PRACTICE DOMAIN FOR BACCALAUREATE NURSING EDUCATION: GUIDELINES FOR CLINICAL PLACEMENTS AND SIMULATION

A COMPANION DOCUMENT TO
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Baccalaureate Education Committee

Name	Representation
Cynthia Baker, RN, PhD	CASN Executive Director (Ex-officio)
Peggy Colbourne, RN, MN	Western Regional School of Nursing
Sandra De Luca, RN, BNSc, PhD	Fanshawe College, University of Western Ontario, CASN Board of Directors
Gwen Duhn, RN, MSc	St Lawrence College
Kerry Lynn Durnford, RN, MN	Aurora College
Kim English, RN, BScN, MN	Trent University; COUPN Representative
Carol Enns, RN MN	University of Manitoba
Deborah Gibson, RN, MSN	Trinity Western University
Sandra Gessler, RN, MPA	University of Manitoba
Sandra Gordon, BN, MN, GNC(c), Co-chair	Mount Royal University
Nicole Harder, RN, PhD, CHSE, Co-chair	University of Manitoba
Kathleen Lechasseur, inf. Ph.D	Université Laval
Karen MacRury-Sweet, RN, M.N,M. Ed.	Dalhousie University
Gina Marasco, RN BScN MSN	Ryerson University; COUPN Representative
Brian Parker, RPN, RN, BScN, PhD	Grant MacEwan University
Monica Reilly, BA, MPA, MA	Colleges Ontario
Jayne Smitten, RN, Med, PhD, CHSE-A	University of Alberta
Andrea Watkins, RN, BN, MN	Memorial University
Bev Williams, RN, PhD	University of Alberta

In recent years nursing educators have been struggling with how best to provide practice experiences that prepare students in baccalaureate nursing programs to enter the profession. Considerable diversity has emerged as to how much and what type of clinical placements nursing students receive in Canadian schools of nursing. Historically, except for skills labs, and some community/public health experiences, most practice learning occurred in the acute care sector. The challenge of securing clinical placements for students has driven a search for alternative strategies for practice experiences. Placements have become wide-ranging (Smith, Corso & Cobb, 2010) and simulation is being increasingly used to prepare students for practice. Some educators see simulation as valuable but complementary to clinical placements, others have introduced it as a substitute. An area of research interest has recently emerged investigating the extent to which simulation may be used to replace clinical placements. A national simulation study in the United States, for example, concluded that 50% of clinical placements could be replaced by simulation (Hayden et al., 2014). The purpose of this document is not to examine if or how clinical placements can be replaced with simulation but rather how different types of practice learning in baccalaureate nursing education can together help achieve learning outcomes expected of graduates. It provides guidelines for promoting quality practice-based learning through clinical placements and/or through simulation.

In 2013, a CASN task force with was struck in response to calls from nursing organizations and educators to examine issues related to securing placements for students and the role of simulation in nursing education. Members were drawn from jurisdictions across the country and included nursing experts in clinical education and/or simulation, representatives of stakeholder groups, and both anglophones and francophones. Its mandate was to develop national, consensus-based guidelines for practice learning in baccalaureate education.

The task force identified the following objectives in order to fulfil its mandate:

1. Identify the outcome expectations to be achieved through practice learning;
2. Examine practice learning through clinical placements and through simulation in relation to outcome expectations;
3. Formulate principles for practice learning and specify guidelines for clinical placements and simulation.

Nursing, like other practice professions such as law, medicine, and pharmacy, initially provided education to new recruits through apprenticeship models of training. Unlike these professions, however, apprenticeship based nursing education persisted in Canada well into the latter half of the 20th century. It wasn't until the end of the 1960's that nursing education began to move from hospital training schools to universities and colleges. Hospital training was grounded in a highly structured military type approach, and lasted for over 100 years, influencing expectations about practice readiness among new graduates for decades following the closure of these schools (CASN, 2012).

