In collaboration with American Nurses Association\California, Association of California Nurse Leaders, California Association of Colleges of Nursing, California Hospital Association, California Organization of Associate Degree Nursing Program Directors, and Health***Impact*** (convener)**,** the **California Board of Registered Nursing presents Regional Nursing Summits:**

Regional Nursing Summits

Bridging the Gaps in Clinical Capacity

Issue

The demand for pre-licensure Registered Nurse (RN) clinical education capacity/clinical placements is outpacing current acute care capacity for pre-licensure Associate Degree Nursing (ADN) Baccalaureate Science Nursing (BSN), and Entry Level Masters (ELM) nursing programs and students. Increasing numbers of clinical training slot requirements, resulting from both increased enrollments in existing pre-licensure RN programs in some areas of the state coupled with simultaneous decreases in acute care training capacity due to a number of factors is causing flow disruption and concern among academia and healthcare organizations.

The degree of operational disruption has been slowly surfacing over the past several years as both academia and healthcare settings strive to meet the needs of a dynamic transforming health care system while achieving effective organizational efficiencies and targeted quality outcomes and improvements.

This year several issues and concerns arose that highlighted the need for re-examination of all aspects of academic and industry educational clinical placement coordination and programming. Left unresolved these issues can impact and potentially compromise effective RN student learning and strain organizational efficiencies. Most importantly, if not addressed, these issues/concerns may threaten the significant progress California has made in maintaining a viable professional workforce in the future.

The complex systemic challenges in academia, healthcare and the regulatory environment today all influence the depth and breadth of pre-licensure RN education. It is crucial that all stakeholders continue to work together so these complex multilayered issues, concerns and challenges are discussed and solutions identified. As many stakeholder groups and Summit participants already recognize, the clinical capacity/clinical displacement issues are part of a much larger complex set of nursing education and nursing practice issues partners deal with regularly. These encompasses, but are not limited to, how

best to prepare new RNs for the ever-changing practice environments, how to achieve the best patient care outcomes, how to maximize use of available resources while achieving operational efficiencies and effectiveness, how to manage changes in clinical capacity and availability of clinical placements in inpatient, outpatient/ambulatory and community based settings, how to maintain continued support for implementation of nursing education redesign initiatives, how to ensure seamless academic progression, how to effectively select and implement a variety of direct and indirect instructional methods that will most effectively prepare the RN graduate for clinical practice (direct patient care, indirect care skills/simulation labs), how to best to accomplish review and revision of nursing curriculum and how to effect regulatory changes to keep pace with the changing health care environment, how to address preceptor requirements, labor requirements, sufficiency of resources, and how to move forward so all pre-licensure RN nursing education programs in California have the necessary resources to support program implementation, compliance with Board of Registered Nursing Regulations and attainment of voluntary national nursing accreditation.

Addressing these very complex issues is a daunting challenge that demands academia, practice, labor and regulatory partners collectively and effectively work together to identify and implement new and different solutions and actions while sustaining those practices/processes that are working well and do not need to be modified.

Irrespective of the challenges and issues, it is crucial moving forward, that stakeholders remain committed to resolving the current and future issues. This will ensure California maintains effective clinical partnerships, placements and clinical learning experiences that continue to prepare pre-licensure RN program graduates that provide safe, competent, quality care for California residents/consumers, families and communities.

Summit Goals

The goals of the Summits are to discuss clinical capacity and identify better ways to sustain adequate clinical capacity and clinical placements for all three types of pre-licensure nursing education programs. It is believed addressing these complex multilayered issues ensures there will continue to be a sufficient supply of well-educated, safe and competent nursing professionals in California's RN work force now and in the future.

Summit Outcomes

Moving forward, the information gathered from the Summit discussions will be used to develop a comprehensive plan for student clinical experiences across the state, taking into consideration regional and local differences.

