Leader to Leader

Nursing Regulation & Education Together

Spring 2013

A Day in the Life of a Nursing Regulator

Dennis Corrigan, RN, is a busy man. Last year, he investigated 280 complaints made against nurses; that's almost six a week. He's always on the go, interviewing witnesses, coordinating with local law enforcement, requesting official documents and filling out paperwork (there's always paperwork). It's all in a day's work for Corrigan.

For the past 11 years, Corrigan has worked as a compliance agent for the Ohio Board of Nursing (OHBON). He is responsible for protecting the public by investigating drug, practice and criminal complaints made against nurses. While the job can be overwhelming at times, Corrigan enjoys it. "There is no such thing as a typical day," he said. "Each case takes its own path."

For Corrigan, the path to investigative work started more than decade ago when he was an emergency room/ICU nurse. He was called on as a witness for an investigation in his hospital. The process piqued his interest and shortly afterward, Corrigan switched careers and started working as a compliance agent for the OHBON. Corrigan credits his nursing background for giving him the ability to see things as an investigator from a different perspective. "I am there to protect the public," he said, "but I am a nurse first."

Corrigan talks about his investigation process, how he stays on top of his workload and how his background as a nurse impacts his role as an investigator. Corrigan also rips a page from his day planner as he walks us through a day in his life.

continued on page 2

IN THIS ISSUE …

WANTED:
Your Feedback!
We want to know what you think about *Leader to Leader*. Tell us in this quick survey.

Ask NCSBN Q&A

Q: Is it true that the NCLEX® will be used as the licensure examination in Canada? When will it be available? What process will you go through to make this happen?

A: Beginning in January 2015, 10 Canadian provinces will begin using the NCLEX-RN® Examination for nursing licensure/registration. The NCSBN Examinations department, members of the Canadian Council of Registered Nurse Regulators (CCRNR) and NCLEX testing partner Pearson VUE have created a team responsible for the NCLEX transition,

Answer continued on page 3

NCSBN
National Council of State Boards of Nursing

continued from page 1

For many of us, our idea of what an investigation entails is directly influenced from what we see on TV dramas and in the movies: investigators collect evidence, follow the paper trail and interview witnesses. Is this what your investigation process is like?

Our process of investigation is certainly not like what you see on those TV drama shows. We aren't kicking down any doors and we don't confront nurses in a harsh manner. For the most part, our process is very amicable.

Almost half of my cases involve a criminal process and I will try and work with law enforcement. On those cases I retrieve or subpoena documents, interview witnesses and research the nurse's past. I look into their narcotic prescription history through a state database, check any criminal history, check into civil court history (financial and personnel), talk to past employers and look for any other information that may help me in my investigation. Having close relationships with law enforcement agencies like drug task forces, sheriff's departments, police departments and other state agencies help me complete criminal investigations. I will use any source I can if it helps to substantiate or unsubstantiate a complaint involving a nurse.

What happens to the nurses that you investigate?

Unless there is direct evidence of patient harm by the nurse, we take the approach that they made mistakes and they are going to go through a process with us to turn themselves around. It's usually up to the nurse. This might include drug rehabilitation and criminal charges for a nurse who stole narcotics or monitoring and education for a nurse with practice issues. Of course some licensees are not cooperative and we need to take a more direct approach. If there is patient harm or a potential for patient harm, our approach is to get the licensee out of practice as quickly as possible. Usually this involves asking the nurse to voluntarily make their nursing license inactive (as long as there is strong evidence of a serious issue).

continued on page 3

A Look at Corrigan's Day: FRIDAY

8:00 am – Open up my home office, turn on my computer, check my emails and begin looking at cases.

8:30 – Finish typing up a case on a nurse. I need to get a letter from the pharmacy detailing the authorized codes for nurses to remove one-time doses of narcotics. I determined that the nurse faked the code and confirmed this with the pharmacy (great evidence of diversion).

8:45 – Contact a narcotics agency to let them know I have additional evidence that supports drug diversion and will send over my report.

8:50 – Receive a phone call from a nurse I am investigating for boundary issues who used a patient's credit card. This conversation lasts a long time as I explain the OHBON's disciplinary process.

9:45 – Receive a phone call from a facility informing me that they suspect a nurse of diverting narcotics. I contact the OHBON by email to open a new case.

10:00 – Back to finishing up the case I started at 8:30.

10:15 – Receive a phone call from a prosecutor with information on an arrest of a nurse who was making methamphetamine at a hotel.

10:30 – Email the OHBON to open a case. I forward an article from the prosecutor's office to my supervisor to alert her, in case there are any calls from the media.

11:30 – Complete the case I started this morning.

Lunch

12:00 – Begin to type up another case where all the information was already gathered and the interview was completed by phone.

12:15 – Receive a call from a detective requesting information on a nurse. We determine that the person is not a nurse but a nurse aide. I email the Ohio Department of Health (which is the licensing agent for nurse aides) for the detective.

