencies need to be measured by student outcomes or the achievement of behavioral objectives rather than solely the number of clinical hours. The additional competencies in autonomous practice,

¹ Berlin, L.E., Harper, D., Werner, K.E., & Stennett, J. (2002). *Master's level nurse practitioner educational programs. Findings from the 2000-2001 Collaborative Curriculum Survey*. Washington, DC: American Association of Colleges of Nursing and National Organization of Nurse Practitioner Faculties.

leadership, practice inquiry, and policy are as much a part of the fabric of professional preparation for the NP with a practice doctorate as direct patient care.

NONPF Position on Clinical Hours:

1. The clinical practice experiences of the student NP earning a practice doctorate need to include learning activities beyond expected clinical hours in direct patient care. A broad range of learning activities could assist the student NP earning a practice doctorate to achieve the expected student outcomes. Examples of learning activities include:
 - participating in a clinical agency's committee to evaluate a practice protocol;
 - participating in a health initiative in the state's health department;
 - participating in components of program evaluation within a clinical unit.
2. Nurse practitioner education, which is based on the core and population-focused NP competencies, needs to recognize that the student's ability to show successful achievement of the competencies is of greater value than the number of clinical hours the student has performed. Although NP curricula have been developed around domain and competencies since 1990, the measurement of student successful achievement of the competencies as an educational outcome is not standardized across NP educational programs.
3. NONPF recommends research to support an evidence base for educational, accreditation, and certifying bodies to evaluate achievement of critical outcomes and competencies of NPs and other advanced practice nurses.
4. Although the scientific basis for the current national standard of 500 clinical hours in NP education is minimal at best, expert opinion supports a minimum of 500 hours as a reasonable timeframe that has led to successful achievement on national nurse practitioner certification examinations and satisfaction with **beginning** practice skills of NPs prepared in master's programs. In the *Criteria for Evaluation of Nurse Practitioner Programs*, 500 hours in direct patient care is also the minimum required for NP programs. However, we also know that the average number of hours in programs is reported at 650 hours. In addition, for students to achieve the DNP competencies as outlined by NONPF and AACN, a combination of direct care to individuals and families in a specific area of NP practice and other mentored learning experiences will be required. Moreover, it is very likely that more than 500 hours will be needed for students to meet the first NONPF DNP competency of Independent Practice, which is not an expected competency for master's level NP programs. Consequently, while 500 hours of direct patient care is the minimum required by the *Criteria for Evaluation of Nurse Practitioner Programs*, DNP programs will need to require significantly more hours than this in order for students to obtain the core, population-focused and DNP competencies. *These hours must include both direct patient care and in other mentored learning experiences.*

Therefore, for post-BSN NP students, NONPF requires a minimum of 500 clinical hours (as defined by NONPF focusing on direct care to individuals and families in a specific area of NP practice) in order to document attainment of the core and population-focused NP competencies. In addition, other mentored learning experiences should be part of the educational experience in order to achieve all other DNP competencies as outlined in the *NONPF DNP Competencies* and *AACN DNP Essentials*. Post-master's NP students who

are nationally certified need to have sufficient clinical experience to demonstrate achievement of DNP competencies as outlined in the *NONPF DNP Competencies* and *AACN DNP Essentials*.

ADDENDUM

Approved by the NONPF Board of Directors

April 2010

The NONPF Board recognizes that masters-prepared nurse practitioners are presumed to have met the NP core competencies and, as post-master's DNP students, are developing DNP competencies. If the site of employment is determined to be a suitable placement for clinical, it should be a clear expectation that new practice opportunities should be provided in order for the student to meet DNP competencies and that these new practice opportunities are beyond the current expectations that the DNP student has as an employee. DNP competencies are not associated with specific clinical practices or practice sites. Rather, they ensure that students have the opportunity to achieve a different level of clinical practice regardless of clinical site. The issue is whether or not the DNP student demonstrates the achievement of DNP competencies, regardless of whether they are in their current place of employment or in different clinical setting. With these principles in mind, the DNP faculty and DNP student should be able to determine whether or not a clinical site is suitable for achieving DNP competencies and the decision should be between the student and faculty.

