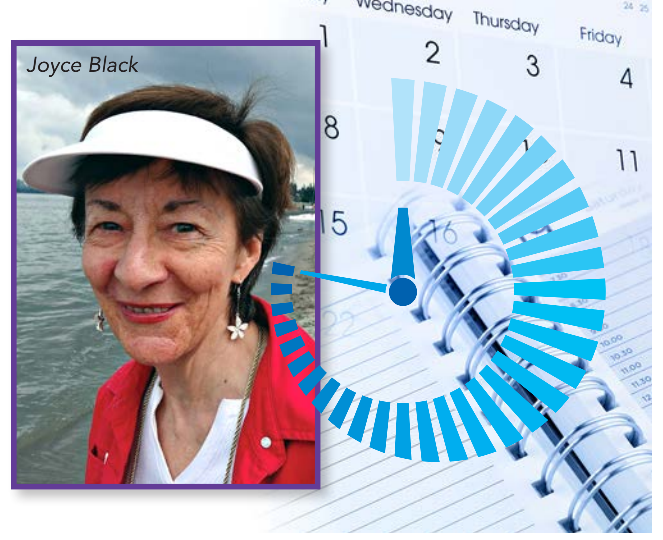
Leader to Leader

Nursing Regulation & Education Together

Fall 2014

A Day in the Life of a Nursing Regulator



Joyce Black

Describing the path of her career, **Joyce Black, RN, BN, Ed.D,** likes to joke that she's an "Atlantic to Pacific person." Black pursued her doctoral studies in Vancouver at the University of British Columbia. She started out as a public health nurse, first in Prince Edward Island and then in the city of Vancouver, before becoming an educator in both baccalaureate and master's programs. Black's experience as a nurse educator for more than two decades was gained primarily at the Dalhousie University School of Nursing in Halifax, Nova Scotia where she taught in undergraduate and graduate programs before becoming director of the school.

As senior education consultant at the College of Registered Nurses of British Columbia (CRNBC), Black regularly reviews, for registration purposes, all entry-level and refresher registered nurse (RN) and nurse practitioner (NP) education programs in British Columbia. This includes the development and revision of competencies and nursing education standards used in the program review process. Black has 17 years of experience in this role at CRNBC, during a time of significant changes in the competencies and education requirements.

To give educators a clear idea what the role of an education consultant is, could you give us an idea what your primary responsibilities are?

My primary responsibility is for the review of nursing education programs in this province. We operate under provincial legislation here, so that governs

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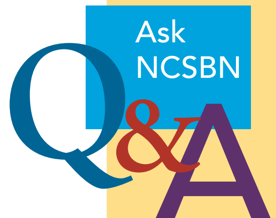

Q: We have seen the NCSBN webpage with prelicensure nursing education requirements for out-of-state programs, and we have found it very beneficial. However, we'd like to see the boards of nursing's (BON) requirements for out-of-state advanced practice registered nurse (APRN) programs. Is that list available?

A. Thank you for that feedback on our prelicensure distance education requirements. For those of you who haven't seen NCSBN's webpage that houses prelicensure BON requirements for out-of-state programs, it can be found here.

At this time, we do not have the requirements for out-of-state APRN programs. However, NCSBN's Board of Directors has convened a committee to develop guidelines for the BONs related to APRN distance education programs. As part of that work, we are planning to develop a webpage for out-of-state APRN distance education programs as well. You'll learn more about that in the next *Leader to Leader.* Stay tuned!

NCSBN
National Council of State Boards of Nursing

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what we do with the nursing education programs and how we work with the educational institutions.

We have a statutory committee of our board that consists of 12 members—quite a diverse membership—and I provide support and work with that committee to review the programs and orchestrate the program reviews, including contracting with site visitors.

> "I find it hard to think about challenges, because I enjoy the work so much that every new development is normally quite exciting."
> — Joyce Black

I also provide support, information and consultation to the nursing education programs when they're preparing for review and I keep them informed through the entire process until the board decision is made. The education program review committee makes recommendations to the board. So I handle that work, dealing with many players, including staff in both our Ministry of Health Services and our Ministry of Advanced Education.