12:45 – Receive information I requested from a facility. Copy that information and quickly review it to make sure it is complete. I put the information in the file and move the file to the "ready to be typed up" pile.

1:30 – Receive a call from another detective. He will be late to our 2:15 pm meeting at a facility.

2:00 – Travel to a nearby facility to talk with staff and interview a patient witness prior to a nurse arriving for work at 3:00 pm. I reviewed the records the prior day and had enough to interview the nurse when she showed up to work. Evidence is very good for diversion, but I need an admission. I already have an open case on this nurse from a prior employer, but that evidence is thin.

2:30 – After getting a copy of nurse's application and determining she has falsified her application (a rules violation), I interview the patient witness with the detective and assistant director of nursing.

2:50 – The nurse arrives and is brought to an office for an interview. The nurse voluntarily agrees to talk to us, telling us she has nothing to hide.

3:30 – The nurse admits to drug theft. I turn things over to the detective. He reiterates that because she was cooperative with us that he would allow her to turn herself in. The nurse agrees to make her nursing license inactive and I provide information on the OHBON's Alternative Program for Chemical Dependency.

4:15 – Arrive back at the office, fax the inactive status sheet, and check messages and emails. No return calls needed so I finish documenting my daily itinerary and shut down my computer.

continued from page 2

My main goal is to protect the public. Investigators want to gather evidence that supports that a nurse did or did not make an error. I want to identify system issues that attributed to an error so I can discuss prevention with the facility and avoid a repeat of the issue.

At any given time you can have 50 open cases. How do you prioritize your case load?

The most difficult part of an investigator's job is that we work hard to complete one case and there's always another one to immediately replace it. Our investigators are all carrying more than 50 open cases at a time and some double that. So, just like an emergency department triage nurse, I need to prioritize which cases need my attention first.

Cases are prioritized at the OHBON before coming out to a field agent. We use a rating system of 1-4. Priority 1 cases (I only had 12 of these in 2012) need immediate response and action; these include imposter cases, serious abuse, practice complaints and criminal cases. Investigators are required to complete these cases in five business days. Priority 2 cases are typically criminal, drug and serious practice cases. If I have an impaired nurse, they need to be contacted within 48 hours. Priority 3 cases are our lowest priority cases that can usually be handled with a letter to the licensee, asking them to respond to the complaint. Priority 4 cases do not go out to investigators, unless there is a specific document that needs to be retrieved. These are typically clerical cases regarding lapsed licenses or similar issues.

Before you began investigating criminal and practice complaints for the OHBON, you were an ICU/ER nurse. How did you make the transition from nurse to nurse investigator? Was it a difficult transition to make?

I found my transition from the ICU and emergency department nurse to compliance agent to be very easy. In my experience as a clinical nurse, I worked in surgical, medical, cardiac, neuro-intensive care units, step-down units, a level one trauma center (my longest tenure) and several other Cleveland area emergency departments. I understood how to review documents and why there was a complaint because I had worked in high acuity settings. The hardest part though was learning how to interview a nurse, organize information and evidence, and write a report. To help understand the investigative processes, the OHBON sent me to the Council on Licensure Enforcement and Regulation (CLEAR) training during my first two years (I took basic and specialized courses). This provided a base of understanding on how to complete an administrative investigation.

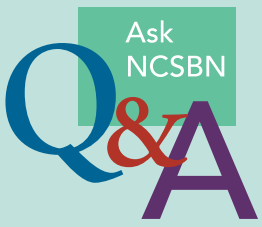
> "The biggest difference I found between investigators from other agencies and law enforcement and myself is that at the core, I am a nurse."
>
> — Dennis Corrigan

Working in the ER and ICU taught me how to quickly adapt and trust my knowledge and experience. When I conduct an investigation, I'm constantly adapting to new and challenging situations. All of our investigators rely on their knowledge and experience to determine a line of questioning or figure out what information or question will provide the answers.

How does being a nurse impact your role as an investigator?

The biggest difference I found between investigators from other agencies and law enforcement and myself is that at the core, I am a nurse. Nurses need to have empathy. It's who we are and what we do. As a nurse investigator, I believe my investigations are different than other disciplines. I don't believe that nurse investigators look at those they investigate as a stat. We don't separate our caring nature when dealing with a nurse who, for example, has developed a drug problem and stolen drugs. I am always seeking cooperation with the nurse. I might suggest they go into drug rehabilitation or seek educational opportunities to improve their practice.