Summit Planning Group Beliefs/Assumptions

The collective beliefs and assumptions held by the Summit Planning Group set the backdrop to facilitate Summit discussions. This document is designed to provide a brief overview and basic information about the various factors/issues that may be impacting clinical capacity in some way.

First, the group supports the need for changes in the ways nurses are educated for the future. This was a specific recommendation in the *Nursing Education Plan White Paper and Recommendations for California. (*HealthImpact, August 2016). Also relevant to Summit discussions is California's White Paper Recommendation II: "Promote academic progression for all registered nurses to obtain a BSN or higher degree by 2030." California recognizes the crucial importance of providing education opportunities to California's very diverse population. Stakeholders recognize and support the educational opportunities and inclusive teaching and learning environments all three types of degree programs (AD, BSN, ELM) provide to meet the diverse educational, cultural, and economic needs of the communities the programs serve. All three types of programs support the value of lifelong learning and afford all Californians, irrespective of economic means, the opportunity to achieve their educational goals. These programs consistently provide rigorous, high quality nursing degree preparation. Collectively these programs provide graduates with excellent RN educational preparation for safe competent entry in to registered nursing practice. All Board approved pre-licensure nursing programs provide clinical learning experiences in a variety of clinical practice settings that ensure graduates are prepared to function safely and competently in the current and emerging practice environments. RN licensure examination (NCLEX-RN) first-time tester pass rates for the majority of California's nursing programs are at or exceed the annual national pass rates for each type of degree program. California's Education White Paper recommendations are consistent with the Future of Nursing Report (IOM, 2010) recommendation that established a goal of 80% of nurses in the workforce having a BSN or higher degree by 2020. Recommendation V in California's Education Plan White Paper states, "Provide transformative learning opportunities that prepare nurses for evolving roles in rapidly changing interprofessional practice environments."

The Summit Planning Group also believes and supports attainment of voluntary national nursing accreditation by all pre-licensure RN nursing education programs in California. Presently, all BSN and ELM nursing programs are accredited by a national nursing accreditation body (CCNE or ACEN). About 30% of Associate Degree nursing programs hold national nursing accreditation. In California, Board of Nursing approval is required and national nursing accreditation decisions are made by each nursing program. State Board of Nursing approval and national nursing accreditation processes have the same goals to provide society with a safe competent RN workforce. Both bodies review and evaluation processes use appropriate evidenced based outcome metrics to determine program success in meeting compliance and established standards of quality and improvement.

In 2012 the National Council of State Boards of Nursing (NCSBN) published "Model Rules" for State Boards of Nursing (SBON) to consider adopting related to national nursing accreditation. This Model Rule if adopted by the SBON called for all pre-licensure nursing programs to achieve voluntary national nursing accreditation by January 1, 2020. NCSBN also noted that the determination to require national nursing accreditation is made by individual SBON based on needs.

To date, the BRN has not adopted regulations requiring national nursing accreditation for initial BRN program approval or continuing approval. Although the Board supports nursing program decisions to obtain voluntary national nursing accreditation, the Board has not identified the need to adopt new regulations that require Board approved also obtain national nursing accreditation. In the past, some nursing education programs in California indicated funding resources for initial and ongoing nursing accreditation were cost prohibitive. *The Summit Planning group supports external review for accreditation as valuable and recommends that nursing programs be nationally accredited.*

Lastly, the Summit Planning group supports program curriculum change initiatives to achieve less variability in the total degree units and required clinical units/hours beyond the BRN minimum requirements (18 semester units or 27 quarter units). It is believed that curriculum changes would help to even out the need for clinical space. While the BRN regulations set the overall minimum clinical unit and hours requirements for nursing education programs, it is each college/nursing program that determines the total number of units required to earn the nursing degree. If all nursing education programs adopted the BRN clinical minimums required, this action alone may "open up" a number of additional clinical slots and hours for other nursing programs needing placements.