The other big thing is the work I do across the country with my counterparts in the other provinces and territories. Part of that is done under the umbrella of the Canadian Council of Registered Nurse Regulators (CCRNR), which is somewhat equivalent to NCSBN. In particular, we develop the entry level competencies for RNs with 10 jurisdictions. I've been involved with that for 10 years now, and chaired that group at one time. The document we produced is on the CCRNR website. Each of our boards or councils has endorsed or decided what competencies they would use for education program review. We've gone through three revision cycles to keep them up to date, taking two to three years for each cycle. We surveyed and got input provincially and fed that into our cross-jurisdictional work—that's major. I've also been quite heavily involved with the nurse practitioner (NP) competencies we require.

Are there any differences you've noticed between how education programs function in the U.S. compared to Canada?

We operate under provincial legislation here, so that governs what we do with the nursing education programs and how we work with the educational institutions. Licensed practical nurses (LPNs) are a separate regulatory body in most jurisdictions in Canada, but not all. In Canada, the vast majority of our programs for RNs are baccalaureate programs. In British Columbia, the only educational route in the province for initial RN registration is through baccalaureate programs. There are no diploma programs, and all of our NP programs—we have three—are family nurse practitioner programs and they're all masters in nursing programs.

The role of the education consultant does vary by jurisdiction as well, depending in part on the legislation and the size of the province or territory. A lot of people have a dual role as a practice consultant and an educational consultant. For example, in some provinces there are a few—one, two or three—nursing educational programs that they would review.

What is the greatest challenge you face in your role? Alternately, what's your favorite part of the job?

I find it hard to think about challenges, because I enjoy the work so much that every new development is quite exciting. However, juggling the workload at times would be the greatest challenge. And setting and sticking to priorities. All of the things I do are so rewarding, like working with the nursing education programs and the nursing education leaders in the province. I enjoy working with our education program review committee. It never ceases to amaze me how the committee does such high-level, quality work. There's quite a variety on the committee. And they're not all nurses, although the majority are. It's always been a wonderful group. As committee members turn over, I'm amazed by how well the atmosphere and the culture of the committee continues, with a great respect for different perspectives.

A very close second would be working with my counterparts across Canada. That's been absolutely tremendous in relation to the competencies work. The work on the competencies has been a highlight in my career. I'm on an electronic network with all of my counterparts across the country under CCRNR, where we share information and ask each other questions. I enjoy that broad linkage and connection. Any time we're at conferences we try to meet and catch up.

Is Canada's upcoming transition to the NCLEX-RN® Examination impacting your role?

The transition to the exam does have some impact, but there are other staff here who are more directly involved, certainly at the operational level. I'm at a bit of an arm's length, which I think is appropriate given my role with program review. We have a group in British Columbia called the Nursing Education Council of British Columbia (NECBC). All of the deans, directors and chairs participate in that group, so that's been a terrific forum for us, and for our registrar and CEO Cynthia Johansen, to dialog about the issues on both sides and try to address them.

It is, of course, a major change for the nursing education programs and one that's being done relatively quickly given the size of the change. The programs are taking the change very seriously, and doing very extensive work to understand how the test plan and methodology—the computer-adaptive testing—are different from what we had in the past, and to provide resources and support to the students so they will be well-prepared. I'm very impressed by their transitional planning and engagement and how they have taken hold and are supporting students. I commend our national group, the Canadian Association of

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Schools of Nursing (CASN), on the work they've done with educators across Canada to help them transition to the NCLEX.

How do you see the role of the associate members in NCSBN?

I'd say gaining a broader knowledge, access to the resources, tools, information and continuing professional development. I have really enjoyed and benefited from the education calls, and understanding some of the different issues; the work on the transition of the new graduates, the most recent research on simulation, conferences and the *Journal of Nursing Regulation* are great as well. We used the tools and resources such as those around social media and referenced it when developing our own materials. A number of our staff here has been able to share their work, as I have. Others have gone to conferences and have participated in your committees, and even some of the research and formal scholarship programs. So it's really enlarged our networking and connections, and we've gained a great deal from the knowledge and resources.

Looking back, what motivated you to join the CRNBC?

This position became available and it sounded quite intriguing. I had been involved in education program review with regulatory bodies and with our national accreditation body here, so I thought it was an opportunity to be involved from the perspective of regulatory body staff. I felt it fit with my experience and I really found that it has. I enjoy it tremendously.

