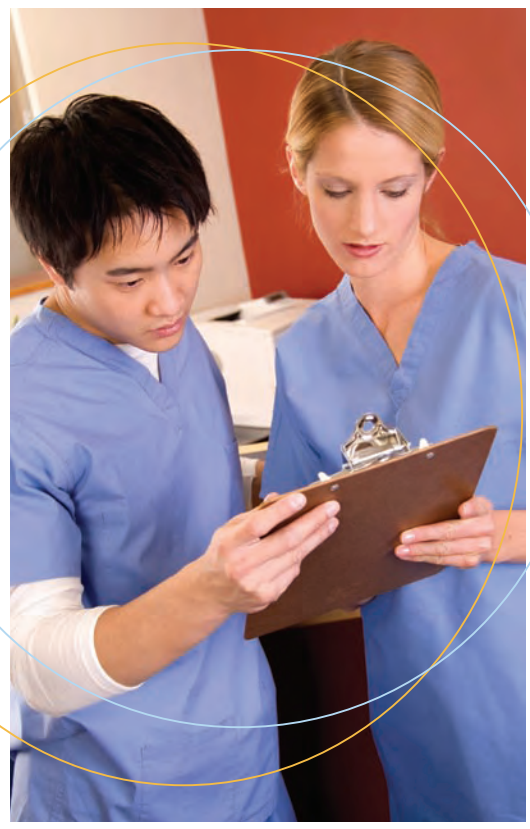
Leader to Leader

Nursing Regulation & Education Together

Fall 2008

Implementing Quality and Safety at the Unit Level in an Innovative Clinical Education Model

Kathleen Williams Kafel, MS, RN
Senior Lecturer and Course Coordinator of Adult Health
University of Massachusetts Boston, College of Nursing and Health Sciences



The Dedicated Education Unit (DEU) is an innovative model of clinical nursing education where nursing practice informs nursing education and nursing education influences nursing practice. This article further describes how the education and practice gap was addressed by integrating the quality and safety competencies into new teaching and learning experiences at the unit level.

The formation of the clinical education model of the DEU served to meet many of the Quality and Safety Education for Nurses (QSEN) competencies and operated as a framework for the utilization of the competencies and the vehicle to effect change in the clinical setting.

The partnership between University of Massachusetts Boston College of Nursing and Health Sciences, Massachusetts General Hospital, and Brigham and Women's Hospital is one that is mutually beneficial. This partnership seeks to bridge the gap between education and practice, to address the faculty shortage and to implement the QSEN competencies from an academic/practice perspective. Eighteen students in their junior year beginning their first adult health acute care clinical course were selected to participate in this pilot DEU program during spring semester 2008.

This partnership served to implement the Institute of Medicine's 2003 call for change in the learning experiences of graduates.[1] The students involved in this pilot program were educated to deliver patient-centered care, to collaborate as a team in evidence-based practice and quality improvement initiatives, and utilize informatics. In addition, the students implemented the QSEN competencies in collaboration with nurse educators and nurse managers to effect the beginnings of change in the clinical setting. The knowledge, skills and attitudes (KSAs) of each competency were addressed in the projects chosen and served as effective teaching strategies. The students led the way in identifying areas where change or reinforcement of criteria were needed in their clinical units.

Teamwork and Collaboration

The competency of teamwork and collaboration was present throughout the formation of the DEU, as well as during the institution and completion of the students' project. Knowledge of the strengths, limitations and scope of practice of each of the team members was described. Roles were clarified and each member's contribution was sought out, communicated, valued and respected, thus operationalizing the skills and attitudes needed to successfully function and collaborate as a team.

continued on page 2

INSIDE . . .

Ask NCSBN Q&A

Q. How does NCSBN assure cultural sensitivity in NCLEX® examinations?

A. NCLEX® is a high-stakes examination that assesses the knowledge, skills and abilities of entry-level nurses in order to protect the public from unsafe practitioners. An examination of this caliber must not only identify current nursing practice, but also undergo a development process that ensures fairness to all candidates. The NCLEX examination development process assures that essential content is presented in a fair and sensitive manner without bias.

Recognizing that the nursing student population becomes more culturally diverse every year, NCSBN has historically reviewed NCLEX examinations and items for cultural sensitivity. Each item on the examination is reviewed for both fairness and sensitivity. The purpose of a fairness review is to identify and remove any construct-irrelevant factors that might interfere with an examinee's ability to respond appropriately to an item.