For example, in the California State University system nursing education programs consistently require 120 units for the bachelor's degree, but that may not be the case for all other California BSN degree programs. For the Associate Degree Nursing programs, total degree units across this degree type programs may vary and range from 70 units to 90 or more units. The Summit Group suggests now is an opportune time for nursing programs and faculty to make the curriculum revisions necessary. The recommendation is … *To create efficient educational pathways that minimize student burden (including debt), maximum credit units should be 70 units for ADN and 120 units for BSN programs to avoid programmatic variability and even out need for clinical space.*

In summary, the academic and healthcare agencies/service partners and the BRN have agreed to host regional summits to collectively identify practical solutions to the pre-licensure nursing clinical placement capacity dilemma. The regional summit planning group has identified the aforementioned beliefs and assumptions as guiding principles for Summit discussions. Moreover, the Summit Planning group recognizes the value, nature and importance of present regional planning consortiums and related infrastructures where they exist and the invaluable role regional clinical planning groups play managing the complex clinical placement scheduling, programming, and coordination activities associated with securing needed clinical placements in the various regions

throughout California. These groups have been pivotal to the many successes achieved in matching regional clinical placement requests by large numbers of nursing education programs with available clinical sites in an efficient and effective manner. Action steps specific to each region will specifically address local needs, using the identified assumptions to guide conversation and solutions.

Stakeholder Information

The Board of Registered Nursing (BRN) pre-licensure nursing education program approval is an integral part of the BRN's mission of public protection in California. The laws and regulations governing program approval and inspections are found in Business and Professions Code (BPC) Sections 2786-2788 and California Code of Regulations (CCR) 1420-1432. The educational regulations, standards, and policies established by the BRN are designed to produce safe competent RN graduates. These laws and regulations describe the standards, formal mechanisms and requirements for Board actions related to initial program approval, clinical facilities, continuing approval visits, curriculum/enrollment changes, skills and simulation lab hour regulations, as well as, a number of other areas. Each approved program is assigned a Board nursing education consultant to facilitate and enforce compliance with Board regulations. This includes compliance with clinical facilities regulations and approval processes.

The Board regulations pertaining to clinical learning experiences mirror the National Council of State Boards published work related to Clinical learning experiences (Spector et al. 2018). Board regulations reflect the national standards that student clinical experiences require faculty planned and supervised "hands on" clinical learning experiences with patients in a variety of settings in order for students to be able to apply the knowledge and skills in accordance with Board regulations. The Board requires the clinical learning experiences be designed by faculty to meet progressive clinical learning objectives/outcomes across the curriculum. The clinical experiences should be consistent with program and clinical learning outcomes and enable students to gain clinical judgment, decision making and clinical management skills necessary of safe competent entry in to RN practice.

In California, it is each clinical agency that decides which nursing education programs they will establish clinical education affiliation agreements with, and provide placements in their agency clinical sites. Nursing education programs provide the Board staff with evidence of compliance that the program has secured and maintained the necessary clinical learning experience to implement the approved curriculum inclusive of an adequate type and number of clinical sites to meet program objectives and achieve student learning outcomes.

BRN regulations require pre-licensure nursing education programs obtain BRN approval of all clinical sites prior to use. The program submits required forms/paperwork and sufficient evidence showing compliance with the regulations. For decades, the Board has supported and approved clinical placements in a wide variety of clinical settings across all levels of care including inpatient,

outpatient/ambulatory care, and community-based healthcare agencies. There is no Board regulation that requires all of an approved program's clinical learning experiences be completed in an acute care clinical agency. In the past, some programs may have depended on available acute care agencies to achieve a significant portion of program objectives and student learning outcomes. Board approved nursing program faculty select, plan, implement, and evaluate the appropriateness and suitability of the clinical placements to meet clinical objectives and student learning outcomes.

The selected and approved clinical placements are expected to provide a sufficient number and type of learning experiences and an adequate patient census to support the number of students placed in the clinical rotation. Selected approved clinical sites/placements need to provide the appropriate level of complexity to meet learning objectives, and enable student mastery of the knowledge, skills, abilities and clinical judgment that facilitates student progression in providing safe competent care at the level of required complexity in each nursing course.