NCSBN Opens Registration for NCLEX® in Canada

In November, NCSBN opened NCLEX-RN® Examination registration for Canadian students and graduates, international applicants and others looking to take the NCLEX for licensure/registration in Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Northwest Territories and Nunavut, Nova Scotia, Ontario, Prince Edward Island and Saskatchewan.

Once a student is deemed eligible by their regulatory body and receives an Authorization to Test, they may schedule an examination appointment on or after Jan. 5, 2015.

The NCLEX-RN Examination is currently offered in 10 countries around the world for the purpose of domestic licensure in the U.S. When the exam is offered early next year it will be the first time that the test will be used for the purpose of licensure in another country.

In the last three years, NCSBN has worked with 10 Canadian registered nurse (RN) regulatory bodies to prepare for the Canadian transition to the NCLEX.

Learn more by visiting the Canadian Educators & Students FAQs on our website.

Simulation Study Results Released

As the number of nursing education programs increases to address the nursing shortage, the number of clinical sites has not grown with it. While programs find innovative ways to provide students with a quality clinical experience, high-fidelity simulation has gained notice as a way for students to develop their nursing skills in a controlled environment. Existing research, however, has not provided clear direction on how much simulation could be used as a substitute for traditional clinical experiences without sacrificing educational quality. Therefore, NCSBN conducted the National Simulation Study, a large-scale, randomized, controlled study that encompassed the entire nursing curriculum.

Led by primary investigator Jennifer Hayden, MSN, RN (see below), the study began in 2010 with the selection of 10 participating programs. Five associate degree (ADN) and five bachelor's degree (BSN) programs were selected to make up a sample that was diverse in both geographic location and size of institution, and representing populations in both urban and rural areas. The cohort of students entered the nursing programs in fall of 2011 with an expected graduation date of Spring 2013. Those who consented were randomized into one of three groups, all using simulation for at least part of their clinical hours. In the control group, clinical hours were spent in largely traditional clinical experiences, utilizing no more than 10 percent simulation. The other two groups replaced 25 percent and 50 percent, respectively, of clinical hours with simulated clinical experiences.

In order to ensure consistency of instruction, a standardized curriculum was developed, and faculty selected the simulations that would meet their learning objectives. The simulation scenarios included in the curriculum included medium- and high-fidelity manikins, standardized patients, role playing, skills stations and computer-based critical thinking simulation, all subject to the same requirements as a traditional clinical setting. A study team of faculty and staff was appointed at each school. These staff attended three weekend-long training sessions to achieve mastery of both the simulation framework and the debriefing method.

Participants were evaluated on their nursing knowledge using the ATI Content Mastery Series® examinations, and instructors rated their competency throughout the program using the Creighton

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In Memoriam

Jennifer K. Hayden, MSN, RN
Associate, NCSBN Research Department
1972–2014

The principal investigator of the NCSBN National Simulation Study died Nov. 3, 2014, after a 13-year battle with breast cancer. An employee of NCSBN since 2009, Jennifer is remembered for her perseverance and dedication as an inspired nursing researcher as well as generous and respected colleague. She will be greatly missed.

Under her direction, the National Simulation Study was the recipient of two prestigious awards honoring its contributions to the body of nursing knowledge.

The International Nursing Association for Clinical Simulation & Learning (INACSL) presented Jennifer with the first INACSL President's Award in recognition of her role as the project director for the National Simulation Study and her leadership in bringing this seminal work to fruition. INASCL has also named a scholarship in her honor.

NCSBN was the recipient of the first Excellence in Educational Research Award, a program of the Sigma Theta Tau International/Chamberlain College of Nursing Center for Excellence in Nursing Education, presented at STTI's International Nursing Research Congress in Hong Kong. It was unanimously selected by the judges because it was a broad-based study that has nationwide and potentially international impact on nursing education.

Jennifer Hayden (center) pictured here with Chamberlain College of Nursing President Dr. Susan Groenwald (left) and Sigma Theta Tau International President Dr. Hester Klopper (right) at an award presentation at the 25th International Nursing Research Congress, July 2014.

Jennifer graduated from Indiana University in 1992 with a BS in Psychology. She then went on to pursue a career in Nursing, receiving a Bachelor's Degree in Nursing from Rush University in 1996, and a Master of Science in Nursing in 1999. Her work has been published in numerous medical and nursing journals.