All examination items undergo a thorough review process where items are looked at critically to assure that they do not unnecessarily increase the candidate reading load. Following the review process, items are determined to be written correctly (appropriate for current entry-level practice) and free from grammatical errors before being pretested. All pretest items are reviewed for sensitivity, which is designed to eliminate item wording and content that could be considered elitist or stereotypical, have different meanings for different ethnic, gender or geographic groups, or have inappropriate tone. A panel is convened to perform a sensitivity review of pretest items. The panel itself must have at least three members from ethnic focal groups of NCLEX examinees, including African American, Asian Indian, Asian other than Indian, Hispanic, Native American, and/or Pacific Islander. Composition of the panel must also include at least one male and one panelist representing Americans with disabilities or English as a second language (ESL) students. Panel members are not required to have a background in nursing since their focus is not related to the content of the items.

continued on page 3

Implementing Quality and Safety… *continued from front page*

Patient-Centered Care

The role of the nurse in not only relieving, but also in preventing all sources of pain was recognized, and the respect and sensitivity for both physical and emotional comfort was communicated. The students attained a higher level of knowledge and skill as well as a more proactive attitude in providing patient-centered care.

Evidence-Based Practice

The students were brought as a group to one of the hospital's libraries where, with the assistance of a nurse librarian, they conducted a search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Articles were chosen by members of the literature review team; annotated bibliographies were written and shared with all members of the student team. Knowledge of the scientific process, the skills of seeking evidence and consulting experts and, perhaps most importantly, the significance of professional research was recognized and its role in effecting change was realized.

Quality Improvement

As they looked at existing policies for practice that affect outcomes, students became knowledgeable regarding systems of care. They sought out information on current quality improvement projects and an appreciation of individual and team contributions in the enhancement of care was ignited.

Informatics

Very early in the process, students involved in these projects understood the importance of information technology, the various degrees of quality sources of health care information and the necessity for health professionals to seek out continuous learning of information technology.

Safety

The safety of commonly utilized practices was examined, strategies for reduction of harm were demonstrated and the policies of system vigilance were valued.

The students did a literature review, a poster presentation, developed informational pamphlets and began in one of the institutions to develop a tool based on the literature reviewed specific to their unit's patient population. The presentation at both institutions was well attended by staff, fellow students, nursing educators and nursing administrators. The students experienced a great deal of pride and a sense of both personal and professional accomplishment.

With the expansion to 20 students on the DEUs during fall semester 2008, continual work will be done on the projects initiated by the pioneer group.

The DEU model of clinical education served to alter the clinical learning experience, allowing these students to fully grasp and integrate the KSAs of the Quality and Safety competencies into their early days of practice that will ultimately shape their professional identity.

I would like to recognize the members of the QSEN faculty and advisory board for selecting U Mass Boston to participate in the QSEN initiative, the Robert Wood Johnson Foundation for supporting this work in quality and safety education, and the nurse leaders at U Mass Boston, Mass. General Hospital, and Brigham and Women's Hospital. I most sincerely thank the dedicated nurses on 14 AB at Brigham and Women's Hospital and Ellison 7 at Mass. General Hospital, who continue to educate and nourish our future generations of professional nurses.

REFERENCE

1. Institute of Medicine. (2003). *Health professions education: A bridge to quality.* Washington, D.C.: The National Academies Press.

Model for APRN Regulation

The NCSBN Board of Directors endorsed the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education paper at their September 2008 meeting. The NCSBN Delegate Assembly adopted revised Advanced Practice Registered Nurse (APRN) Model Act and Rules to parallel this model in August 2008.

As health care has evolved over the last few decades, APRNs have become a vital and integral part of patient care and management; however, because of a lack of uniformity across the nation, APRNs cannot easily move from state to state to practice. Each state independently determines the APRN legal scope of practice; the roles that are recognized; the criteria for entry into advanced practice; and the certification examinations accepted for entry-level competence assessment. Additionally, educational programs, certification agencies and accreditation agencies each face considerable differences within their own disciplines. This leads to practice barriers and decreased access to care for patients.

The result of a multiyear collaboration between NCSBN and the APRN Consensus Process Work Group, the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education document presents an APRN regulatory model created by APRN educators, accreditors, certifiers and licensure bodies, which establishes a set of standards that protect the public, improves mobility and expands access to safe, quality APRN care.

The paper defines APRN practice, describes the APRN regulatory model and presents strategies for implementation. The model recommends independent APRN practice; licensure at the role (certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners) and population foci level (family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health); and allows for the emergence of new APRN roles and population foci.

The complete text of the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education is posted at www.ncsbn.org/7_23_08_Consensue_APRN_Final.pdf. The APRN legislative language which parallels the Consensus Model can be found at www.ncsbn.org/APRN_leg_language_approved_8_08.pdf.

NCLEX® Regional – On the Road Again

Lorraine Kenny, MS, RN
Content Manager, NCLEX® Examinations

NCSBN is committed to sharing information about the NCLEX® examinations with nursing educators and candidates. As part of its strategic initiative, the NCLEX® Examinations department seeks to provide this information to nursing educators while developing programs to facilitate preparation of students for successfully passing the NCLEX examination. One way that this is accomplished is through the NCLEX® Regional Workshop for Educators.