The Board has been asked by nursing education programs to increase the percent of allowable hours for skills and simulation labs beyond the 25% stated in current regulations (CCR 1420(e) and CCR 1426 (g)(2)) due to program challenges in securing needed clinical learning experiences in each of the five required clinical areas (Geriatrics, Medical Surgical, Obstetrics, Pediatrics, and Psych/Mental Health), particularly the latter three clinical areas, in the past several years. Nursing education regulation changes are needed for the Board to approve more than the allotted 25%. BRN annual school survey data shows many nursing programs currently use a small percentage of the allowable clinical course hours for skills and simulation lab clinical learning.

The BRN is working closely with the BRN Nursing Education and Workforce Advisory Committee (NEWAC) and its simulation workgroup to facilitate quality driven simulation to the allowable amount. Currently the NEWAC simulation workgroup has developed a set of uniform simulation standards and is working on nursing program adoption of a uniform set of simulation moving forward. Adoption of a uniform set of simulation use standards is an important next step in relation to simulation and ensuring the delivery of quality simulation learning experiences across all nursing programs. Simulation is also a regular agenda item for the NEWAC BRN advisory committee.

The BRN annual school surveys provide a significant amount of data regarding pre-licensure nursing education programs. Annually, the NEWAC committee reviews the annual school survey tool and makes needed revisions. The NEWAC group has done a fine job of revising the surveys year to year. Recently the BRN received a comment suggesting it may be valuable to capture more information via the annual school survey processes in relation to Associate Degree to BSN Degree Program affiliations that support academic progression and information regarding co-enrolled students (AD-BSN). This may be an opportunity for consideration at the BRN's upcoming Fall 2018 NEWAC committee meeting.

Over the past couple of years, the Board has received public testimony in relation to approval of new RN

programs, the impact of increased program enrollment by existing approved programs in some regions, and increasing instances of denial of long-established clinical placements for some programs. Most recently, testimony was provided by a number of Associate Degree Nursing Program Directors reporting some agencies the programs had been affiliated with for years were no longer accepting AD students' placements or were limiting clinical placements unless AD program students were co-enrolled in a BSN program.

To address the clinical placement concerns being reported to the Board, the Board has recently required nursing programs requesting program expansion, to obtain written letters "in support" or "not in support" and other detailed clinical scheduling evidence to ensure the Board's approval of program expansions and new program approvals adheres to current regulations (CCR 1420 -1432). Board has also received public comments that these more recent requirements have added an additional level of tension between community colleges and universities.

Board Curriculum Regulations

The Board's minimum curriculum requirements are listed below. As mentioned earlier in the Colleges and Universities Nursing Education Program section of this document, each Board approved nursing education program makes the final determination in regard to the total number courses, units, and hours required beyond the Board's minimum requirements as listed below.

§ 1426. Required Curriculum

(a) The curriculum of a nursing program shall be that set forth in this section, and shall be approved by the board. Any revised curriculum shall be approved by the board prior to its implementation.

(b) The curriculum shall reflect a unifying theme, which includes the nursing process as defined by the faculty, and shall be 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.

(c) The curriculum shall consist of not less than fifty-eight (58) semester units, or eighty-seven (87) quarter units, which shall include at least the following number of units in the specified course areas:

(1) Art and science of nursing, thirty-six (36) semester units or fifty-four (54) quarter units, of which eighteen (18) semester or twenty-seven (27) quarter units will be in theory and eighteen (18) semester or twenty-seven (27) quarter units will be in clinical practice.

(2) Communication skills, six (6) semester or nine (9) quarter units. Communication skills shall include principles of oral, written, and group communication.

(3) Related natural sciences (anatomy, physiology, and microbiology courses with labs), behavioral and social sciences, sixteen (16) semester or twenty-four (24) quarter units.