On the other hand, when I see that a nurse intentionally caused harm to a patient or practiced in a way that could be harmful, I take a strong stance. As nurses we have that need to protect our patients and we cannot tolerate nurses who don't. ●



continued from page 1

which is explained in the NCSBN and CCRNR newsletter, the NCLEX® Communiqué. This newsletter provides Canadian students, nurses and nurse regulators with a plethora of information, including timelines showing the progress towards implementation, highlights of transition milestones and clarifies NCLEX terminology. NCSBN will also host the 2013 NCLEX Conference for Canadian Educators April 22, 2013, in Toronto to further prepare nurse educators. ●

Coaching Leads to Many Rewards

Mindy Schaffner, PhD, MSN-CNS, RN
Nurse Education Advisor, Washington State Nursing Care Quality Assurance Commission

Joy Ingwerson, MSN, RN
Interim Executive Director and Nursing Education Consultant, Oregon State Board of Nursing

While the 2012 Summer Olympics predominantly focused on the athlete crossing the finish line or "sticking" the landing, most of those who took home a medal wouldn't have been at the games without their dedicated coaches. At least one coach received this acknowledgement from gymnast Aly Raisman, who placed the gold medal she received around her coach's neck after the medal ceremony. She stated she was only on the podium because of his support, training and guidance. Her coach, Mihai Brestyan, had the chance to share in the reward of the medal as one of the biggest investors in Raisman's success. Many of us may not have the chance to medal, but there is an opportunity to share in the success of others: through coaching.

> The assistance of a coach helps the new team member move along more quickly in their role development and gets them started with a strong support system.

The main purpose of a coach is to aid in the orientation and socialization of a new team member. Coaches should provide guidance on available resources, facilitation of networking with others in the same role and training when necessary. The assistance of a coach helps the new team member move along more quickly in their role development and gets them started with a strong support system.

Navigating various political networks when new to an organization can sometimes lead to confusion and/or conflict. An experienced coach may be able to help their protégé craft approaches to address conflicts and gain confidence in their new role. A coach can help identify (and avoid) potential landmines and provide guidance as to how new team members can connect with appropriate stakeholders.

Coaching Practices at Boards of Nursing (BONs)

BONs are big proponents of coaching. Joy Ingwerson, MSN, RN, interim executive director and nursing education consultant, Oregon State Board of Nursing, coached Mindy Schaffner, PhD, MSN-CNS, RN, nurse education advisor, Washington State Nursing Care Quality Assurance Commission. Early meetings focused on finding helpful resources and comparing laws between the neighboring states. Ingwerson and Schaffner shared petition forms and processes, and through their collaboration, clarified the "chain of command" for students who needed information or assistance. Their relationship promoted more consistency in processes. Schaffner also attended a survey visit to a Portland nursing program, which provided her a complete view of the process used for ongoing program approval in Oregon. Ingwerson and Schaffner are currently planning joint stakeholder meetings between the states that specifically address distant learning issues. The benefits of observing a seasoned nursing education consultant like Ingwerson provided Schaffner with an opportunity to observe and learn the role, techniques, and tools for effective school evaluations.

Transitioning to Coach

As individuals become a bit more seasoned in their roles, they may want to consider serving as a coach themselves. A positive chain of events was started when Janice Hooper, PhD, nursing consultant for education, Texas Board of Nursing, agreed to coach Ingwerson, who then agreed to coach Schaffner. Through the positive experience of being coached by Hooper, Ingwerson was more than willing to continue the guidance by working with Schaffner. Even though the formal relationship between Oregon and Texas has ended, emails with a subject line "Mentor Help Still Needed" do show up every so often in Hooper's inbox.

Lasting Effects

A mentoring connection is not a one-sided relationship. The opportunity to serve as a coach is a positive, rewarding

continued on page 5

continued from page 4

experience. The questions asked and the dialogues that occur stimulate the thought processes. The coach and new team member learn from one another while forging a new friendship. For the coach, it can be rewarding to monitor the successes and accomplishments of those they've helped mentor.

Many nursing education program administrators and faculty bring a variety of skills and interests to their roles. For those who are at the point of feeling solid in their role development, it is time to consider how you can be involved in a mentorship program for new team members. This relationship promotes learning of the role and socialization into this new area of guiding students. The assistance of a supportive coach to review course materials, facilitate introductions in clinical settings, and direct the new faculty members to helpful resources establishes a pathway to success. This is especially important for part-time clinical faculty who often feel they are not connected to the faculty team. A strong mentoring relationship may encourage the part-time faculty member to grow into the perfect candidate for that next full-time faculty opening.

Perhaps it is time you consider coaching someone to the medal podium. ●

Eight Ways to Be a Successful Coach

1. Partner with someone who has mutual professional and personal interests.
2. As the coach, set the meeting schedule at first, but over time, transition the responsibility to your team member.
3. Use internal and external resources to facilitate learning.
4. Communicate. A lot.
5. Always listen. Be prepared to provide guidance, when needed.
6. Be open minded and willing to learn. This is a shared learning experience.
7. Never stop communicating, even after the formal coaching program is completed.
8. Encourage those who were coached to be coaches themselves. It's important to pay it forward.