The NCLEX® Regional Workshop is a full-day conference designed specifically for nurse educators, which is held in conjunction with a board of nursing. There is an extensive agenda, with topics such as preparing nursing students to take the NCLEX, identifying the practice analysis process, applying the results to keep the examination current, interpreting the steps of the item development process and reviewing alternate item formats. Also presented is an overview of the basic principles of computer adaptive testing (CAT) and standard setting in addition to understanding how to interpret candidate performance records.

Highlights of the program include a hands-on item writing demonstration to show the audience how to apply principles of item writing in the NCLEX style to their writing goals. There is also a discussion on the use of *NCLEX® Program Reports* to determine a school's strengths and weaknesses along with a description of the Candidate Performance Reports to help faculty work with students who have failed the exam.

On Oct. 17, 2008, the Kansas State Board of Nursing sponsored the most recent NCLEX® Regional Workshop in Wichita, Kansas. There were more than 100 attendees representing various nursing programs across Kansas and the surrounding region.

Nursing programs interested in organizing an NCLEX® Regional Workshop should contact their local state board of nursing. NCSBN, as requested by a member board, will provide speakers free of charge. The NCLEX® Regional Workshop can be hosted in any of the three areas not hosting the NCLEX® Invitational that same year, based on staff availability.

To request an application to host a workshop, please e-mail Jen Gallagher at jgallagher@ncsbn.org.

North Dakota Board of Nursing Nurse Faculty Intern Pilot Study

Linda Shanta, PhD, RN
Constance B. Kalanek, PhD, RN, FRE
Patricia Moulton, PhD

Background

Although national health care news highlights the nursing shortage, there is another looming shortage that will compound the problem many times over: the nationwide shortage of nursing faculty (Arias, 2006, NLN, 2006). North Dakota, like most states, has been experiencing the shortage and misdistribution of nurses. Moreover, in the last few years nursing education programs in North Dakota have begun to struggle to recruit and retain qualified faculty. In the last five years, the state of North Dakota has increased its efforts to satisfy the need for nurses through a "grow-your-own" process by expanding nursing education programs in community colleges and distance sites in rural communities. However the shortage of qualified faculty threatens to derail the process. The trend of utilization of faculty with less than a master's degree continues. For example, this past year 26 percent of all faculty in BSN programs (including Nurse Faculty Intern [NFI] participants) held less than a master's degree in nursing.

Problem Statement

Qualified applicants are being turned away from nursing education programs by the thousands, in part because of a shortage of qualified educators to teach them (AACN, 2003). The shortage of nurses cannot be addressed unless there are qualified educators to guide future nurse professionals (AACN, 2003). Economics plays a large part in the problem. As nurses choose to advance their education, many choose to follow an educational path that leads to becoming a nurse practitioner or nurse anesthetist because of the salary benefit compared to that of a nurse educator (AACN, 2005; AACN, 2003). Furthermore, in many instances staff nurses have higher salaries than nurse educators. Consequently, there is increased dependence on clinical instructors and part-time faculty to cover the shortage (Riner & Billings, 1999).

Nurses often do not become faculty through deliberate intention; rather they enter the role because of circumstance (James, 2004). Nurse faculty members are usually skilled members of the profession that emerge from practice (AACN, 2003; James, 2004). While they may be expert baccalaureate level practitioners, they are often not prepared for the faculty roles (Sweitzer, 2003). Many teach as they were taught or learn to teach through trial and error (James, 2004). In the same light, possession of exceptional clinical skills does not guarantee an excellent teacher. Unlike traditional preparation for nursing practice, which requires clinical education, the role of nurse teacher often has no systematic preparation (Sweitzer, 2003).

Purpose

The purpose of the NFI Pilot Study was to investigate the role development of nurse educators and expand the general knowledge about the mechanism in which nursing graduate students gain competencies related to teaching and learning through practical experience while working closely with seasoned mentors in their employing nursing education programs.

Conceptual Framework

The conceptual framework which emerged from the literature identifies key components, which naturally fall into three distinct themes that interact in the role development of the NFI. The NFI is the central component of the conceptual framework, representing an individual who is interested in entering the academic arena as a nurse faculty member. However, at the time of entry, the individual has not completed the process to receive appropriate credentials for education, specifically a graduate degree in nursing. In addition, although the NFI might be a skilled clinician, the preparation for clinical practice often does not prepare one to be an educator (Sweitzer, 2003). As such, when an individual enters academe without preparation, it is as a novice educator. This novice educator is influenced by the formal academic preparation. For the purposes of this study, the theme of formal academic preparation was represented by an academic consultant. Conceptually, the academic consultant was positioned to provide theoretical insight to the NFI related to pedagogy. This individual held an earned doctorate and ideally was employed by the graduate program in which the NFI was enrolled. The third component of the study was a mentor who was assigned to the NFI by the employing institution. Conceptually, this individual provided close collegial support and coaching, as well as providing supervision for the pedagogical activities.