In 1965, the Hall Commission Report recommended that nursing education be removed from the service sector with 25% of students to be educated in university schools of nursing at the baccalaureate level for leadership roles, and 75% in community colleges at the diploma level. The three-year diploma program was reduced to two, based on the premise that much of the three years had been taken up in providing service and little learning occurred when students were providing service. Soon after the first graduates from the two year diploma programs entered the workforce, however, major concerns were identified related to their lack of clinical judgement and clinical skills compared with the hospital graduates. As a result, the programs were lengthened to provide more clinical practice, and typically included a continuous preceptored consolidation experience at the end of the program. Graduates from baccalaureate programs also faced similar criticism when they entered the workforce both in Canada and in the United States. Senior nurses reportedly would say, they can analyze and synthesize but they can't catheterize (Kramer, 1974).

In contrast, the hospital-trained nurses entered the workforce seamlessly and were able to take on the full responsibilities of a staff nurse immediately. Although classroom teaching in hospital schools increased considerably during the twentieth century, much of what students learned came from practice. They began providing service early in their program as probationers with responsibility for basic patient care on the units where they were assigned for a continuous period of time. More complex tasks and greater responsibilities were added as they progressed in the program. The stability of their patients and length of stay were considerably greater, whereas the monitoring, diagnostic, and treatment technology they managed were far less complex than is the case today. By their second year, student nurses were often assigned to evening and night shifts alone with minimal supervision from a circulating nursing supervisor (CASN, 2012). Although little is known about how safely they performed their responsibilities, as they gained experience, students certainly mastered psychomotor skills, learned to prioritize, complete tasks in a timely fashion, recognized and responded to changing client conditions, made clinical decisions on their own, and understood the particularities of the organizational culture of their hospital's wards. When they graduated, there was no transition period from student to staff nurse.

Although most hospital-trained nurses are now retired, a legacy of practice related expectations for the new nurse lingered for many years despite enormous changes in the complexity of nursing practice. Hospital-trained nurses were educated to work in the particular hospital providing their training, whereas educational institutions prepare students for a career in the profession. Graduates today enter a dynamic, rapidly changing workplace reality, often dominated by high patient acuity and heavy workloads, (Laschinger & Leiter, 2006). Nurses need a much deeper knowledge and skill base than in the days of the hospital schools of nursing. There are also far more risks to patient safety and, therefore, a greater need to supervise students and novice nurses. In addition, while some 62% of nurses are employed in the acute care sector (CIHI, 2012), many now work in diverse services in the community or in long-term care, and require a much broader and more diversified knowledge and skill base than in the past.

Despite recognition that educational programs cannot prepare new graduates to function at the same level as an experienced staff nurse, their transition into the workforce is often problematic (Dutscher, 2008). The practice readiness of nursing graduates has been, and continues to be, an issue for employers, governments, educators, and new nurses themselves (Romyn, Linton, Giblin et al., 2009; Boychuk Duchscher, 2008). While transition-to-practice programs have been found to facilitate the successful integration of new nursing graduates into the workforce (Dyess & Parker, 2012; Spector, Blegen, Silvestre et al., 2015), the nature and quality of practice experiences during the nursing program are also important.

A multi-step, iterative process was used to develop the guidelines. It began with a literature review, environmental scan, and a stakeholder consultation at the CASN undergraduate forum in 2013. Guidelines were drafted based on these activities, reviewed, revised, and refined: further input was sought at a second face-to-face stakeholder consultation in 2014. The document was modified to incorporate the feedback obtained, carefully reviewed and modified by the Task Force at a face-to-face, day long meeting in October 2015. A final consensus based document was adopted in November 2015.

The first objective set by the task force was to determine what outcome expectations should result from practice learning. In 2015, CASN published a *National Nursing Education Framework* for graduates of nursing programs. As this national framework specifically articulates outcome expectations for practice learning at the baccalaureate level, these were identified as the end points to be achieved.

CASN National Nursing Education Framework

The CASN *National Nursing Education Framework* organizes expectations for graduates into six domains;

1. Knowledge;
2. Research, methodologies, critical inquiry and evidence;
3. Nursing practice;
4. Communication and collaboration;
5. Professionalism; and
6. Leadership.