NCSBN
NATIONAL
SIMULATION
STUDY

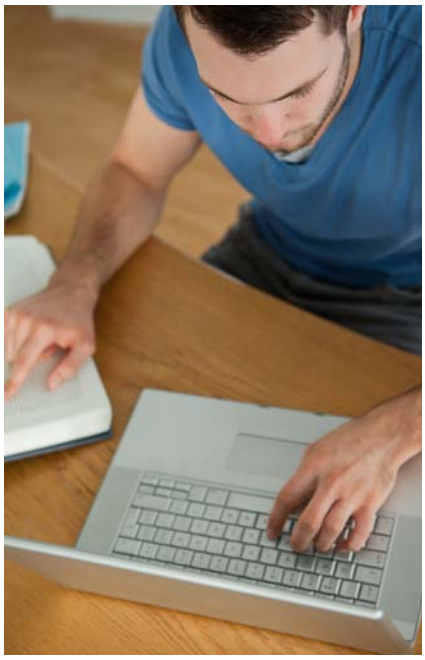
Simulation Study Update

The NCSBN National Simulation Study is in the final semester of data collection. Students participating in the study will be graduating in May 2013; soon thereafter, they will be taking the NCLEX-RN® Examination and then begin work as registered nurses. Study results will be discussed for the first time at the NCSBN Scientific Symposium in the spring of 2014.

Study participants will continue to be followed for one year as they begin their clinical positions. This final phase of the study will evaluate readiness for practice by studying clinical competency and critical thinking of the new graduate nurses. The longitudinal follow-up phase of the study will collect data through Dec. 31, 2014, with results available in spring 2015. ●

A Comparison of Student Perceptions: Online and Face-to-Face Learning

Virginia D. Ayars, EdD, MS, RN
Nursing Consultant for Education, Texas Board of Nursing



Since 2000, online learning has enabled unprecedented access to education for learners unable to attend face-to-face classes (Coose, 2010; O'Neil, Fisher, & Newbold, 2009). The increase in the number of online nursing students, online nursing courses, and online nursing programs of study is expected to continue (Coose, 2010; Institute of Medicine [IOM], 2011; O'Neil et al., 2009). A review of demographic data submitted annually by the Texas Board of Nursing (TXBON) approved prelicensure nursing education programs reveals an increasing use of the online method of delivery, in both nursing courses and nursing programs of study; as 95 percent of the 211 TXBON-approved programs provide online learning experiences to enhance curricula (Texas Center for Nursing Workforce Studies [TCNWS], 2013). At the July 2009 quarterly TXBON meeting, the first solely online nursing program of study with no face-to-face component, Western Governors' University, was approved to establish a baccalaureate degree nursing (BSN) education program in Texas (TCNWS, 2009). In Fall 2012, more than 20 prelicensure nursing programs presented learners the option of enrolling in an online or a face-to-face track in the same program of study (TCNWS, 2013).

> To ensure educational rigor and excellence in online prelicensure nursing education, evidence is required to validate that online nursing education is at least as effective as face-to-face nursing education.
>
> *(Coose, 2010; Gabbert, 2007; McLaren, 2010; Patti, 2010)*

To ensure educational rigor and excellence in online prelicensure nursing education, evidence is required to validate that online nursing education is at least as effective as face-to-face nursing education (Coose, 2010; Gabbert, 2007; McLaren, 2010; Patti, 2010). Although Web technology can establish effective learning communities and support learner-centered strategies for online nursing students, considerations of online nursing program outcomes have been anecdotal rather than based on evidence-based research (Gabbert, 2007; Holly, 2009; Kim, 2009; McLaren, 2010; Patti, 2010). While online learning has been researched extensively, there is little evidence-based research specific to prelicensure nursing education available regarding actual online learning outcomes (Gabbert, 2007; Holly, 2009; McLaren, 2010; Smart & Cappel, 2006).

Purpose and Methodology of Study

The purpose of this study was to compare perceptions of learners' educational experiences in an associate degree nursing (ADN) education program, based on the enrollment track (online vs. face-to-face) in which the learner was registered. The sample included 20 online learners and 59 face-to-face learners enrolled in an ADN program at a large community college in central Texas. The participants either graduated in December 2010 or were candidates for graduation in May 2011. Both online and face-to-face learners in the prelicensure nursing program were expected to participate and successfully complete the required faculty-supervised clinical learning experiences, regardless of the method of delivery of the didactic content.

The two theoretical frameworks underpinning the study were the theory of adult learning principles (Knowles, Holton, & Swanson, 2005) and the theory of human caring (Watson, 2008).