Table 1: NONPF Practice Doctorate (DNP) Nurse Practitioner Entry-Level Competencies

Competency Area: Independent Practice

- (1) Practices **independently** by assessing, diagnosing, treating, and managing **undifferentiated patients**
- (2) Assumes full accountability for actions as a **licensed independent practitioner**

Competency Area: Scientific Foundation

- (1) Critically analyzes data for practice by integrating knowledge from arts and sciences within the context of nursing's philosophical framework and scientific foundation
- (2) Translates research and data to anticipate, predict and explain variations in practice

Competency Area: Leadership

- (1) Assumes increasingly complex leadership roles
- (2) Provides leadership to foster **interprofessional** collaboration
- (3) Demonstrates a leadership style that uses critical and reflective thinking

Competency Area: Quality

- (1) Uses best available evidence to enhance **quality** in clinical practice
- (2) Evaluates how organizational, structural, financial, marketing, and policy decisions impact cost, outcomes, quality, and accessibility of health care
- (3) Demonstrates skills in **peer review** that promote a **culture of excellence**

Competency Area: Practice Inquiry

- (1) Applies clinical investigative skills for evaluation of health outcomes at the patient, family, population, **clinical unit**, systems, and/or community levels
- (2) Provides leadership in the translation of new knowledge into practice
- (3) Disseminates evidence from inquiry to diverse audiences using multiple methods

Competency Area: Technology & Information Literacy

- (1) Demonstrates **information literacy** in complex decision making
- (2) Translates technical and scientific health information appropriate for user need
- (3) Participates in the development of clinical information systems

Table 1 continued.

Competency Area: Policy

- (1) Analyzes ethical, legal, and social factors in policy development
- (2) Influences **health policy**
- (3) Evaluates the impact of **globalization** on health care policy development.

Competency Area: Health Delivery System

- (1) Applies knowledge of organizational behavior and systems.
- (2) Demonstrates skills in negotiating, consensus-building, and partnering.
- (3) **Manages** risks to individuals, families, populations, and health care systems.
- (4) Facilitates development of **culturally relevant** health care systems.

Competency Area: Ethics

- (1) Applies ethically sound solutions to complex issues

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NATIONAL ORGANIZATION OF NURSE PRACTITIONER FACULTIES

**Eligibility for NP Certification for Nurse Practitioner Students
In Doctor of Nursing Practice Programs**

August 2008

The NONPF membership requested guidance on the issue of when nurse practitioners (NPs) in post-baccalaureate Doctor of Nursing Practice (BSN-DNP) programs should be eligible to sit for a national certification exam. NONPF has established core competencies for nurse practitioner practice that were revised in 2006, and that same year NONPF released the *Practice Doctorate (DNP) Nurse Practitioner Entry-Level Competencies*. The core competencies for all NP graduates, the population-focused competencies, and the additional competencies beyond the master's level that address autonomous practice, leadership, practice inquiry, and policy identify the skills to prepare graduates for future practice. This enhanced practice is attained through additional education and practice experience beyond that required to meet the basic core competencies of the NP. The question is "At what point should DNP students be eligible to take NP certification examinations?"

The issues surrounding eligibility for DNP students to sit for certification are discussed below. The discussion includes both the background of the current discussion and issues relating to fiscal, current certification requirements, factors related to legislation, state educational systems and institutional programs.

Background

In response to increasing inquiries from members, the NONPF Board of Directors charged the Curricular Leadership Committee with addressing this issue. The Entry Point Subcommittee, a subgroup of NONPF members serving on the Curricular Leadership Committee, developed an initial draft of a document describing current factors impacting clinical education of nurse practitioners and making recommendations regarding the point at which NPs in DNP programs should be eligible to sit for the national certification examination. The factors that needed to be considered include: current legislative language within individual states, current individual state educational systems, institutional program designs, requirements of national certification boards, and fiscal considerations.