She is survived by her husband and two children.

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Competency Evaluation Instrument (CCEI). Students also rated the extent to which their learning needs were met via the Clinical Learning Environment Comparison Survey (CLECS). Finally, study participants who notified the primary investigator of their first position as an RN were followed through their first six months of employment, with managers or preceptors periodically rating them on performance, critical thinking skills and competency.

> For educators and regulators, these findings are game-changing, clearly supporting the use of up to 50 percent high-fidelity simulation in place of traditional clinical experiences.

Of the 847 students who consented, 666 graduated in the spring 2013 cohort and completed the study. At the time of graduation, no statistically significant differences were found between the three study groups in clinical competency (p=0.688), nursing knowledge (p=0.478), and NCLEX® pass rates (p=0.737). This carried into the employment setting, where employers found no statistically significant differences in the participants' competency or readiness for practice at six weeks (p=0.706), three months (p=0.511), or six months (p=0.527).

For educators and regulators, these findings are game-changing, clearly supporting the use of up to 50 percent high-fidelity simulation in place of traditional clinical experiences. As nursing programs make changes based on these results, however, the investigators emphasize three important facets of the study that impacted this outcome:

1. The simulation methods used were of high fidelity, replicating the experiences of a traditional clinical opportunity as closely as possible.
2. Faculty underwent extensive training in the delivery and debriefing of simulation content, and their proficiency was monitored throughout the study by team leaders to ensure consistent delivery of content.
3. The faculty and staff of each program were fully committed to the changes required by the study, adapting to new teaching methods and allocating the needed infrastructure, resources, equipment and staffing to make the change successful.

Programs wishing to further enhance their clinical experiences with simulation should plan carefully to address each of these three factors in order to achieve success. NCSBN is currently compiling a set of guidelines and recommendations for the successful implementation of simulation.

According to the evidence presented by the National Simulation Study, there are several factors that go into a successful nursing program: the buy-in of the institution, the resources of the program, the ongoing training of faculty, and a culture of feedback and communication. Based on the statistically near-uniform results, however, it appears that the amount of simulation used by a program is not one of these factors. In either learning environment, excellent student outcomes originate from a well-prepared educator in a supportive environment and equipped with the proper tools.

The complete report of the National Simulation Study can be found in the July 2014 supplement of the *Journal of Nursing Regulation*, available at the JNR website.

Watch Our New Professional Boundaries Video

As health care professionals, nurses strive to inspire confidence in their patients and their families, treat all patients and other health care providers professionally, and promote patients' independence. Patients can expect a nurse to act in their best interests and to respect their dignity. This means that a nurse abstains from obtaining personal gain at the patient's expense and refrains from inappropriate involvement with a patient or the patient's family members.

Crossing a professional boundary is a violation of the nurse practice act and can be the cause of professional discipline and termination of employment.

Our new video helps explain the continuum of professional behavior and the consequences of boundary crossings, boundary violations and professional sexual misconduct. The video illustrates how to maintain professional boundaries and strengthen the therapeutic nurse–patient relationship. Internal and external factors that contribute to professional boundary issues, including social media, are explored.

Watch the new video and access other professional boundaries resources.

Clinical Reasoning in Nursing Practice: Importance and Benefits

by Linda L. Kerby, MA, RN, C-R, Mastery Education Consultations

Clinical reasoning is the process by which nurses collect cues, process the information, come to an understanding of a patient problem or situation, plan and implement interventions, evaluate outcomes and reflect on and learn from the process (Jones, 2010).

Clinical reasoning may be defined as the process of applying knowledge and expertise to a clinical situation to develop a solution (Carr, 2004).

The concept of this type of process dates back over two millennia to Socrates. The importance of searching for evidence, examining fundamental concepts and examining implications are still crucial to the clear thinking and decision making needed in today's world.