(d) Theory and clinical practice shall be concurrent in the following nursing areas: geriatrics, medical-surgical, mental health/psychiatric nursing, obstetrics, and pediatrics. Instructional outcomes will focus on delivering safe, therapeutic, effective, patient-centered care; practicing evidence-based practice; working as part of interdisciplinary teams; focusing on quality improvement; and using information technology. Instructional content shall include, but is not limited to, the following: critical thinking, personal hygiene, patient protection and safety, pain management, human sexuality, client abuse, cultural diversity, nutrition (including therapeutic aspects), pharmacology, patient advocacy, legal, social and ethical aspects of nursing, and nursing leadership and management.

(e) The following shall be integrated throughout the entire nursing curriculum:

(1) The nursing process;

(2) Basic intervention skills in preventive, remedial, supportive, and rehabilitative nursing;
(3) Physical, behavioral, and social aspects of human development from birth through all age levels;
(4) Knowledge and skills required to develop collegial relationships with health care providers from other disciplines;
(5) Communication skills including principles of oral, written, and group communications;
(6) Natural science, including human anatomy, physiology, and microbiology; and
(7) Related behavioral and social sciences with emphasis on societal and cultural patterns, human development, and behavior relevant to health-illness.

(e) The program shall have tools to evaluate a student's academic progress, performance, and clinical learning experiences that are directly related to course objectives.

(f) The course of instruction shall be presented in semester or quarter units or the equivalent under the following formula:

(1) One (1) hour of instruction in theory each week throughout a semester or quarter equals one (1) unit.

(2) Three (3) hours of clinical practice each week throughout a semester or quarter equals one (1) unit. With the exception of an initial nursing course that teaches basic nursing skills in a skills lab, 75% of clinical hours in a course must be in direct patient care in an area specified in section 1426(d) in a board-approved clinical setting.

Note: Authority cited: Sections 2715 and 2786.6, Business and Professions Cod. Reference: Sections 2785-2788, Business and Professions Code

Healthcare/Clinical Agencies/Industry Partners

Total hospital numbers in California have remained flat between 2014 and 2018, from a high of 443 in 2016 to a low of 441 in 2018. The number of licensed and staffed beds decreased slightly between 2016-2017, by 417 licensed beds and 503 staffed beds.

California	2014 CALENDAR YR	2015 CALENDAR YR	2016 CALENDAR YR	2017 CALENDAR YR	2018 3Q2017 – 1Q2018
Licensed Beds	78,800	78,187	79,033	78,616	78,631
Staffed Beds	57,682	58,147	58,641	58,138	59,742
Discharges	2,981,246	3,009,509	3,093,912	3,054,542	3,055,336
Patient Days	16,079,987	16,432,227	16,914,156	16,603,301	16,599,776
Occupancy Rate – Available Beds	59.9	61.5	62.9	62.0	62.0
Length of Stay	5.4	5.5	5.5	5.4	5.4
Acute Length of Stay	4.5	4.6	4.6	4.6	4.5
All Other Length of Stay	13.9	14.1	14.2	14.1	14.1
Outpatient Visits	44,675,128	46,427,046	48,299,507	47,560,174	47,974,379

Overwhelmed by internal demands (e.g., meeting quality indicators, hiring new graduate employees, census reductions) and rethinking hiring preferences for ADN vs BSN new graduates, there are anecdotal reports and May 2018 BRN survey results indicating some information about some clinical agencies (e.g., medical centers) reduction in the number of clinical placements available for any nursing program. This may be more of a trend in heavily populated cities and especially in highly sought after teaching clinical practice settings, and less of an issue in rural areas. Although there is a sense clinical placement issues are occurring throughout California, this is probably not the case.