The dependent variables were didactic content, learner-faculty interaction and the learning environment, as measured by three subscales of the Learner Perception Assessment (LPA), a survey designed for this study. Both reliability and validity of the instrument were established prior to data collection. The LPA contained 20 items measured on Likert-type scales with values ranging from 1 (strongly agree) to 5 (strongly disagree). Statements were designed to address adult learning concepts (the environment promoted open communication among learners; current and prior professional experiences were acknowledged and respected; information was provided describing how each course applied to professional nursing practice; and learner objectives were clearly described at the beginning of each course) and human caring concepts (whether faculty members provided positive and constructive feedback; responded to learner needs in a timely manner; encouraged learner feedback through both formative and summative evaluations; and were available to provide extra assistance).

continued on page 7

continued from page 6

Results and Implications for Nursing Education

The research outcomes revealed no significant differences between the online and face-to-face learners for perceptions of didactic content, learner-instructor interaction, and learning environment. Further, almost 90 percent (89.2 percent) of all respondents in both the online and the face-to-face groups indicated they agreed or strongly agreed with the statements supporting the application of the theory of adult learning principles to the prelicensure nursing education program. Similarly, 90 percent of all respondents in both the online and the face-to-face groups indicated they agreed or strongly agreed with the statements related to human caring.

The results are aligned with existing research findings that state perceived differences between online and face-to-face instruction are not significant. However, it should be noted that there are several limitations to this study, including that self-reported data could reflect subjectivity, the results cannot be generalized to other institutions, and the small sample size limits the interpretation of the results.

Registered nurses (RNs) who do not possess BSNs view online programs of study as not only cost-effective options for BSN completion, but also convenient, practical alternatives to traditional, face-to-face environments (Smith, Passmore, & Faught, 2009). Online programs more often meet the needs of both the employer and employee, thus hospital administrators typically promote the online option for RN staff to complete their BSN (Morgenthaler, 2009). Hospital administrators may offer tuition assistance and allow time for pursuing an education to RNs who contractually agree to remain at the facility following graduation (Morgenthaler, 2009). Employer support of educational activities is of particular concern to RNs because nurses usually work assigned shifts, do not have the flexibility to attend a face-to-face class, and often juggle on-call schedules in addition to regular shift hours (Morgenthaler, 2009).

Conclusion

An analysis by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services projected a record shortage of more than 1 million nurses in the U.S. by 2020 (HRSA, 2010; IOM, 2011). In addition, the TCNWS (2009) estimated that Texas will have 71,000 fewer nurses than needed in 2020. As a result, it is an appropriate time for administrators and faculty members in prelicensure nursing programs to perform critical evaluations of nursing educational models to determine how to produce increased numbers of graduates who will become safe and competent practitioners.

Findings from the study are valuable in addressing the need for educating more nurses through online education. By offering evidence that online prelicensure nursing education is comparable in quality to face-to-face programs, findings from this study confirm that the risk of online learning is low, whereas the benefits are high. The research outcomes may be used to initiate a dialogue among nurse educators about the value of online prelicensure nursing education programs.

Online tracks in prelicensure nursing education programs, including total program evaluation at pertinent data points, could increase the output of qualified graduates, while minimizing the investment in facilities and faculty. Ultimately, the findings could lead to an increase in the nursing workforce.

Adapted from Ayars' EdD dissertation: Ayars, V. D. (2011). A comparison of perceptions of online and face-to-face learners in the same associate degree nursing program. (Doctoral dissertation). Available from ProQuest Dissertations and Theses database (UMI No. 3486053).

REFERENCES

Coose, C. S. (2010). Distance nursing education in Alaska: A longitudinal study. *Nursing Education Perspectives, 31*(2), 93-96.

Gabbert, W. L. (2007). *Beyond online: Enhancing caring and professional practice in nursing education.* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database (UMI No. 3278088).

Holly, C. (2009). The case for distance education in nursing. *MERLOT Journal of Online Learning and Teaching, 5*(3), 506-510.

Institute of Medicine. (2011). *The future of nursing: leading change, advancing health.* Washington, DC: The National Academies Press.

Kim, K-J. (2009). Motivational challenges of adult learners in self-directed e-learning. *Journal of Interactive Learning Research, 20*(3), 317-335.

Knowles, M. S., Holton, E. F., & Swanson, R. A. (2005). *The adult learner.* New York, NY: Elsevier.

McLaren, A. C. (2010). *The effects of instructor-learner interactions on learner satisfaction in online masters courses.* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database (UMI No. 3398368).

Morgenthaler, M. (2009). Too old for school? Barriers nurses can overcome when returning to school. *AORN Journal, 89*(2), 335-345.

O'Neil, C. A., Fisher, C. A., & Newbold, S. K. (2009). *Developing online learning environments in nursing education* (2nd ed.). New York, NY: Springer.

Patti, P. A. (2010). *The invisible classroom: Learning style and learner satisfaction in a virtual, audioconferenced technical training environment.* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database (UMI No. 3398693).

Smart, K. L. & Cappel, J. J. (2006). Students' perceptions of online learning: A comparative study. *Journal of Information Technology Education, 5,* 201-219.