Many factors contribute to the necessity for clear and rapid thinking in contemporary clinical nursing practice. They are interrelated, increasing the complexity of the issues. This includes, but is not limited to:

1. **Morbidity and mortality** in the patient population. As lives are being extended, issues arise related to management and rehabilitation of people with chronic conditions, severe debilities or co-morbidities. Flexibility in thinking is required to produce individualized plans of care in the face of more complex situations.
2. **Interdisciplinary approach.** Specialization has become more common, and new treatment modalities bring to the table health care professionals with varied backgrounds, experiences and perspectives. Coordination of efforts is required to produce desired outcomes and ensure quality of life.
3. **Electronic Health Records.** The processes of recording and retrieving information have been streamlined to facilitate the availability of patient data, but this carries the burden of being more clear and objective than ever. Precious time can be saved when providers can reach across distances to review previous test results, consultations or outcomes of treatment, but this must be standardized so that empirical evidence can be cited for interventions. With respect to diversity of language, tradition and culture, variations can occur in smaller distances than one might think.
4. **Accountability.** As the scope of practice for nurses continues to expand, more independent functioning follows the trend, from bedside care to nurse practitioner clinics. From clear explanations to other health care personnel, to education and information provided to patients, the nurse must be adept at problem solving and communication. Community health nurses are dealing with situations at patients' homes that were once found only in acute care settings. The responsibility for such practices requires a very high degree of professionalism from the nurse.

5. **Reimbursement.** Insurance companies and others have instituted more stringent review policies for the payment of claims and determination of coverage for particular conditions. Even in health-maintenance and preferred-provider groups, review and allowance are rigorously utilized to determine payments. With the rate of litigation from patients who disagree with some payers' decisions, it is important for providers at every level to be able to implement evidence-based practice with clear and concise rationales.
6. **Technology.** Many time-honored procedures (such as dressing changes) have been replaced by equipment and supplies that perform a more efficient job with less labor for the nurse. Diseases that were once thought incurable are now being subjected to scrutiny through such databases as genomic testing, making targeted therapy a reality. Computer technology has made calculating, storing, and retrieving information faster and wider, and continues to expand its abilities. Patient and staff education, updates, reviews and bulletins can be made available on demand, facilitating the spread of information in a timely manner. Consultations can take place between nurses who are widely separated geographically, but need to exchange information and provide feedback to one another.
7. **Forensics.** Many patients who are alleged to be involved in events that may relate to criminal activities (homicide, rape, theft, etc.) are in the health care system due to conditions incurred during a situation under examination by law enforcement officials. Charting that once was the tool of the agency

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for exchanging information might be subpoenaed for review and/or presentation in trial or in a grand jury. This requires detailed and objective reporting when communicating about findings and conclusions. And as nurses are called upon to testify as expert witnesses for lawsuits, critical thinking must form the opinions and statements of the professional in court.

These factors also overlap in their scope, adding further complexity to the interface between clinical practice and other entities and agencies. New situations arise constantly that put the nurse into unfamiliar territory, and great care must be taken to follow prevailing standards and guidelines in delivering patient care.

> In order to function effectively and efficiently, the nurse must be able to call upon a foundational repertoire of knowledge to plan, implement and evaluate patient care.

As health care becomes more complex, nurses are called upon to perform at an expert level in a rapidly changing environment. In order to function effectively and efficiently, the nurse must be able to call upon a foundational repertoire of knowledge to plan, implement and evaluate patient care. Unlike educators and supervisors who previously assessed performance based on technical knowledge and ability to follow algorithms and protocols, today's profession calls for critical thinking that is conducive to clinical reasoning and clinical judgment.

In addition to bedside care, the reasoning process is crucial to the functions of patient education; reporting to other shifts, agencies or staff; summary reports of patient progress; evaluations of performance; and project proposals. The continuity of communication is the infrastructure to the management of information. Maintaining individualized, patient-centered care requires thoughtful and reflective teamwork throughout the spectrum of services.

Effective clinical reasoning depends upon the nurse's ability to collect the right cues and take the right action, for the right patient, at the right time, for the right reason.

Summary and Conclusions

Numerous factors influence the delivery of patient care in the changing and growing industry. Nurses must invoke scientific guidelines to perform in ways consistent with regulations, standards and needs.

Using critical thinking as the foundation, nurses can focus on clinical situations in an objective and scientific manner by using clinical reasoning processes.

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Visit NCSBN's New Website

NCSBN has launched a redesigned www.ncsbn.org, complete with engaging graphics and enhanced navigation designed to improve your visitor experience.

The relaunched site features:

- Improved accessibility for individuals with a visual or hearing impairment;
- Additional targeted services and resources on every page;
- Responsive design, so that the website is effectively viewable on any device.