Following preparation of an initial draft by the Entry Point Subcommittee, the Review Subcommittee of the Curricular Leadership Committee evaluated the document for its overall readability and flow. A revised draft was submitted to the NONPF Board of Directors. The NONPF Board of Directors integrated the member input received at the 34th Annual Meeting in April 2008 with the recommendations from both the Entry Point and Review Subcommittees to finalize this paper regarding entry point for doctor of nursing practice programs with nurse practitioner students. *Since this is a time of transition from master's education to DNP education for NPs, this document is meant to be interpreted as a guide during this time of transition.*

Factors Related to Legislation

Since individual states govern licensure, recommendations on certification must be sensitive to state legislative requirements. Currently, 19 states require a Master's degree for nurses to practice in an Advanced Practice Nursing (APN) role. The remaining states either require a graduate degree or have no language regarding degree requirements for the APN role. For those 19 states, for the BSN-DNP graduate to enter practice, either the educational institutions will need to grant a Master's degree at some point in their program or legislative changes will be required.

State Educational Systems

There are several states in which only one or a limited number of institutions are able to grant doctoral degrees. Currently, in those states, the vast majority of nurse practitioners are prepared in institutions at the master's level. If eligibility for NP certification is upon completion of the DNP program, institutions that are not able to award doctoral degrees could be prevented from preparing nurse practitioners unless institutional policies and/or state's educational regulations are amended. It has been suggested that if eligibility for NP certification at completion of the DNP program, there will be the potential to significantly reduce the number of nurse practitioner graduates and ultimately affect access to care in those states. Safeguards should be in place. An example of such safeguard could be partnering of current master's level institutions with DNP granting institutions, to insure access to NP educational opportunities, while enabling the progress of NP education from the Master's to DNP level. Such partnering would continue educating NPs whose entry to practice will continue to increase access to health care for consumers.

Institutional Program Designs

NONPF supports the evolution of nurse practitioner education from Master's level to Doctoral level education. Historically, NP programs have increased both didactic content and clinical hours to meet the demands of changes in the clinical practice. Like physical therapy and pharmacy, evolution to doctoral education provides natural academic progression for NP education.

The NONPF Board does not support a "tiered approach" to NP education and has emphasized its commitment to certification occurring at the end of a NP program. The process of earning

any degree is one upon which a knowledge base is built, with integration and synthesis throughout the program. The DNP is a degree that will weave doctoral education and development of critically global thinking into the BSN-DNP curriculum. It would, therefore, not be appropriate to compartmentalize knowledge as “masters” or “doctoral” and NONPF would not recommend creating a master’s exit point in a BSN-DNP program.

As noted above, institutions who are at present unable to grant doctoral degrees need to explore changing their institution’s doctoral degree granting policies, as well developing DNP consortiums similar to existing educational consortiums. Partnering with DNP granting institutions will enable those NP programs unable to award the DNP to continue to provide NP education while anticipating offering a DNP degree. Considering the legislative and educational changes needed to be completed in order to transition to DNP education, the proposed timeline of 2015 by AACN as a goal is optimistic.

Fiscal Considerations

Traditionally, many nurses pursuing advanced practice preparation are full time employees and are often supported by tuition reimbursement/remission benefits from their employers. Because DNP students may not have access to funding sources and may not be supported by employee tuition reimbursement, promoting the “tiered” approach to DNP education is a dilemma. It raises the issues for a potential model of two tiered NP licensure, differences in clinical practice privileges, pay scales, etc. As noted above, NONPF does not support a “tiered approach” to NP education.

Health care agencies willing to provide clinical practice opportunities or “residencies” to DNP students have indicated that they may not be able to provide these opportunities or a stipend to the student if they cannot bill for the student’s services. Presently, health care agencies and institutions do not bill for NP students’ services. Few BSN-DNP programs have begun, and fewer have yet to graduate students. The majority of the students presently enrolled in DNP programs are Post-Master’s, certified NPs to whom this issue does not apply.