Study Design and Implementation

This study is funded by the North Dakota Board of Nursing and NCSBN. The study design was constructed in collaboration between the North Dakota Board of Nursing, the North Dakota College and

continued on page 6

Ask NCSBN Q&A

continued from page 1

Each panel includes a currently licensed registered nurse to assist in explaining specific content or eliminate descriptions that may otherwise appear to panelists as potential sensitivity issues. Sensitivity panels are held four times per year.

Sensitivity panel sessions begin with training on the NCLEX sensitivity guidelines, along with clear examples of materials that violate these guidelines. Sensitivity issues are presented as concrete illustrative examples, not abstract possibilities. The items are presented in batches and each batch is reviewed by a trained sensitivity reviewer for inappropriate terminology, stereotypes, underlying assumptions, ethnocentrism and elitism, tone of language, or inflammatory materials. Once individual reviewers identify sensitivity issues, a generative discussion is held among all reviewers and staff to identify the sensitivity issue. Any item that is identified for sensitivity issues does not continue on to operational status but is forwarded to the NCLEX® Examination Committee (NEC) for review and action.

In addition to the aforementioned sensitivity review of pretest items, each pretest and operational pool of items is examined for potential differential item functioning (DIF). DIF is a statistical analysis that is conducted for items following a prescribed number of exposures to determine if items contain bias. Briefly, this analysis identifies if an item is statistically testing easier or harder for a particular group based on a predetermined control group, provided that the abilities between the two groups are comparable. For the sensitivity panels, panelists represent the same ethnic groups and gender; however, for DIF review, the items are first reviewed by the group as a whole, not individually.

Items (with keys and distracters) are shown with the relevant reference and/or focal groups that showed DIF. Additional information, such as frequent options chosen by reference and focal groups, along with rationale statements, are also provided. This information helps panelists understand how the items might be functioning differently for different groups. Any items that may be problematic are also referred to the NEC for a final decision as to whether or not to retain the item.

The NCLEX examination is based on current entry-level practice as determined by scheduled practice analysis research. In addition, the NCLEX is continually monitored through established processes to determine that the items reflect both fairness and cultural sensitivity, allowing all candidates to demonstrate their competence. For more information, please visit the research and technical briefs associated with the NCLEX examination at www.ncsbn.org/1232.htm.

NCSBN's Faculty Qualifications Recommendations

Background

Boards of nursing reported that some nursing programs were struggling to maintain their faculty standards because of the current faculty shortage. Programs were having problems attracting qualified faculty and in some states, lawmakers were calling for a lowering of faculty standards so that more nursing students could graduate. Boards of nursing asked, was lowering standards the answer? The Institute of Medicine (Greiner and Knebel, 2003) has called for an "overhaul" of health care education, stating that health professionals aren't adequately prepared to address the ever-changing demands of health care. Similarly, the Carnegie study of nursing education has found that nursing education classroom teaching suffers from a lack of adequate teaching in the areas of natural sciences, social sciences and humanities (Dr. Patricia Benner, personal communication, April, 2008). In this complex health care environment where medical errors are a major concern (Kohn, Corrigan and Donaldson, 1999), neither the boards of nursing, whose mission is public protection, nor educators thought the answer was to lower standards. Therefore, the NCSBN Board of Directors charged the 2007–08 Faculty Qualifications Committee with reviewing and presenting recommendations for future faculty qualifications and roles.

Data Collection

The Faculty Qualifications Committee members comprehensively reviewed the literature and other evidence before making their recommendations. The following include some of the data they reviewed:

- Input from a collaborative conference call with representatives from the American Association of Colleges of Nursing (AACN), the Commission on Collegiate Nursing Education (CCNE), the National Association for Practical Nurse Education and Service (NAPNES), the National League for Nursing (NLN), and the National League for Nursing Accrediting Commission (NLN-AC).
- More than 35 evidence-based articles and/or consensus statements by experts in nursing education.
- Input from the speakers and participants of the "Faculty Shortage: Implications for Regulation" conference hosted by the committee members on March 26, 2008.
- Reports developed by 2006–07 Practice, Regulation and Education (PR&E) Committee members, including the "Faculty Shortage Survey" and the "Comparison of Faculty Qualifications in National Documents" reports.
- Minutes from NCSBN's Education Consultant Network calls.
- Relevant surveys from the Education Consultant Network.

Recommendations to the Boards of Nursing

The following recommendations were adopted by the boards of nursing at the NCSBN Annual Meeting in August 2008 and NCSBN's model education rules have been revised accordingly (available on www.ncsbn.org). NCSBN's model rules are guidelines for the boards of nursing when they promulgate their own rules and regulations.