Universities & Community Colleges

There has been a 6% increase in the number of nursing programs across the state between 2007- 2017 (132-141); however, in the past 5 years, there has been a decrease by 1 program (142-141). This has generated an additional 2,531enrolled nursing students in the same time period, with almost all of the growth happening in one region of the state. (2016-2017 BRN Pre-licensure Schools Report)

In 2017, 77 of the 141 nursing programs (54.6%) reported being denied clinical space; however, 31 programs were offered alternative sites by industry partners. The remaining lack of clinical space resulted in a loss of 302 clinical placements, units or shifts, which affected 2,147 students, a number that has remained relatively stable over the last several years (2016-2017 BRN Pre-licensure Schools Report).

Reasons cited in the California Board of Registered Nursing 2016-17 Annual School Report for clinical placement denial were: 1) staff nurse overload or insufficient qualified staff (51%); 2) displacement by another academic program (50.8%);3) competition for clinical space due to increase in number of nursing students per region (49%); 4) Joint Commission or other agency visit (33.8%); 5) no longer accepting ADN students(27.2%); 6) nurse residency program (26%); 7) change in facility management (24.7%); 8) Magnet designation (15.6%) ;9) EHR implementation (13%); 10) facility change in location (2.6%); 11) facility fee charge (1.3%). It is important to note that both community colleges and universities have lost traditional clinical placements in acute medical centers, and that these data represent the opinions of programs of nursing. The clinical agencies may identify different reasons for lost space than nursing education programs. Currently, there is no identified organization or established processes or tool to collect this type of clinical placement data from clinical agencies on an annual basis. This may be an important area to pursue moving forward.

Programs of nursing have long had a preference for clinical placements able to accommodate larger cohorts of students in traditional rotations (medical-surgical, pediatrics, obstetrics, behavioral health, etc.) rather than in placements of individual/small groups in nontraditional settings (ambulatory clinics, homeless shelters, programs, etc.) It may also be the case that nursing programs and clinical agencies alike may not understand BRN clinical placement approval processes, and or may have misinformation, misperceptions, or misunderstandings about BRN regulations regarding clinical facility placements and clinical site approvals.

The table below displays the reduction or increase in students enrolled by various regions around the state (BRN 2017):

California Nursing Programs & Student Census by Region

School Years	# of Nursing Programs			Student Census		
	ADN	BSN + ELM	Total	ADN	BSN + ELM	Total
Bay Area						
2012-2013	18	12	30	1872	3393	5265
2013-2014	18	12	30	1826	3156	4982
2014-2015	18	12	30	1789	3233	5022
2015-2016	18	12	30	1718	3216	4934
2016-2017	18	12	30	1795	3211	5006
Central Coast						
2012-2013	5	0	5	354	37	393
2013-2014	5	0	5	361	44	405
2014-2015	5	0	5	385	0	385
2015-2016	5	0	5	403	0	403
2016-2017	5	0	5	393	0	393
Central Sierra (Zero Programs in Region)						
2012-2013	0	0	0	0	0	0
2013-2014	0	0	0	0	0	0
2014-2015	0	0	0	0	0	0
2015-2016	0	0	0	0	0	0
2016-2017	0	0	0	0	0	0
Greater Sacramento						
2012-2013	6	1	7	604	539	1143
2013-2014	6	1	7	582	467	1049
2014-2015	7	1	8	541	314	855
2015-2016	6	3	9	534	393	927
2016-2017	6	3	9	532	509	1041
Northern California						
2012-2013	3	1	4	165		165
2013-2014	3	0	3	158	0	158
2014-2015	3	0	3	170	0	170
2015-2016	3	0	3	175	0	175
2016-2017	No Data	No Data	No Data	No Data	No Data	No Data
Northern Sacramento Valley						
2012-2013	2	2	4	286	259	545
2013-2014	2	2	4	264	261	525
2014-2015	2	2	4	279	258	537
2015-2016	2	2	4	280	265	545
2016-2017	No Data	No Data	No Data	No Data	No Data	No Data
San Joaquin Valley						
2012-2013	10	5	15	1681	982	2663
2013-2014	10	5	15	1479	1129	2608
2014-2015	10	5	15	1799	969	2768
2015-2016	10	4	14	1574	1033	2607
2016-2017	No Data	No Data	No Data	No Data	No Data	No Data