Each diverse audience group (nurses, nursing students, nursing educators, researchers, consumers and NCSBN members) have their own unique section of the website that offers materials and resources tailored especially for them.

www.ncsbn.org

Prelicensure Distance Education Recommendations

Two national reports have recommended that nurses advance their education (Benner, Sutphen, Leonard & Day, 2010; IOM, 2011). Distance education programs provide tremendous opportunities for nurses to further their education, particularly by offering quality programs in small communities or rural areas where nursing programs don't exist, or by allowing flexibility for students who otherwise couldn't attend a program.

However, boards of nursing (BONs) have reported issues with distance education programs, and some educators have complained about the varying BON regulations with which they must comply. Therefore, NCSBN's Board of Directors convened a committee of the NCSBN membership which met from 2012 to 2014 to identify the issues that BONs and prelicensure nursing education programs face due to distance education, and to develop recommendations.

Issues the committee identified included:

- Core education requirements for approving distance education programs are needed so that states/jurisdictions are consistent when approving programs for having students in host states.
- A need for licensure clarification, particularly with faculty who only teach didactic courses, though there was consensus that preceptors or clinical faculty who work with patients be licensed in the host state where the patients are located.
- BONs in certain states/jurisdictions want to know when students from out-of-state programs take clinical experiences in their states/jurisdictions.
- Host states/jurisdictions want assurance that students participating in clinical experiences in their states/jurisdictions are being supervised by qualified faculty or preceptors.
- BONs want to know how to communicate distance education issues with BONs that don't have authority over nursing education.
- BONs report that the quality of online programs is more varied than traditional programs, and they have requested information on the uniqueness of the programs for evaluating their quality.
- Educators worry about complying with all the different regulations from Boards of Higher Education as well as BONs.

To answer these concerns, the committee members took several steps. First, they developed definitions, including the following:

1) **Distance education** – Instruction offered by any means where the student and faculty are in separate physical locations. Teaching methods may be synchronous or asynchronous and shall facilitate and evaluate learning in compliance with BON approval status/regulations.

2) **Home state** – Where the program has legal domicile.

3) **Host state** – State/jurisdiction outside the home state where students participate in clinical experiences or didactic courses.

After conducting interviews, conference calls and surveys with BONs, educators and representatives of the new National Council of State Authorization Reciprocity Agreement (NC-SARA) organization, the committee developed guidelines for BONs that were translated into model administrative Rule/Act language[1] and adopted at NCSBN's 2014 Annual Meeting.

The summarized guidelines are:

1. Distance education programs must meet the same approval guidelines of any other program.
2. Only the home state approves distance education programs.
3. The home state ensures faculty supervision over clinical students in the host states.
4. **(a)** Clinical faculty or preceptors are licensed where the patients/students are located.

   (b) Faculty who only teach didactic content are licensed in the home state. Model rule language was written to exempt host state licensure of faculty who only teach didactic content from the home state.
5. BONs will include a question on their annual reports on whether or not students are engaging in clinical experiences in host states.

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[1] *NCSBN's model administrative Rule and Act language is developed by NCSBN members for the BONs to use as they write and revise their administrative Rules and Practice Act. Find the NCSBN Model Rules and Act here.*

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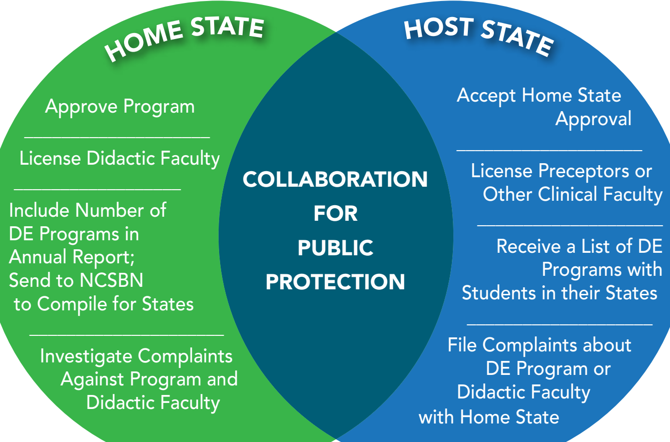
The committee encouraged the BONs to make these changes by 2020, which is in line with the 2011 IOM Future of Nursing recommendations. This model clearly depicts the roles of the home and host states with these new guidelines. Moving forward, there will need to be more collaboration among the home and host states for program approval and for allowing programs to enroll students in host states. See Lowery & Spector (2014) for a more comprehensive discussion of this committee work.