Although in reality the domains are interwoven, each targets a specific sphere of degree-level outcomes. The nursing practice domain refers to the exercise of activities of a broad range of nursing roles involving direct nursing care and/or indirect nursing care (CASN, 2015).

Table 1- Domain 3: Nursing Practice   **Outcomes for Baccalaureate Education**
The program prepares the student to demonstrate…
3.1   Holistic and comprehensive assessment of diverse clients, to plan and provide competent, ethical, safe, and compassionate nursing care.   **3.2**   The use of clinical reasoning, nursing knowledge, and other evidence to inform decision-making in diverse practice situations.   **3.3**   The ability to synthesize findings to develop or modify a person-centered plan of care.   **3.4**   The ability to recognize and respond safely, competently and ethically to rapidly changing client-conditions and contexts.   **3.5**   The ability to monitor and manage complex care of clients in stable and unstable contexts using multiple technologies.   **3.6**   The use of information technologies to support quality patient care.   **3.7**   The capacity to engage in RN entry-level scope of practice as defined by the provincial/territorial regulatory body.*   **3.8**   Engagement and leadership in the provision of comfort care, including pain and symptom management.   **3.9**   The ability to counsel and educate clients to promote health, symptom and disease management.   **3.10**   The coordination of patient care in collaboration with individuals, families and other members of the healthcare team.   **3.11**   The ability to facilitate client navigation through health care services.   **3.12**   The ability to promote the health of individuals, families, communities, and populations through actions to address health disparities.   **3.13**   The use of the core elements of patient safety and quality care.

*Currently the entry level registered nurse referred to in 3.7 is prepared at the baccalaureate education level (except in Quebec) to be a generalist, practice in situations of health and illness, with people of all genders, and across the lifespan, in a variety of practice settings, with clients who are defined as individuals, families, groups, communities, and populations (CNO, 2014).

The outcome expectations of the practice domain provide direction for the types of learning students should acquire through practice experiences in clinical placements and/or simulation.

The second objective in developing guidelines was to examine clinical placement and simulation-based learning opportunities in relation to outcome expectations. There is considerable diversity in the types of placements and simulations currently being used in Canada. Clinical sites incorporate the full spectrum of health care sectors as well as non-health care settings. Simulation involves a widely varying degree of technology, and simulation modalities are classified based on their fidelity, the extent they represent real world clinical situations. While there is overlap in what students may learn in different types of placements or simulations, each provides practice opportunities that foster the development of a number of the outcome expectations identified.

Acute care settings
Traditionally the main site for clinical placements, acute care settings settings continue to be essential given the large number of nurses in Canada employed in this health care sector (almost 65% according to CIHI, 2015). Acute care placements provide experiences that are particularly relevant for outcomes related to the care of unstable clients with complex conditions such as the ability to recognize and respond safely, competently and ethically to rapidly changing client-conditions and contexts (3.4); and the ability to monitor and manage the care of clients being treated for unstable, rapidly changing conditions and life-threatening symptoms, using multiple complex technologies (3.5).

Long-term care and ambulatory care
Long term care facilities, clinics, and day surgery are growing in Canada, and are expected to continue to do so. They offer students practice opportunities that foster the development of a number of the outcome expectations identified including the ability to conduct a holistic and comprehensive assessment of diverse clients, to plan and provide competent, ethical, safe, and compassionate nursing care (3.1); to develop engagement and leadership in the provision of comfort care, including pain and symptom management (3.8) and, the coordination of patient care in collaboration with individuals, families, and other members of the healthcare team (3.10)

Community care
Community care covers a very broad set of placement sites including traditional public health agencies, formal community based health agencies; non health-care settings including senior housing/facilities, schools, Aboriginal communities, recreation centers, home care, mental health care facilities, assertive outreach, and correctional facilities. Depending on their particular focus, community placements provide learning experiences for the development of a variety of outcomes including the ability to counsel and educate clients to promote heath, and symptom and disease management (3.9); The ability to facilitate client navigation through health-care services (3.10); and the ability to promote the health of individuals, families, communities, and populations through actions to address health disparities (3.12)

High fidelity simulation
High fidelity simulation refers to the use of computerized mannequins that can be programmed to present a wide range of signs and symptoms congruent with complex physiological responses to various conditions as well as to therapeutic interventions. These simulations can provide students with targeted practice experiences related to the nursing care of stable and unstable clients such as the assessment of physiological signs and symptoms of specific stable and unstable conditions (3.1) and the ability to recognize and respond safely to rapidly changing conditions and life threatening symptoms (3.4).

