Seamless Simulation for Undergraduate Pedagogy and Practicum Alignment

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Modern nursing education reflects many pedagogical traditions. National calls for reform have sparked a need for critical evaluation of nursing curriculum and their corresponding teaching strategies. These calls emphasize the importance of critical thinking, leadership, communication, policy, health care regulation, clinical judgment, caring behaviors and information management (Hegarty, Walsh, Sweeney, Condon, 2009) to adequately prepare new nursing graduates for the demands of modern health care environments. The challenges impacting nursing education (i.e., the nursing and faculty shortage, limited clinical site availability, increasing student enrollment and alterations to program length) have necessitated an exploration for innovative models of curriculum design that address these challenges, while also meeting the expectations of stakeholders.

As a result of the evolution of health care and education, Roxburgh et al. (2008) suggest that current nursing curricula focuses primarily on content and process; didactic, clinical and simulation learning occur in isolation. In other words, these different teaching methods are not situated into a collective context. For instance, a time-motion study on clinical nursing education by Polifroni, Packard, Shah and MacAvoy (1995) suggests that only 44 percent of student time is spent providing direct patient care. The remaining time was considered nonproductive clinical time. Furthermore, it was noted that only 25 percent of the total time was spent in the presence of the assigned unit registered nurse (RN) and the clinical instructor combined. This suggests that 75 percent of a student's time in clinical is unsupervised, with a large percentage of learning occurring through trial and error. Given these findings, current nursing education can be likened to giving students pieces of a jigsaw puzzle. They are expected to put the pieces together, yet lack the direction provided by the picture on the box.

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Ask NCSBN Q&A

Q. Do Most Boards of Nursing Have Administrative Rules Related to Simulation Requirements?

Editor's note: This is a frequently asked question and being that this issue features several articles related to innovations in nursing education, I surveyed boards of nursing (BONs) on Oct. 20, 2009, to ask how simulation is evaluated when nursing programs go through the approval process. Responses are below.

Nancy Spector, Director, Regulatory Innovations, NCSBN

A. Of the 40 respondents, seven BONs (18 percent of respondents) stated they have rules that address simulation. Of those:

- Two BONs have rules that define simulation as complementing clinical experiences;
- Two report actual percentages of simulation as substituting for clinical experiences;
- One states that simulation should be considered lab hours and not replace clinical experiences;
- One states that simulation experiences are at the discretion of the nursing education program; and
- One reports that while simulation may be used as a teaching strategy, clinical experiences with actual patients are also required.

When asked if the state/jurisdiction considers simulation when approving programs, of the 40 respondents, 25 BONs (or 62 percent) said that the use of simulation is examined. Some examples include:

- Are there adequate resources to effectively use simulation?
- Simulation is seen as a complement/adjunct to clinical experiences with patients.
- "Special attention is paid to 'hands-on' clinical opportunities across the lifespan."
- Consider the integration into the whole of the program and the purposes of its use.
- "Simulation is addressed very broadly as a teaching strategy."
- Simulation is considered "for alignment/meeting of program objectives."
- "Simulation is considered as a learning methodology appropriate to accomplishment of objectives."

There were six states that reported requiring a limit on how much simulation (percentage of current clinical hours) can replace clinical experiences:

- < 10 percent: one state/jurisdiction
- 11– 20 percent: two states/jurisdictions
- 21–30 percent: five states/jurisdictions

Some BONs reported that they are revising their rules to include language on simulation. One BON is collaborating with the Board of Regents in their state to assure that all nursing programs have access to simulation. BONs, like educators, are waiting for more research on simulation, particularly related to the outcome of this teaching strategy. Educators are encouraged to access their BON's education rules to determine what their states/jurisdictions require.

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The SSUPPA Model

A consideration of these collective factors led to the development of a new multi-modal educational model. The Seamless Simulation for Undergraduate Pedagogy and Practicum Alignment (SSUPPA) model utilizes mirrored pedagogical methods in both simulation and clinical settings that correspond directly to didactic content. The model employs a phased learning approach of prework, brief, immersion, debrief, synthesis and postwork. In this model, immersion (both in simulation and clinical) is defined as in-depth experiences that move the student beyond skill acquisition into formative learning. It requires the learner to make clinical decisions and take appropriate actions. These immersion experiences reflect the threads of communication, clinical judgment, caring behaviors, as well as many other threads and concepts recommended by national nursing organizations. They are then integrated into both the clinical and simulation environments. The thread's built-in complexity become more dynamic within each semester, as well as from semester to semester. For instance, information management is a continuous thread in every clinical experience and is mirrored in simulation through the utilization of the simulated Electronic Health Record (EHR).