1) Nursing faculty in RN programs (full time and part time) shall have either a master's degree or a doctoral degree in nursing. Their education should include graduate preparation in the science of nursing, including clinical practice, and graduate preparation in teaching and learning, including curriculum development and implementation.
2) Nursing faculty in PN programs (full time and part time) shall have either a master's degree or doctoral degree in nursing. Their education should include graduate preparation in the science of nursing, including clinical practice, and graduate preparation in teaching and learning, including curriculum development and implementation.
3) Clinical preceptors shall be educated at or above the level for which the student is preparing.

The following recommendations were made to the boards of nursing, though these are not part of the NCSBN model education rules:

1) For RN programs, other supportive faculty with graduate degrees in related fields may participate on a nursing faculty team to enrich and augment nursing education. Similarly, for PN programs, other faculty, such as BSN prepared, may participate on a nursing faculty team to enrich and augment nursing education.
2) When boards of nursing evaluate the preparation of nursing faculty members, it is essential to consider the three roles of faculty: collaborator, director of learning and role modeling. See the NCSBN Faculty Qualifications Report for more details of these roles (NCSBN, 2008).
3) When boards of nursing evaluate the preparation of nursing faculty members, they should assess processes of faculty orientation. All part-time faculty members, adjunct faculty members, preceptors, novice faculty members and others should be oriented to the nursing program's curriculum and engaged in formal mentorships and faculty development.
4) Boards of nursing are encouraged to collaborate with educators to foster innovation in nursing education.

The Innovations in Education Regulation Committee is seeking your input on real or perceived regulatory barriers …

NCSBN's Faculty Qualifications report (NCSBN, 2008) presents a comprehensive discussion of the evidence that supports the recommendations that were made to the boards of nursing. Because of the last recommendation addressing innovation in nursing education, NCSBN's Board of Directors charged a new committee, the Innovations in Education Regulation Committee, with the following:

- Identify real and perceived regulatory barriers for educators; and
- Develop a regulatory model for innovative education proposals.

In 2008–09, the Innovations in Education Regulation Committee will hold a collaborative conference call with representatives from nursing education organizations to discuss real and perceived barriers that are posed by boards of nursing. In addition, they will develop some model rules for boards of nursing to adopt related to fostering innovations in nursing education. The Innovations in Education Regulation Committee is seeking input from educators on real or perceived barriers that limit innovations in nursing education.

Please email Nancy Spector, PhD, RN, at nspector@ncsbn.org if you have any input for the committee.

REFERENCES

Greiner, A. C. and Knebel, E. Eds. (2003). *Health professions education: A bridge to quality.* Washington, D.C.: The National Academies Press.

Kohn, L., Corrigan, J. and Donaldson, M. Eds. (1999). *To err is human: Building a safer health system.* Washington, D.C.: The National Academies Press.

NCSBN. (2008). Faculty Qualifications Report. Retrieved October 9, 2008, from www.ncsbn.org/Final_08_Faculty_Qual_Report.pdf.

Toward an Evidence-Based Regulatory Model for Transitioning New Nurses to Practice

NCSBN is developing an evidence-based regulatory model for transitioning new nurses to practice. Several factors have inspired this inquiry, most notably, the Institute of Medicine's reports of medical errors and the need to transform health care education. In addition, there is an increased complexity of care for sicker patients with multiple conditions, a continued need for systems thinking and an exponential growth of technologic advances. Furthermore, the shortage of nurses and nursing faculty is expected to continue into the future, thus affecting the transition of new nurses to practice.

There have been some national calls for a formal transition program for new nursing graduates, including from the Joint Commission (Joint Commission White Paper, 2002), the draft of the Carnegie study of nursing education recommendations and in a synthesis of national reports (Hofler, 2008). Several standardized transition programs around the country have been very successful and worldwide transition programs are being designed (NCSBN, 2008a). Additionally, the Commission on Collegiate Nursing Education (CCNE) has developed an accreditation process for residency programs.

Last year NCSBN's Transition to Practice Committee identified the evidence that supports a transition regulatory model *(see model below)*. Committee members will continue to work this year to refine the model, making it feasible for boards of nursing to implement and develop consensus for the model across regulation, education and practice. (Please refer to the Transition Evidence Grid [NCSBN, 2008a] and the NCSBN Transition to Practice Report [NCSBN, 2008b] for an explication of the available evidence supporting the NCSBN's transition regulatory model.)

NCSBN's transition regulatory model will be implemented through regulation, though collaboration across education, regulation and practice will be essential for this model to be successful. Educators are the experts in curriculum design and evaluation and will be able to assist with the design of transition modules. Practice provides a crucial link that will equip new graduates with planned, precepted practice experiences. Regulators provide new graduates with information on their scope of practice, the Nurse Practice Act and maintenance of their license throughout their careers.