Requirements of National Certification Bodies

Recommendations on certification need to address potential impact on national certification processes. The certification program eligibility for certification requires completion of a master’s, post-master’s or DNP program prior to examination eligibility. Examination eligibility requirements for national certification exams are currently structured to ensure that the examinees have: a) met certain minimum role related requirements including advanced pathophysiology, advanced pharmacology, advanced health assessment; b) completed diagnosis and management courses; and c) completed a specified minimum number of precepted clinical practice hours. At present, certifying bodies have not announced a specific certification examination for BSN-DNP graduates that differ from existing certification exams offered following completion of master’s NP education.

Conclusion

With the movement to the Doctor of Nursing Practice (DNP) as the entry into nurse practitioner practice, the impact of this change on the current entry into the nurse practitioner role is a complex issue. The certifying bodies and state regulators will examine their requirements and weigh the needs of their consumers during this transition period. As with most transitions, the process is not without unanticipated challenges. Realization of the DNP as entry to NP practice will be a process requiring the collaboration and advocacy of NPs, NP educators, certifiers and legislators. NONPF fully supports the DNP as entry to practice and does not support decisions that will delay progress toward national standards that support this outcome. NONPF does not recommend a master's exit point in a BSN-DNP program, but realizes that individual schools will need to determine the process that best fits their needs during the transition period to the DNP as the entry level to NP practice.

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NATIONAL ORGANIZATION OF NURSE PRACTITIONER FACULTIES

Clarification of Terminology to Describe Clinical Experiences:

Residency versus Practicum

2010

Nurse Practitioners prepared with a Doctor of Nursing Practice (DNP) degree will possess policy skills and a systems/population health focus with an emphasis on collaborative, independent, interdisciplinary, and evidence-based practice. As nurse practitioner (NP) programs evolve to the DNP degree questions about the clinical practicum experiences will continue to arise. This paper addresses the question of terminology used to describe clinical experiences for NPs.

The term “residency” has sometimes been used to describe the experiences related to the clinical component of nursing education (Hollinger-Smith & Murphy, 1998; Wall, Novak & Wilkerson, 2005, Upvall and Ptachcinski, 2007.) However, the use of the term “residency” has a different meaning outside of the NP profession. Traditionally, in other health care disciplines such as medicine, podiatry, pharmacy and optometry the term “residency” has been used to describe clinical experiences which are clearly delineated as post graduate experiences and refer to a focus on direct patient care. In these disciplines the “Resident” is salaried, the education is planned, and the residency programs are either certified or accredited.

The NONPF Board views that the use of the term “residency” within the context of nurse practitioner clinical education has the potential for creating confusion and misinterpretation since the definition of the term is not consistent across programs or disciplines. As a result, the NONPF Board recommends that the term “residency” should be avoided when describing clinical educational experiences that occur as part of the degree program. A “practicum” is a term used to describe the clinical experience that accompanies the DNP capstone. By the nature of the clinical experience associated with the capstone project, this practicum experience would be more clinically focused, e.g. outcomes research.

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NATIONAL ORGANIZATION OF NURSE PRACTITIONER FACULTIES

Simulation in the Context of Clinical Education

2010

Simulation experiences can be used as to ensure that students have the opportunities for participating in complex decision making scenarios which can be evaluated in supervised settings that may arise infrequently or unpredictably in the clinical setting. The literature suggests that a simulated clinical experience can be considered as a different kind of clinical experience. For example, specific skill sets may not be able to be learned if on a clinical day a patient does not present needing a specific skill such as inserting chest tubes, suturing, or inserting lines. In the context of clinical evaluation, simulation includes the ability of faculty to develop Objective Structured Clinical Examinations (OSCEs) as well as other “high-fidelity” simulations such as SimMan (Gaba, 2004). In addition, simulations such as “Second Life” (<http://secondlife.com/?v=1.1>) can offer ways for exposing students to the lived experiences of being a patient and “walking in the shoes” of vulnerable populations. This document will focus on simulation in the context of nurse practitioner clinical education.