One of the aims of the SSUPPA model is to support the development of critical thinking as an essential component of nursing practice through the practical application of the nursing process. Learning experiences are fashioned to foster the critical thinking needed to help students keep their patients safe, recognize changes early and make appropriate clinical decisions, regardless of setting or context. This is accomplished by front-loading the first two semesters of a four semester nursing program with extensive immersive simulation hours, thus replacing a significant portion of clinical time. During the third and fourth semesters, the number of simulation hours decreases, yet the complexity of the scenarios increases. This cultivates simulation experiences that closely resemble the learners' lived clinical experiences. By doing these things, the program is in a position to replace a portion of clinical hours with simulation, expand clinical site availability and support increased student to faculty face time. Although the model has not been formally evaluated, other benefits of the model seem to include a significant increase in learner, preceptor, faculty and site satisfaction; more diverse learning experiences; the ability to ensure consistency across the curriculum and pedagogies; and improvements in critical thinking and clinical judgment, to name a few.

One of the fundamental challenges for modern nursing education is to restructure pedagogical approaches to support the efficient use of faculty and student time. This is accomplished through reducing redundancy, modeling the use of evidence-based and professional standards of practice, and shifting educational focus from skill acquisition to producing graduates with holistic perspectives of what it means to be a nurse. This brief overview of the SSUPPA model suggests one method of addressing the challenges facing modern nursing education.

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New Journal to Launch in 2010

Journal of Nursing Regulation (JNR), the new official journal of NCSBN will launch its first issue in April 2010. *JNR* is peer-reviewed with an academic/professional focus and will be published quarterly.

JNR is dedicated to advancing regulatory excellence and providing a worldwide forum for sharing research, evidence-based practice, and innovative strategies and solutions related to nursing regulation and practice, with the ultimate goal of safeguarding the public. The journal will maintain and promote NCSBN's values of integrity, accountability, quality, vision and collaboration in meeting readers' knowledge needs.

With a concentration on topics related to nursing education and practice, academic research and investigation, discipline, and the NCLEX® examinations, *JNR* will offer a wide range of articles, including original research; features on regulatory issues, policies, and laws; critical reviews; evidence-based best practices; public safety; case reports; book reviews; and continuing education (CE).
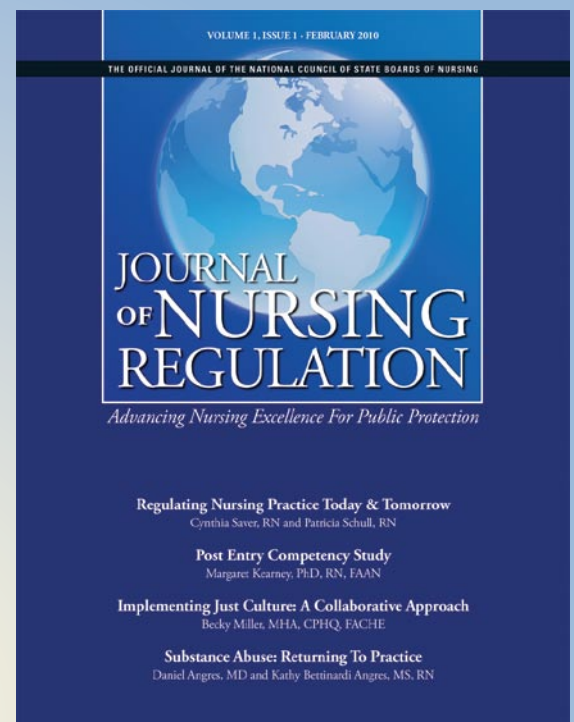
Journal Content

The content of *JNR* consists of "in-every-issue" copy, including letters to the editor, an editorial from the editor-in-chief and a CE article. The main content includes a cover story, three feature articles, and additional section articles and columns or departments.

Main Sections of *JNR* and Its Departments

JNR has four main sections, with several departments in each section:

- **Nursing Practice** covers nursing licensure and certification, patient safety, delegation, nursing assistive personnel and continued competence.
- **Research & Education** presents an analysis of the issues and changes that nursing regulators face, and discusses solutions that address them. It also addresses such issues as evidence-based elements of nursing education resulting in safe entry-level practitioners, best practices in nursing education, statewide programs that transition nurses from education to practice, approval/accreditation of boards of nursing (BONs) and distance learning.
- **Discipline & Investigation** includes such topics as nurse chemical dependency; regulatory and alternative management programs of impaired nurses; drug screening; disciplinary actions taken against nurses; investigative tools; investigation models; and criminal background checks for BONs.
- **NCLEX®** encompasses the NCLEX-RN® and NCLEX-PN® examinations; NCLEX test plan(s); minimal data set for applicants; exam psychometrics, test development process; how to become a test item writer, reviewer, or judge; and international administration of the NCLEX examination.