Mid-Range fidelity simulation
Mid-range fidelity includes a variety of simulation modalities such as interactive computer videos, standardized patients, and virtual reality that are dynamic and three-dimensional. Depending on the specific simulation modality used, students may develop assessment skills related to specific stable and unstable conditions; learn to counsel and educate clients to promote health, symptoms and disease management (3.8); and in the case of computer videos, develop their ability to recognize and respond to rapidly changing client conditions (3.3).

Low fidelity simulation
Low fidelity simulation includes non-computerized task trainers and role playing. The former offer students the opportunity carry out specific psychomotor, and technical skills, and the latter may foster the development of relational and problem solving skills. Low fidelity simulation allows students to develop a specific skill or skill set that represents a necessary component of a number of the practice outcome expectations.

While both clinical placements and simulation provide opportunities for students to develop practice outcome expectations, there are some important differences in the practice experiences they offer. As a result, there are also some differences in the nature of the learning they foster.

As table 2 indicates, during a clinical placement, students bring knowledge, skills, attitudes and judgement to unplanned, real life situations that the instructor has little control over. As with mid-range and high fidelity simulations, they often respond to unanticipated events, but in an environment where multiple, multidimensional, non-linear environmental variables are at play, including the ebb and flow of emotions. Moreover, their actions in such settings may have significant consequences (both positive and negative) on the person or persons in their care, as they will when they enter the workforce. In contrast, simulations occur in a simulated environment, however realistic these may be. The scenario and the contextual variables have been selected in advance by the instructor. Moreover, the contextual variables impinging on the situation are limited, and do not represent the full range present in a real life situation. Students, however, can make mistakes, and can learn from these mistakes because there are no consequences on the recipients of their care. In addition, as scenarios are planned, programs can target practice situations identified as necessary for all students to have experienced. These may include conditions or situations that are serious, prevalent, and important for every student to have encountered. They may also include uncommon but high risk situations that students need to be prepared for to but are unlikely to experience during a clinical placement.

Table 2 - Key Characteristics of Clinical and Simulation Experiences	
Clinical Placement Experiences	**Simulation Experiences**
• Unplanned, unpredictable, and uncontrolled by the instructor • Inconsistent from one student to another within the patient care environment • Situated in a practice environment that involves the ebb and flow of interacting emotions and communication among multiple players • Require skilled supervision because errors may have serious consequences • Require students to perform tasks or skills as the need arises as occurs in the workplace	• Planned, predictable, and controlled by the instructor allowing selection based on learning needs • Delivered consistently from one student to another within a learning group • Situated in a simulated environment of emotions and communication among a limited number of members of the interprofessional team • Allows students to make errors and learn from them • Allows skills to be learned in isolation with components of the skill mastered through repeated practice.

The differences between the experiences offered by simulation and by clinical placements affect the nature of the learning they foster. Table 3 illustrates the nature of the learning fostered from clinical placements and from simulation.