Smith, G., Passmore, D. & Faught, T. (2009). The challenges of online nursing education. *Internet and Higher Education, 12,* 96-103.

Texas Center for Nursing Workforce Studies. (2009). *Professional nursing education in Texas: Demographics & trends.* Austin, TX: Author.

Texas Center for Nursing Workforce Studies. (2013). *Demographics and trends: Texas 2011.* Austin, TX: Author.

U.S. Department of Health and Human Services, Health Resources and Services Administration (2010). *The registered nurse population: Initial findings from the 2008 national sample survey of registered nurses.* Retrieved from http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyinitial2008.pdf

Watson, J. (2008). *Nursing: The philosophy and science of caring, revised edition.* Boulder, CO: University Press of Colorado.

NCSBN Examines the Future of Distance Learning

NCSBN's Distance Learning Education Committee is going full thrust! The committee is charged with identifying regulatory issues related to distance learning education programs; and developing model rules for distance learning programs. To comprehensively study the issues and propose future recommendations, the committee carried out the following activities:

- Reviewed the literature on distance education in nursing;
- Surveyed the BONs for factual information on their requirements of distance learning programs and to learn about regulatory issues;
- Identified the regulatory issues that educators perceive as barriers to nursing distance learning programs;
- Held two conference calls with NCSBN's membership to follow up on the distance learning survey and further discuss regulatory issues; to clarify misinformation that is perceived by educators as regulatory barriers; and to discuss ways BONs can collaborate with educators on distance education programs;
- Learned about the U.S. Department of Education's requirements for distance education programs and heard about the national database on distance learning that is available to the public; and
- Explored the complexity of regulatory issues from many different agencies that distance education programs face.

The committee outlined the regulatory issues that were identified during their data collection and have proposed regulatory standards and definitions related to distance learning programs. The committee also proposed a one-page checklist that programs could complete when sending clinical students into distant states. This checklist would inform the programs of specific state distance learning requirements for clinical students and would also inform BONs which programs are sending clinical students into their states.

The committee's work was presented at NCSBN's Midyear Meeting and is currently awaiting feedback from the NCSBN Member Boards. The final report, with recommendations, will be provided to the NCSBN Board of Directors (BOD) at their May 2013 board meeting. If adopted by the BOD, the report will be presented to the NCSBN Delegate Assembly at the 2013 Annual Meeting in August, and if approved, will be available to the public in the fall.

NCSBN is on Facebook and Twitter

"Like" NCSBN on **Facebook** to receive the latest organizational news, product announcements and service updates instantly. All the news you need about nursing regulation is available in one convenient location.

Follow the NCLEX® examinations on **Facebook** and **Twitter** to get access to all the examination information you need.

With NCLEX review courses and 40 online continuing education classes, Learning Extension helps busy nursing students, nurses, and nurse educators meet their educational goals. Join this growing online community on **Facebook** and **Twitter.**

Effective April 1: New NCLEX-RN® Test Plan

NCSBN reviews the NCLEX-RN® Test Plan every three years to make sure it accurately reflects the current knowledge, skills and abilities needed by registered nurses to practice. The 2013 NCLEX-RN® Test Plan went into effect April 1, 2013, and is now available.

In addition to the NCLEX-RN Test Plan, NCSBN also published the 2013 *NCLEX-RN® Detailed Test Plan*, which offers a thorough and comprehensive listing of content for each client needs category and subcategory as outlined in the test plan. There are two versions of the detailed test plan available: a candidate version and an item writer/item reviewer/nurse educator version. They are identical in content, except the item writer/item reviewer/nurse educator version offers an item writing guide and a section with case scenarios to provide nurse educators with additional item examples.

Changes and Clarifications Made

A number of changes/clarifications were made between the 2010 test plan the 2013 version. The definition of client as the individual, family or group, which includes significant others and population, was added. The 2013 test plan also further clarifies the NCLEX® setting to help the public better understand the NCLEX exam process and potential exam questions.

In addition, the results from the *2011 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* suggest that the Management of Care and Safety and Infection Control client needs categories of the test plan require an increase in test plan percentages. In general, current newly licensed nursing practice suggests activities in these two areas have increased in significance of frequency and criticality based on maintenance of client safety and decrease in the occurrence of complications.

Changes to Client Needs Categories

The first client needs category, Management of Care, which focuses on providing and directing nursing care that enhances the care delivery setting to protect clients and health care personnel, increased in emphasis by 1 percent. In this general category, Consultation was subsumed under all content for Management of Care for the purpose of adding clarity. Also, Delegation and Supervision were separate bullet points in 2010, but were combined into Assignment, Delegation and Supervision in 2013.

The second category, Safety and Infection Control, focuses on protecting clients and health care personnel from health and environmental hazards. In this category there was also an increase by 1 percent. Error prevention was removed as a bullet and combined with accident and injury prevention. This was to reduce redundancy.