To support these efforts, NCSBN has developed a Distance Education webpage with resources for BONs and educators. This webpage has a link for host states distance education requirements that educators have found valuable.



NCSBN is also planning a virtual conference on April 28, 2015, for its BONs. It will feature Dr. Diane Skiba as a keynote presenter on the future of distance education, and Dr. Diane Billings discussing quality indicators for distance education programs. There will be plenty of time for dialogue and panel discussions on the issues. A special session will highlight the NC-SARA initiatives and Case Western Reserve's new massive open online course (MOOC) on quality improvement.

It is imperative for BONs and educators to work together to promote excellent learning outcomes with distance education, which in turn will improve the quality of care and safety of patients. Authentic conversations will be essential as BONs and educators move forward together. ●

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A Review of Entry-level Nurse Characteristics and the NCLEX®

The NCLEX® Examination is developed to measure the minimum knowledge, skills and abilities required to deliver safe, effective nursing care at the entry level. Part of the development process is to periodically review and define the examinee profile, the practice environment for entry-level nurses and the environment's effect on the length of the entry-level period. NCSBN conducts the NCLEX practice analysis every three years to analyze entry-level practice. Using the data collected in the practice analysis, NCSBN then moves to develop the NCLEX Test Plan. Analysis of data from a nine-year span indicated that the environment had become more complex; thus, the question arose about the current length of the entry-level period.

The entry-level nurse exhibits characteristics such as limited confidence and a need for additional skill acquisition of critical thinking and clinical judgment (Cockerham, Figueroa-Altmann, Eyster, Ross & Salamy, 2011; Martin & Wilson, 2011; Welding, 2011). Additionally, the newly licensed nurse delivers client care in today's fast-paced health care environment. The current practice setting of the entry-level nurse reflects delivery of complex care coupled with the need for rapid, appropriate clinical decision making (Dyess & Parker, 2012).

Each profession sets out to define parameters focused on how long a newly licensed incumbent practices with entry-level characteristics. No one profession has identified a methodology to uncover the length of time entry-level characteristics exist (Williams, Kim, Dickison & Woo, 2014). Given the profile of entry-level characteristics, the literature has established that newly licensed nurses are more likely to commit practice errors and therefore require structured transitional support during the entry-level period (Cockerham et al., 2011; Martin & Wilson, 2011; Saintsing, Gibson, & Pennington, 2011; Zhong & Thomas, 2012).

Given these circumstances, the length of time an entry-level nurse practices in the current health care environment with the identified characteristics remains an unknown. As a result, NCSBN conducted an analysis to evaluate the effects of the current practice environment and client population on the length of time entry-level nurse characteristics remain. Before the analysis, the entry-level period for the NCLEX examinee profile was considered to be six months (Williams et al., 2014).

NCSBN analyzed practices used in other professions to identify the entry-level period, the current entry-level practice environment, today's client population and the results of a nurse focus group. A group of 35 registered nurse (RN) and licensed practical/vocational nurse (LPN/VN) volunteers experienced with entry-level RN or LPN/VN practice were divided into four groups. Each group participated in a facilitated discussion surrounding entry-level nurse practice, the practice environment and the current client population. After 15 minutes, the participants were asked to respond to the question of how long a newly licensed nurse must practice before entry-level characteristics begin to dissipate. Each nurse wrote the response on paper; individual responses were not revealed to the group. The RN panel responses ranged from six weeks to 24 months with a mean of 12.19 months and a standard deviation of 6.43. The LPN/VN panel responses ranged from six weeks to 24 months with a mean of 13.40 months and a standard deviation of 6.88.

As a result of the findings, the NCSBN Board of Directors (BOD) approved a revised definition of the entry-level nurse in the NCLEX environment. With the start of the next NCLEX practice analysis cycle and subsequent NCLEX test plan development and item generation, the NCLEX entry-level nurse will be defined as a nurse having no more than 12 months of experience. The revised definition may result in an amended list of entry-level nursing activities. If new entry-level nursing activities are discovered and applicable, they will appear on the NCLEX represented by examination items across varying difficulty strata. Uncovering a vastly different list of activities is unlikely, but a few additional activities may be discovered, (Williams et al., 2014).