Table 3- Nature of the learning fostered through clinical and simulation	
Clinical Experiences	*Simulation*
- apply knowledge, skills, attitudes learned in the classroom and/or simulations to unplanned situations, as they arise - assess most pressing and least pressing concerns in the context of the whole human environment - apply clinical reasoning and problem solving skills in unplanned situations involving multiple players, multiple social interactions, and the ebb and flow of human emotions - manage time and prioritize in response time-frames ranging from critical, urgent, immediate, and ongoing to contexts where interventions take days, weeks or months to carry out. - perform psychomotor/technical skills as part of nursing care in the whole human environment with individuals across the lifespan - engage in relational practice with individuals and families within the context of complex social and cultural systems - coordinate care in collaboration with others who may not be immediately present - collaborate with members of the interprofessional team - provide community and population based nursing care	- apply predetermined knowledge, skills, attitude learned in the classroom and in laboratories to standardized scenarios - assess most pressing and least pressing concerns in the context of a predermined and limited set of environmental interactions - apply clinical reasoning and problem solving skills in planned and targeted situations, that are important for all students to experience in a controlled environment - manage time and priorities in predetermined situations requiring critical, urgent, and immediate responses. - perform the components/steps of a technical/ psychomotor skill. - perform psychomotor/technical skills as a part of the response to complex simulated scenarios - engage in relational practice with individuals and families within the circumscribed simulated environment of a simulated scenario - build trust and collaboration as a member of a team of interprofessional learners in simulated scenarios

In summary, both simulation and clinical placements facilitate learning in relation to practice outcome expectations. Simulation is ideally suited for practice situations that all students should experience as part of their preparation for practice; it provides opportunities to develop skills and abilities in relative isolation from other contingent variables. Clinical placements are essential for students to learn to respond within the context of a fluctuating external environment that impacts on caregiving, and in learning to provide care in a variety of time frames ranging from the immediate to interventions that may take several months to complete.

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The guidelines foster the development of the outcome expectations in the practice domain identified in the CASN National Nursing Education Framework (2015) through the use of clinical placements and simulation. They target the timing of practice experiences within the program, the intensity of practice experiences in terms of their length, frequency, and continuity, the selection of practice experiences, the quality of the instruction, and finally, the pedagogical process.

1. Timing of the practice experience within the program

The timing of practice experiences within the program ensures that they are ordered in terms of demand complexity, and that students have learned the foundational knowledge and skills to be applied in each. Practice experiences are levelled to the knowledge, skills, and ability to be acquired and they build in complexity as students' progress through the program. Skill training and partial care practice experiences, for example may precede full care experiences.

2. Length, frequency, and continuity of the practice experience

Consideration must be given to the length, frequency, and continuity of the practice experience as each of these affect student learning. The intensity of the practice experience should be based on the nature of the learning being targeted. This will depend on the complexity of what students are learning, the centrality of the learning to end-of-program outcomes, the nature of the practice experience, and in the case of clinical placements its location. For example, key tasks to be mastered that are relatively complex require repeated practice through simulation over a designated period of time until skills/steps are achieved. Similarly, learning outcomes related to an acute or critical care situation identified as central to students' learning may require a variety of scenarios over a number of simulation sessions to ensure students integrate the competencies being developed. Full care outcomes involving time management and prioritization in the unplanned and unpredictable environment of a clinical placement, need a degree of continuity for practice learning outcomes to be achieved. For full care outcomes in the community, the placement may not need to be continuous but the period covered may need to be long enough to complete the nursing process.

3. Selection of the practice learning experience

It is essential that the practice learning experiences be carefully chosen based on the learning outcomes to be achieved, the nature of the learning being sought, and the types of health issues they incorporate. Students should have the opportunity to care for clients with the most prevalent health issues in Canada as well as issues such as disasters that may be rare but have a significant impact on health outcomes.

The range of simulation based practice experiences in the program include:
- Low fidelity task training of psychomotor and technical skills;
- Low and mid fidelity learning related to relational skills
- Mid fidelity and high fidelity learning opportunities for physical assessment and intervention with an emphasis on abnormal signs and symptoms and rapidly deteriorating patient conditions

Clinical placements in the program offer the following:
- Practice experiences in acute, chronic and critical care,
- Practice experiences in long-term care,
- Community based care (including health promotion and disease prevention)
- Care of individuals, families, communities/populations

4. Quality of the instruction

Instructors and preceptors play a significant role in the student's practice experience and must be well qualified, well prepared, and well oriented to carry out their responsibilities. They hold, at minimum, a baccalaureate degree in nursing; have experience and expertise in the clinical area they are teaching, possess the relational skills to support student learning, understand the student objectives to be obtained, the alignment of the practice experience with theoretical courses and the curriculum, and work in a clearly articulated organizational structure with reporting guidelines. Systems need to be in place to support instructors pedagogical knowledge related to clinical placements or simulation. Instructors should have a strong understanding of how to promote reflective practice among students.