The third category, Health Promotion and Maintenance, focuses on providing and directing nursing care of the client that incorporates the knowledge of expected growth and development principles; prevention and/or early detection of health problems; and strategies to achieve optimal health. Health and Wellness was subsumed under health promotion and maintenance content. Principles of Teaching/Learning was removed as a bullet because it is an integrated process found throughout the entire test plan.

The fourth category, Psychosocial Integrity, focuses on providing and directing nursing care that promotes and supports the emotional, mental and social well-being of the client experiencing stressful events, as well as clients with acute or chronic mental illness. Substance Use Disorder was added to Chemical and Other Dependencies for clarification. Cultural Diversity was replaced by Cultural Awareness/Cultural Influences on Health, also for clarification.

No changes were made to the Basic Care and Comfort, Pharmacological and Parenteral Therapies, Reduction of Risk Potential, and Physiological Adaptation categories.

NCLEX®
EXAMINATIONS

NCSBN e-Notify: Providing Licensure and Discipline Notification for Employers

Deans and directors of nursing education programs can simplify the process of verifying that their faculty's nursing licenses are current with NCSBN's new e-Notify® system. e-Notify is an innovative nurse licensure notification system that automatically provides employers with licensure and publicly available discipline data as it is entered into Nursys® by boards of nursing (BONs). Organizations will no longer have to proactively seek licensure or discipline information of nurses in their employ; that information will automatically be sent to them.

Where does data come from?

e-Notify provides real-time automatic notification of status and discipline changes delivered directly to organizations. The information in e-Notify is pulled directly from Nursys, the only national database for licensure verification, discipline and practice privileges for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs). Nursys data is compiled from information directly inputted from BONs (in participating jurisdictions).

What type of alerts will employers receive?

The e-Notify system alerts subscribers when changes are made to a nurse's record, including:

- License status;
- License expiration;
- License renewal; and
- Public disciplinary action/resolutions.

This means that if a nurse's license is about to expire, the system will send a notification to the employer about the upcoming expiration date. Employers can receive email notifications daily, weekly or monthly. For licensure renewal notifications, organizations can choose to receive alerts 30, 60 or 90 days prior to a nurse's license expiring. If a new disciplinary action is issued by a BON, the employer will receive a notification, in addition to access to available public discipline documents.

How much does it cost?

The first 100 nurses enrolled into the system are free. After that, each nurse is $1 per nurse, per year. An organization that employs 25 nurses would pay nothing to utilize e-Notify; an organization with 150 nurses would only pay $50 per year. For most nursing programs, the cost for being notified of expiring nurse educator licenses would be free or negligible.

How do employers add nurses into the system?

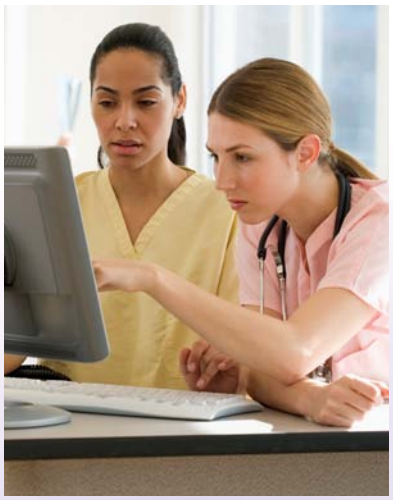
Nurses can be entered into e-Notify individually or through bulk upload; all that is needed is the nurse's license number, license type and the state that issued the license. This information is used to locate the nurse directly from the Nursys database.

A nurse's email address and/or mobile phone number can also be added so that employers can send automatic email reminders or text messages to the nurse to remind him or her about their upcoming licensure renewal.

Sounds easy right?

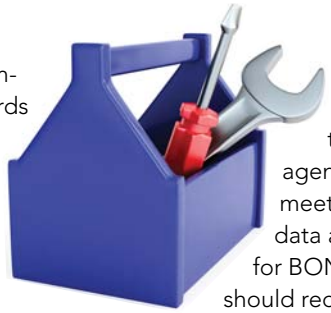
That's because it is! With e-Notify, nursing programs can utilize this system to track licensure and discipline information of their faculty for little or no charge. e-Notify is an innovative tool that provides vital information to employers, saving them money and staff time.

For most nursing programs, the cost for being notified of expiring nurse educator licenses would be free or negligible.



The Future of Approval Toolkit Has Arrived

For the last two years, NCSBN's Nursing Education Committee has been studying the approval process in boards of nursing (BONs). From its research came the development of the Future of Approval Toolkit, a great resource for BONs and educators to better understand BON approval and accreditation processes.



> This could be used for convincing legislators or other policy makers that BONs need to stay in the business of program approval.