Regulation will enforce the transition program through licensure. This is an inclusive model, which would take place in all health care settings that hire newly graduated nurses at all educational levels of nursing, including practical nurse, associate degree, diploma, baccalaureate and other entry-level graduates. It is also intended to be flexible so that many of the current standardized transition programs will meet the requirements of this model.

The new graduate must first take and pass the NCLEX®, obtain employment and then enter the transition program. The preceptors in this model will be trained to work one-on-one with newly graduated nurses. A preceptor will work with the same graduate throughout the six-month transition program. This model is highly dependent on a well-developed preceptor–nurse relationship; the importance of this relationship is supported in the research. Novice nurses will understand the importance of learning from a seasoned, dedicated preceptor, thus encouraging these nurses to serve as preceptors to new nurses in the future. Therefore, it is hoped that this will bring about cultural change in nursing whereby becoming a preceptor and mentor will be an expected part of professional nursing.

Orientation, defined as being instructed on the policies and procedures of the workplace as well as role expectations, is required before entering the transition program. Therefore, orientation, according to this model, is **separate** from the concept of transition to practice, which is defined as a formal program designed to support new graduates during their progression into practice.

The eight transition modules supported in the literature (NCSBN, 2008a; NCSBN, 2008b) for this model include: delegating/supervising; role socialization; utilization of research; prioritizing/organizing; clinical reasoning; safety; communication; and specialty content. These modules could be presented at the institution where the new nurse works, in a collaborative program with other institutions or via the Internet. The Transition to Practice Committee envisions the development of a Web site with online learning modules, as well as a way to connect new nurses to preceptors in those settings or regions of the country where preceptors are in short supply.

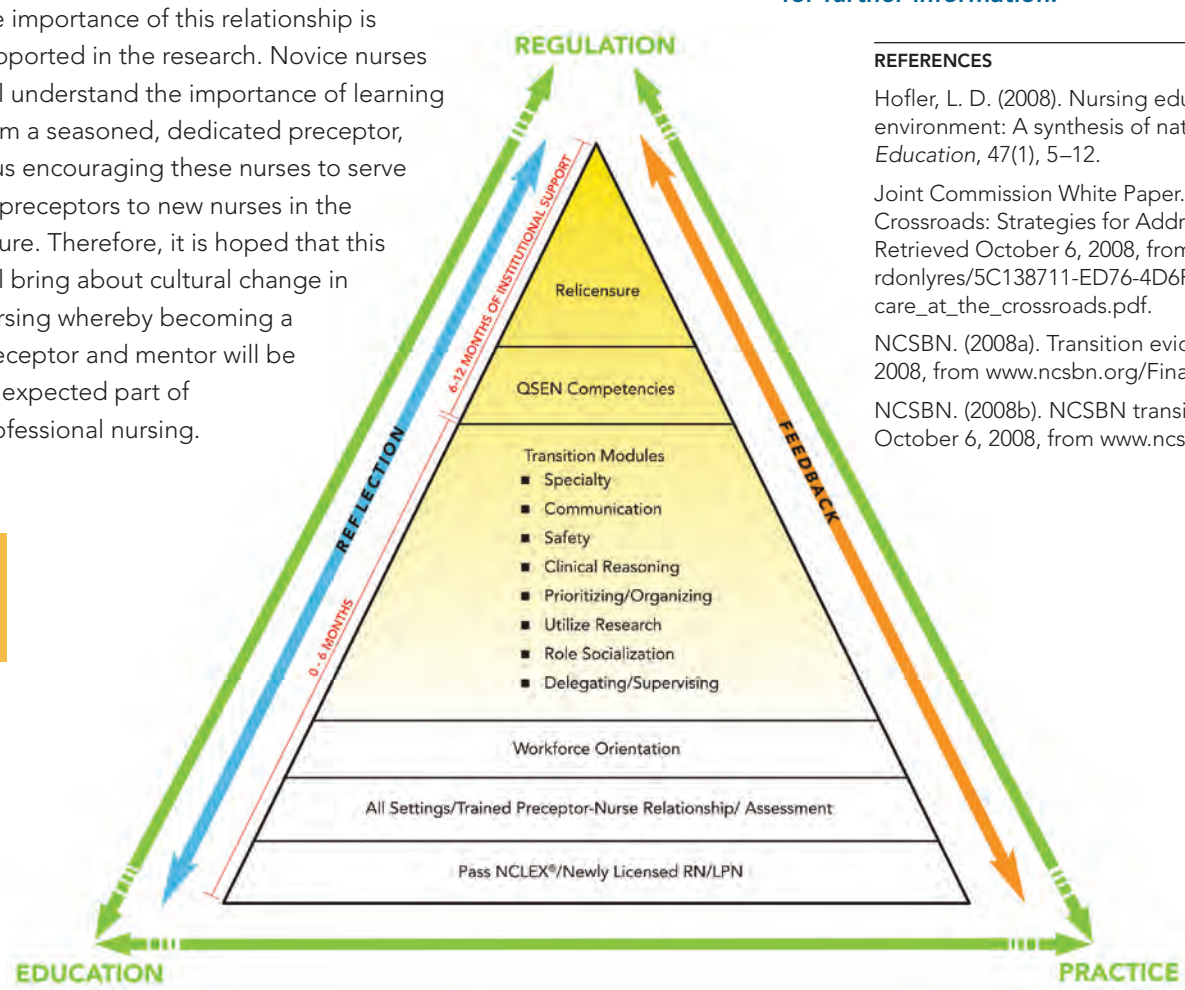
The time period for this Transition Regulatory Model will be six months, though it is expected that the new graduate will have ongoing support for an additional six months. At the end of the year, the new nurse is expected to have met the Quality and Safety Education for Nurses (QSEN) competencies. The QSEN competencies (www.QSEN.org), developed by experts across the health care disciplines, were based on the IOM competencies and include: patient–centered care; teamwork and collaboration; evidence-based practice; quality improvement; safety; and informatics.