For simulation based learning, the instructor/facilitator meets the INACSL (Boese, 2013) criteria and guidelines for simulation-based learning facilitators, understands simulation as a tool, and the teaching/learning principles of simulation. Instructors and preceptors in clinical placements undergo an orientation program that includes an orientation to the school, its organizational structure, and the clinical placement site, and have completed educational preparation for the role.

5. Pedagogical Process

The objectives of the practice learning experience are clearly identified and its role in the curriculum articulated. Students are oriented to the placement site and/or simulation prior to the practice experience, and there is a transparent, well-defined organizational structure supporting it. Engaging students in reflective practice and debriefing is critical and should be evidence based.

For simulation based practice experiences, students are oriented to the technology prior to the simulation. The simulation is well-prepared and is well aligned with the objectives of the practice experience. The prebrief and debrief components of the practice learning experience help to integrate the practice learning.

Contracts between the agency and the school of nursing are in place for clinical placements and are respected. Patient/client assignments reflect the objectives of the practice experience; preparation and debriefing sessions contribute to student learning.

Conclusion

Nursing education must incorporate practice experiences if students are to develop the competencies needed to enter the workforce as registered nurses. Simulation and clinical placements are, therefore, essential components of nursing curricula. Together, they provide the opportunity to better prepare nursing graduates for the transition from education to practice. The practice learning they offer, however, must be well thought out or this opportunity will be lost. While there may be considerable variation across programs in the use of simulation and clinical placements, their timing, intensity, selection, instructional quality, and pedagogical process within curricula are critical for the achievement of outcome expectations for new graduates.

Term	Definition
Delegation	Delegation is a formal process by which a regulated health professional, who is authorized and competent to perform a procedure under one of the controlled acts, delegates the performance of that procedure to someone, regulated or unregulated, who is not authorized by legislation to perform it. (CNO, 2014)
Interprofessional	Teams made up of different professions working together to reach a common goal and share decision making to achieve the goal. The goal in health care is to work in a common effort with individuals and their families to enhance their goals and values. An interprofessional team typically includes one or more physicians, nurses, social workers, spiritual advisors, personal support workers and volunteers. Other disciplines may be part of the team, as resources permit and as appropriate (Ferris et al., 2002) (as cited by RNAO, 2013).
Fidelity	the extent the simulation represents real world clinical situations
Debriefing	An activity that follows a simulation experience and is led by a facilitator. Participants' reflective thinking is encouraged, and feedback is provided regarding the participants' performance while various aspects of the completed simulation are discussed. Participants are encouraged to explore emotions and question, reflect, and provide feedback to one another. The purpose of debriefing is to move toward assimilation and accommodation to transfer learning to future situations (Johnson-Russell & Bailey, 2010; NLN-SIRC, 2013). (Meakim, Boese, Decker, et al., 2013)
Prebriefing (Briefing):	An information or orientation session held prior to the start of a simulation-based learning experience in which instructions or preparatory information is given to the participants. The purpose of the prebriefing or briefing is to set the stage for a scenario and assist participants in achieving scenario objectives. Suggested activities in a prebriefing or briefing include an orientation to the equipment, environment, mannequin, roles, time allotment, objectives, and patient situation. (Meakim, Boese, Decker, et al., 2013)
Pedagogy:	The art or science of instructional methods. The study of teaching methods, including goals of education and the ways those goals can be achieved. (Meakim, Boese, Decker, et al., 2013)
Preceptorship	A frequently employed teaching and learning method using nurses as clinical role models. It is a formal, one-to-one relationship of pre-determined length, between an experienced nurse (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting to a new role. The novice may be a student or an already practicing nurse moving into a new role, domain or setting. (CNA, 2004).
Simulation	A pedagogy using one or more typologies to promote, improve, or validate a participant's progression from novice to expert (Benner, 1984; Decker, 2007).

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