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NCSBN's Transition to Practice® Study

Transition to Practice® (TTP) for new graduate nurses has been a subject of discussion among regulators, educators and practitioners for more than a decade. Two NCSBN national surveys of employers of new nurse graduates reported that fewer than 50 percent of new graduates were prepared to practice safely and effectively (NCSBN, 2002; NCSBN, 2004). Later research by other investigators corroborated this work (Berkow, Virkstis, Stewart & Conway, 2008).

NCSBN and its member boards have had a longtime interest in this subject. Adequate preparation for nursing practice in a given institution is an important part of public protection. For this reason, NCSBN has extensively discussed and studied this issue, convened a committee to analyze existing data, gathered input from experts across nursing, designed an evidence-based TTP program and tested its effectiveness and impact on patient safety.

NCSBN's TTP study adds to the existing data and fills some of the prevailing gaps in knowledge. This multisite, randomized, controlled study enrolled 105 hospitals across three states, employing new graduate nurses. The facilities were randomized into either a control group (maintaining their customary onboarding procedures) or into a comprehensive, evidence-based, structured six-month transition to practice program that included the use of five online modules (based on the Quality and Safety Education for Nurses (QSEN) competencies, with a heavy emphasis on patient safety and clinical reasoning) and a preceptor, who received specific preparation for their role and worked with the new graduate throughout the six months. Institutional support was provided during the next six months. Feedback and reflection were important components of the program and woven throughout. Results indicated the standardized, evidence-based TTP program, implemented in hospitals with new registered nurse (RN) graduates, improves quality and safety outcomes with the following statistically significant findings: new nurses report fewer errors, use fewer negative practices (such as violating standard precautions), felt more competent, experienced less work stress, reported more job satisfaction and were less likely to leave their positions.

NCSBN's TTP study supports a standardized transition program in hospitals that includes the following characteristics:

- A formalized program that is integrated into the institution, with support from the chief nursing officer (CNO) and other administrators;
- A program length of 6–12 months;
- Content in patient safety, clinical reasoning, communication and teamwork, patient-centered care, evidence-based practice, quality improvement, informatics, feedback and reflection;
- Time for new graduates to learn and apply the content and to obtain feedback and share their reflections;

- A preceptorship, and the preceptor should be educated for the role;
- Time for the preceptors to work and connect with the newly graduated nurses; and
- Customization so that the new graduates learn specialty content in the areas where they are working.

In conclusion, a structured, evidence-based formal transition to practice program improves outcomes in new graduate nurses. Programs that are well-established within the institution provide the support new graduates require during their first year of practice. Nurse educators are well positioned to begin this transition to practice journey. Incorporating the QSEN competencies into the curriculum, along with clinical reasoning, opportunities for reflection and provision of constructive feedback, would prepare students for transitioning from education to practice.

Detailed results can be found in the January 2015 edition of the *Journal of Nursing Regulation.* ●

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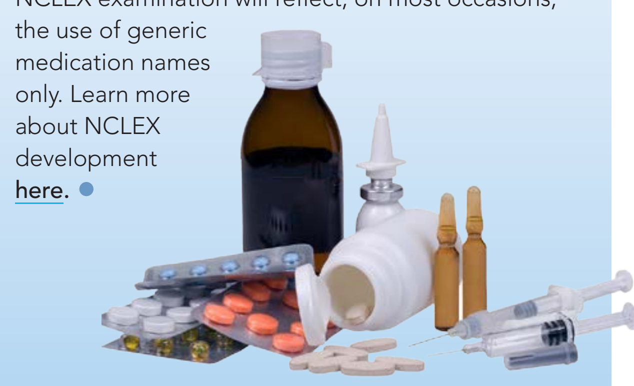
Only Generic Drugs are Addressed on the NCLEX®

NCSBN understands that most clinicians use both generic and brand names when referring to drug medications. In order to be consistent and achieve accurate measurement, terminology used in exam items can have only one meaning. This is why the NCLEX examination will reflect, on most occasions, the use of generic medication names only. Learn more about NCLEX development here.



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