NCSBN's transition regulatory model will be implemented through regulation, though collaboration across education, regulation and practice will be essential for this model to be successful.

Lastly, feedback and reflection are essential parts of this model and must be integrated throughout the entire transition program. This should be built into the preceptor–nurse relationship, while also being maintained after the six-month transition period is complete.

It is the vision of this model that new nurses will be required to provide their board of nursing with evidence of completing all the requirements of this standardized transition program in order to maintain their license after their first year in practice. This model will be voted on at the NCSBN Annual Meeting in 2009. If this regulatory transition model is adopted, each jurisdiction will decide whether or not to implement it or to adapt it to meet the particular needs of their state or territory.

Please contact Nancy Spector, PhD, RN, at nspector@ncsbn.org for further information.



Transition to Practice Regulatory Model

REFERENCES

Hofler, L. D. (2008). Nursing education and transition to the work environment: A synthesis of national reports. *Journal of Nursing Education*, 47(1), 5–12.

Joint Commission White Paper. (2002). Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis. Retrieved October 6, 2008, from www.jointcommission.org/NR/rdonlyres/5C138711-ED76-4D6F-909F-B06E0309F36D/0/health_care_at_the_crossroads.pdf.

NCSBN. (2008a). Transition evidence grid. Retrieved October 6, 2008, from www.ncsbn.org/Final_08_Transition_grid.pdf.

NCSBN. (2008b). NCSBN transition to practice report. Retrieved October 6, 2008, from www.ncsbn.org/388.htm.

North Dakota Board of Nursing … *continued from page 3*

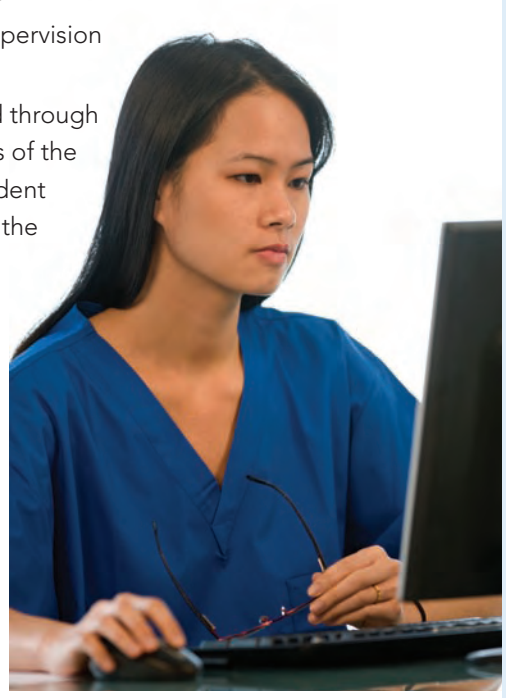
University Nurse Administrators, and the University of North Dakota Center for Rural Health. The study is currently under the approval and ongoing regulation of the University of North Dakota Institutional Review Board (IRB).

An exploratory design of mixed methods was utilized to study the relationships described by the conceptual framework. Specifically, a sequential explanatory strategy was applied for ongoing data analysis. The researchers modified the Nurse Faculty Development Survey tool by Riner and Billings (1999) and used it to measure NFI's perceived competence development for effective teaching of nursing students through self-perception and through the eyes of the NFI mentor. The survey was adapted for each version (self-perception and mentor's perception) with permission from Riner and Billings (1999). Other variables, such as satisfaction with the faculty role, the field of graduate nursing study, salary, and method of orientation and supervision, were solicited through the application process. Qualitative data was collected through focus groups of NFIs and mentors.