Southern Border						
2012-2013	7	6	13	949	1480	2429
2013-2014	7	6	13	962	1396	2378
2014-2015	7	6	13	964	1851	2815
2015-2016	7	6	13	823	1652	2475
2016-2017	7	5	12	994	1955	2949
Los Angeles Area						
2012-2013	24	17	41	4089	3841	7930
2013-2014	24	16	40	3754	3436	7190
2014-2015	25	17	42	3972	5270	9242
2015-2016	25	16	41	4019	5623	9642
2016-2017	27	15	42	3963	5119	9082
Inland Empire						
2012-2013	13	11	24	2068	3730	5798
2013-2014	14	10	24	2096	3592	5688
2014-2015	13	9	22	2128	1892	4020
2015-2016	13	9	22	1982	1981	3963
2016-2017	13	9	22	2205	2048	4253
Total						
2012-2013	88	55	143	12070	14261	26331
2013-2014	89	52	141	11502	13481	24983
2014-2015	90	52	142	12027	13787	25814
2015-2016	89	52	141	11508	14163	25671
2016-2017	91	50	141	11965	14116	26081

Region	Counties
Bay Area	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma
Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara
Central Sierra*	Alpine, Amador, Calaveras, Inyo, Mariposa, Mono, Tuolumne
Greater Sacramento	El Dorado, Placer, Sacramento, Sutter, Yolo, Yuba
Northern California	Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Sierra, Siskiyou, Trinity
Northern Sacramento Valley	Butte, Colusa, Glenn, Shasta, Tehama
San Joaquin Valley	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare
Southern Border	Imperial, San Diego
LA Area	Los Angeles, Ventura
Inland Empire	Orange, Riverside, San Bernardino

Students

Students are aware of clinical placement issues. They know getting clinical placements is a challenge and that sustaining placements is tenuous. Programs report they receive feedback from students of a strong preference for acute care clinical experience, despite the BRN reporting that 43.9% of RNs work outside of in-patient or emergency department settings. (BRN, 2016)

Regional Nursing Summits

Bridging the Gaps in Clinical Capacity

Issue Statement in Brief

The demand for pre-licensure RN clinical education capacity is outpacing current acute care capacity for all pre-licensure nursing programs, ADN, BSN, and Entry Level Masters (ELM). This year, California experienced issues highlighting the need for reexamination of all aspects of academic and practice educational coordination and programming. These issues are inclusive of RN educational effectiveness and strain on organizational efficiencies.

How can the organizations responsible for safe, quality nursing care and optimal health for California citizens not only supply enough nurses to meet demands, but assure the educational pipeline is producing the correct number of highly prepared professional RNs in hospitals and across the care continuum?

Interrelated Clinical Capacity Issues

- Multiple complex issues comprise successful RN education, such as educational goals, accreditation, regulations, practice sites, faculty and preceptor requirements, etc.
- An increasing body of evidence recommends that the BSN-or-higher prepared RN increases the quality and safety of care and is best prepared to work across the care continuum.
- The Nursing Education Plan White Paper and Recommendations for California, (HealthImpact, 2016), recommends: 1) providing transformative learning opportunities that prepare nurses for evolving roles in rapidly changing interprofessional practice environments, including non-acute settings; and 2) providing academic progression for all RNs to obtain a BSN or higher degree by 2030.
- External review for accreditation is valuable and it is recommended that nursing programs be nationally accredited.
- To create efficient educational pathways that minimize student burden (including debt), maximum credit units should be 70 units for ADN and 120 units for BSN programs to avoid programmatic variability and even out need for clinical space.
- Existing best practices, including clinical placement systems/consortiums, will be used as templates for future planning if appropriate to local and regional settings.
- The ongoing tension about clinical placements has had a negative impact on clinical practice and academic work settings to include nursing students.
- New approaches to clinical immersion experiences for pre-licensure nursing students are needed.