Advantages of a simulated clinical experience as a component of clinical hours include providing opportunities for ensuring that students have experiences with specific diagnoses, problems, types of patients, situations, and clinical procedures that are frequently seen in a practice but cannot be guaranteed during their clinical rotations (Overstreet, 2008). Simulated experiences provide an opportunity for practice and repeat practice for common, and uncommon, experiences when the possibilities of repeated “real world” experiences are limited. In terms of practice, simulation also ensures the safety for the patient and a safe environment for the student. (Bradley, 2006). Simulated experiences provide a structured experience that is observable by faculty, with a particular emphasis on students’ ability to think and do in a clinical situation. Simulation has been shown to improve learners skill performance, alter attitudes, and enhance knowledge (Jeffries & Rizzolo, 2006; Radhakrishnan, Roche, & Cunningham 2007; Seropian, Brown, Gavilanes, & Driggers, 2004).

Despite distinct advantages to simulation, there are disadvantages as well. A disadvantage of simulation, when using standardized simulation patient experiences, is the differences when interacting with a human being as opposed to a simulator. Nuances of speech, facial expressions, and other nonverbal cues that a person might demonstrate during history taking or a physical exam may be difficult or impossible to recreated with simulation. Secondly, in regard to time; time in a simulated clinical experience is compressed. For example, an eight hour day may be compressed in into a 3 hours experience (Nehring, 2008).

Several factors must be addressed when considering the use of simulation in nurse practitioner clinical educational experiences. The National Task Force on Quality Nurse Practitioner Education (2008) (NTF Criteria) specifically identifies clinical hours as those in which *direct*

clinical care is provided to individuals, families, and populations in specific population foci of nurse practitioner practice. Although hours not permitted by the NTF Criteria (2008) included skilled lab hours, physical assessment session hours and community projects, educational research is needed to evaluate the different uses of simulation. Evaluating simulation in regard to making clinical decisions is extremely important, so as not to only evaluate the effectiveness of simulation in teaching psychomotor skill sets, but understanding how simulation can be implemented in clinical decision making. Since the DNP competencies tend to be broad and diverse, the role of simulation is yet to be determined.

In general, the NTF Criteria (2008) preclude the use of simulation time as a substitute for clinical practice hours. Those hours spent in simulation cannot be used to meet the minimum 500 hours required for direct care clinical practice experiences. At this time, there is neither research supporting the replacement of direct care clinical practice hours with patients using clinical simulations nor inquiry as to including clinical simulation hours as replacing direct care clinical hours. However, empirical inquiry as to the quality and value of learning with the use of simulation would provide greater insight into comparative learning comparing experiences learned in simulation as opposed to direct clinical care hours.

In conclusion, although the NONPF Board realizes that simulation is a valuable tool, there is a need at this time, for more evidenced regarding learning outcomes before support can be given to use simulation as an “equivalent” to traditional “hands on” clinical hours. Due to the lack of evidence regarding simulation and the learning outcomes of nurse practitioner education, the NONPF Board of Directors supports the NTF Criteria (2008) in which simulations in laboratory or skill set development are not included in the clinical hours requirement for students enrolled in nurse practitioner programs. The NONPF Board of Directors supports clinical simulations as a useful tool in developing specific psychomotor skills in addition to developing skills that address clinical decision-making. Simulation may also be a useful tool to provide essential learning scenarios that may not be predictably present during the required traditional clinical experience.

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Conclusion

Strong curricula and strong clinical practica experiences are the foundation for preparing highly qualified independent nurse practitioners to meet the needs of the nation's health. This document provides NONPF's position regarding clinical education. This series of papers describes and defines terms related to the optimal types of clinical educational experiences in nurse practitioner programs. As more evidence-based knowledge is generated from educational research on learning outcomes of clinical experiences, recommendations will be revisited, updated and revised.