Data Collection

Data collection is accomplished through various methods and begins with the application process, which not only serves to document the informed consent signatures for all participants, but also solicits the following information:

- Years of nursing practice for the NFI;
- Type of graduate education (educator versus advanced practice);
- Salary paid to the NFI; and
- Type of orientation and supervision planned for the NFI.



Further data is gathered through annual employer evaluations of the NFI that also summarize student satisfaction with the work of the NFI. Additionally, an annual focus group of NFIs and mentors has been conducted.

Preliminary Findings

Some of the preliminary findings are that the NFIs and their mentors identified areas of developmental needs of new faculty members. The areas of developmental needs are listed below from greatest need to the area of least need:

- Teaching, evaluation and curriculum;
- Role development;
- Learning resources and technology; and
- Teaching in a changing environment.

The pilot study is now progressing into year three of four and analysis of year two data is in process. For more information on this innovative faculty model, please contact Dr. Linda Shanta at lshanta@ndbon.org.

REFERENCES

AACN. (2005). Faculty shortages in baccalaureate and graduate nursing programs: Scope of the problem and strategies for expanding the supply. Retrieved August 21, 2006, from www.aacn.nche.edu/Publications/WhitePapers/FacultyShortages.htm.

Arias, D. C. (2006). Faculty shortage hurting nation's nursing work force. *The Nation's Health*, 36 (2). Downloaded March 8, 2006, from www.medscape.com/viewarticle/523847_print.

James, K. M. G. (2004). Bridging the gap: Creating faculty development opportunities in a large medical center. *The Journal of Continuing Education in Nursing*, 35(1), 24–29.

NLN. (2005). Core competencies of nurse educators with task statements. Downloaded August 28, 2006, from www.nln.org/facultydevelopment/pdf/corecompetencies.pdf.

Riner, M. E. & Billings, D. M. (1999). Faculty development for teaching in a changing health environment: A statewide needs assessment. *Journal of Nursing Education*, 38(9), 427–430.

Sweitzer, H. F. (2003). Getting off to a good start: Faculty development in professional programs. *The Journal of Continuing Education in Nursing*, 34(6), 263–274.

NCSBN in the Spotlight

Speaking Engagements

Recently, NCSBN staff attended the following events as speakers:

Anne Wendt, PhD, RN, CAE, director, NCLEX® Examinations. (June 2008). *2006 Medication Assistant Job Analysis.* Presentation given at the Med Aide Conference, Chicago, Ill.

Casey Marks, PhD, chief operating officer. (September 2008). Keynote message. Presentation given at the Philippine Nursing Competitiveness Conference, Manila, Philippines.

Anne Wendt, PhD, RN, CAE, director, NCLEX® Examinations. (September, 2008). *Filipino Nurses and The NCLEX® Examination: Trends and Test Performance.* Presentation given at the Philippine Nursing Competitiveness Conference, Manila, Philippines.

NCLEX® Examinations department staff:
Anne Wendt, PhD, RN, CAE, director, **Lorraine Kenny, MSN, RN**, content manager, **Ada Woo, PhD**, psychometrician, **Hershy Pappadis**, MSN, RN, content associate, and **Michael Tomaselli**, administration manager. (September 2008). Presentations given at 2008 NCLEX® Invitational, San Diego, Calif.

Nancy Spector, PhD, RN, director, education. (September 2008). *NCSBN Updates.* Presentation given at the National League for Nursing Conference, San Antonio, Texas.

Nancy Spector, PhD, RN, director, education. (September 2008). *Innovative Faculty Models.* Presentation given for the Texas Board of Nursing and Texas educators.

Kevin Kenward, PhD, director, research. (September 2008). *Linking Education and Practice Data and the Development of a Masterfile.* Presentation given at the Association of Academic Health Centers (AAHC) Workforce Data Conference, Washington, D.C.

Nancy Chornick, PhD, RN, CAE, director, practice. (October 2008). *The New APRN Legislative Language.* Presentation given at the American Board of Nursing Specialties Fall Meeting, Louisville, Ky.

Published Articles

NCSBN staff published the following articles:

Anne Wendt, PhD, RN, CAE, director, NCLEX® Examinations. (2008). Investigation of the Item Characteristics of Innovative Items. *CLEAR Exam Review*, 19(1), 22–28.

Kevin Kenward, PhD, director, research. (2008). Discipline of nurses: A review of disciplinary data 1996–2006. *JONA's Healthcare Law, Ethics, and Regulation*, 10 (3), 81–83.

Nur Rajwany, MS, director, information technology, and **Dawn Kappel, MA**, director, marketing and communications. (2008). What is Nursys? *Wyoming Nurse Reporter*, 4 (2), 8–9.

Leader to Leader

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
Web site: www.ncsbn.org

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

The National Council of State Boards of Nursing (NCSBN), composed of member boards, provides leadership to advance regulatory excellence for public protection.

www.ncsbn.org