The toolkit includes an interactive map that shows current BON approval models; when BONs' processes change, the map will be updated. The models are based on the seven different approval models that BONs are currently using. There is also a one-page document that summarizes the differences between approval and accreditation. This could be used for convincing legislators or other policy makers that BONs need to stay in the business of program approval. Additional resources in the toolkit include guidelines for making joint visits with the national nursing accreditors and BONs, the article "A Collaborative Model for Approval of Prelicensure Nursing Programs" (Spector & Woods, 2013), PowerPoint presentations, webinars and the monograph from the NCSBN World Café™ Education Meeting.

The toolkit was developed by the Nursing Education Committee to learn about the current context of approval. This included searching the literature, holding conference calls with stakeholders, inviting representatives from the national nursing accrediting agencies to a meeting and hosting a World Café meeting. The committee then synthesized these data and made some futuristic recommendations for BONs, including recommending that BONs should require national nursing accreditation of their nursing programs by 2020. This is in accordance with the widely disseminated "The Future of Nursing: Leading Change, Advancing Health" recommendation (Committee, 2011) that 80 percent of the nursing workforce be bachelor of science in nursing educated by 2020. The NCSBN Model Education Rules detail all of the committee recommendations for approval of nursing education programs. Spector & Woods (2013) provide rationale for these recommendations.

Feedback and questions regarding the toolkit can be sent to Nancy Spector, PhD, RN, director, Nursing Regulation, NCSBN.

REFERENCES:

Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health.* Washington, DC: National Academies Press.

Spector, N. & Woods, S. (2013). A collaborative model for approval of prelicensure nursing programs. *Journal of Nursing Regulation, 3*(4), 47-52.

NCSBN Long-term Care Conference

On April 16-17, 2013, NCSBN will host the Long-term Care Conference in San Diego, Calif. The meeting will create a common understanding among nurse educators, regulators, researchers and nursing staff on key issues in long-term care nursing. This will occur through discussions on culture change, transition to practice models, developing environments that promote safe care, and examining the integration of quality of care and quality of life. Karen Schoeneman, MPA, former deputy director of the Division of Nursing Homes at the Centers for Medicare & Medicaid Services, will be the keynote speaker with her presentation, "Spring Cleaning: The Rules in our Heads."

This conference will bring together leaders from practice, research, nursing regulation and education to explore pertinent issues in long-term care. Conference attendees will participate in several small-group discussions addressing culture change, creative solutions for staff development, transition to practice programs and safe systems. These ideas will be captured on iPads and will be used to develop a monograph that will provide decision-making guidance and help cultivate a culture of patient safety.

There is still time to attend. Register today.

Transition to Practice Update

Phase II Is Underway

Phase II of the Transition to Practice™ (TTP) Study includes 42 long-term care, ambulatory, home health and public health sites in Illinois, North Carolina and Ohio. These sites enrolled 44 new graduate nurses (including both registered nurses [RNs] and licensed practical/vocational nurses [LPN/VNs]) and 68 preceptors. Similar to Phase I, new graduate nurses in intervention sites will be assigned to trained preceptors and will be required to complete five online modules developed by NCSBN. Control sites will use their normal on-boarding strategy for new graduate nurses. While Phase I's primary objective is to investigate the effects of a standardized transition program on patient outcomes, Phase II is focused on determining the feasibility of implementing a standardized program in nonhospital sites. Phase II started in April 1, 2012, and will continue until Oct. 31, 2013.

Phase I Is Now Completed

Phase I of the TTP study wrapped up March 31, 2013. The 110 participating hospitals in Illinois, North Carolina and Ohio enrolled more than 1,300 new graduate RNs and 2,500 preceptors. Several new nurses, preceptors and site coordinators from intervention hospitals participated in optional focus groups to gather detailed qualitative data on implementing the model or completing the preceptorship and TTP modules. New graduate nurses and preceptors at intervention and control sites were also invited to complete individual surveys at different points throughout the study to discuss their experiences as new graduates or preceptors. The results of the study will include analysis of participant surveys, hospital-wide outcomes surveys and the focus groups. The site coordinators, state coordinators and TTP Research Advisory Panel put forth tremendous effort to implement and run Phase I of this large-scale study, and continue to do so for Phase II.

As a benefit of their participation, Phase I control sites now have access to the TTP online modules, and are encouraged to implement a preceptorship model alongside the modules. A resource manual was developed for the intervention sites to assist them with the transition away from the TTP online modules. The manual provides a detailed outline of the five new graduate and preceptor training modules, and is intended to be used with a structured preceptorship.

Leader to Leader is published biannually by
National Council of State Boards of Nursing (NCSBN)
111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277

Phone: 312.525.3600
Fax: 312.279.1032
Website: www.ncsbn.org

Editor: Nancy Spector, PhD, RN, director, Regulatory Innovations, NCSBN
nspector@ncsbn.org

NCSBN provides education, service and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection.

NCSBN
National Council of State Boards of Nursing