Other topics covered in *JNR* include state BON initiatives and activities, legal and ethical issues, policy and government relations, Joint Commission updates, and federal legislation and regulations that affect nursing and other health care professions. Formats will include forums, Q&As and case studies.

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JOURNAL OF NURSING REGULATION

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- Others involved in developing and implementing nursing policy

The journal's content will be posted on its companion Web site **www.journalofnursingregulation.com** starting with the premiere issue.

Transition to Practice Regulatory Model Update

As was reported in last fall's *Leader to Leader* (www.ncsbn .org/Leader-to-Leader_FALL08(1).pdf), NCSBN is embarking on an initiative that could potentially change the face of nursing. We have developed an evidence-based regulatory model for transitioning new nurses to practice. Several factors have inspired this inquiry, including recent Institute of Medicine (IOM) reports of medical errors and the need to transform health care education; the increased complexity of care for sicker patients with multiple conditions; a continued need for systems thinking; and the exponential growth of technologic advances.

It is now well accepted that standardized transition programs reduce turnover in that first year of practice (NCSBN, 2009). A review of discipline data from the Illinois Board of Nursing indicates that temporary nurse replacements have more discipline reports than regular staff nurses (Behrens, 2000). This is understandable as evidence shows that unfamiliarity with patients is linked to errors or near misses (NCSBN, 2009). Further, emerging evidence supports that well-developed transition programs decrease practice errors and improve patient outcomes (NCSBN, 2007; Elfering, Semmer & Grebner, 2006). Yet the most heart wrenching evidence is seen in this quote from a newly licensed nurse (Foundation for Nursing Excellence, 2009, p. 48):

I am frightened for my patients and for my own license as I will soon be turned loose with only a resource person and expected to take a full load after only 5 days of orientation in my new assigned unit.

NCSBN does not believe that the education-practice gap is the fault of education falling short or of practice expecting students to "hit the ground running." In nursing we have a missing piece that many of the other health care professions don't have; that is, we do not have a standardized program to transition new nurses to practice. Therefore, for the safety and quality care of our patients, it is time for nursing to take action. NCSBN is developing a regulatory model that will assist regulators in their mission of public protection. However, NCSBN is not doing this alone. We are collaborating with education and practice because it is only through collaboration and consensus with our nursing colleagues that this model will be successfully implemented. To this end, NCSBN has held collaborative meetings and conference calls with more than 35 stakeholders, and have invited a representative from the American Organization of Nurse Executives (AONE) to participate in all meetings of our Transition to Practice Committee, since practice will be critically affected by this initiative.

NCSBN's committee members collaborated with boards of nursing and stakeholders, and decided that the modules needed to be recategorized to be more in line with other national initiatives, such as the IOM's competencies for health care professional (Greiner & Knebel, 2003) and the Quality and Safety Education in Nursing (QSEN) model (Quality and Safety in Nursing Education, 2009). Here is a summary of the recategorization:

- Added **Patient-Centered Care** as a module, where we will include diversity content and incorporate the following from our old modules:
  - Specialty Content; and
  - Prioritizing and Organizing.
- Changed the Communication module to **Communication and Teamwork**, where we will include essential communication content, as well as the following from our old model:
  - Role Socialization; and
  - Delegating and Supervising.
- Kept **Evidence-Based Practice**.
- Added **Quality Improvement**, as we think toward the future and through the lens of practice and regulation. We had incorporated this material in our old Communication module, but now we are making it a module on its own.
- We had categorized **Informatics** in our old Communication module; we will pull that out as a separate module and again, this reflects the future of health care.
- **Safety** and **Clinical Reasoning** will be integrated throughout the modules.

NCSBN's Transition to Practice Committee members have been building the modules and identifying essential content. We envision that these modules will be designed to integrate experiential and active learning, and will not incorporate relearning of content that the new nurses have already learned in their nursing programs. The transition program meeting regulatory standards could be offered by individual employers; or employers could partner with each other or with educators to develop the program. However, so that all new nurses will have the opportunity to meet these regulatory requirements, NCSBN is planning to develop interactive, online modules, using cutting-edge technology.

Transition to Practice Model
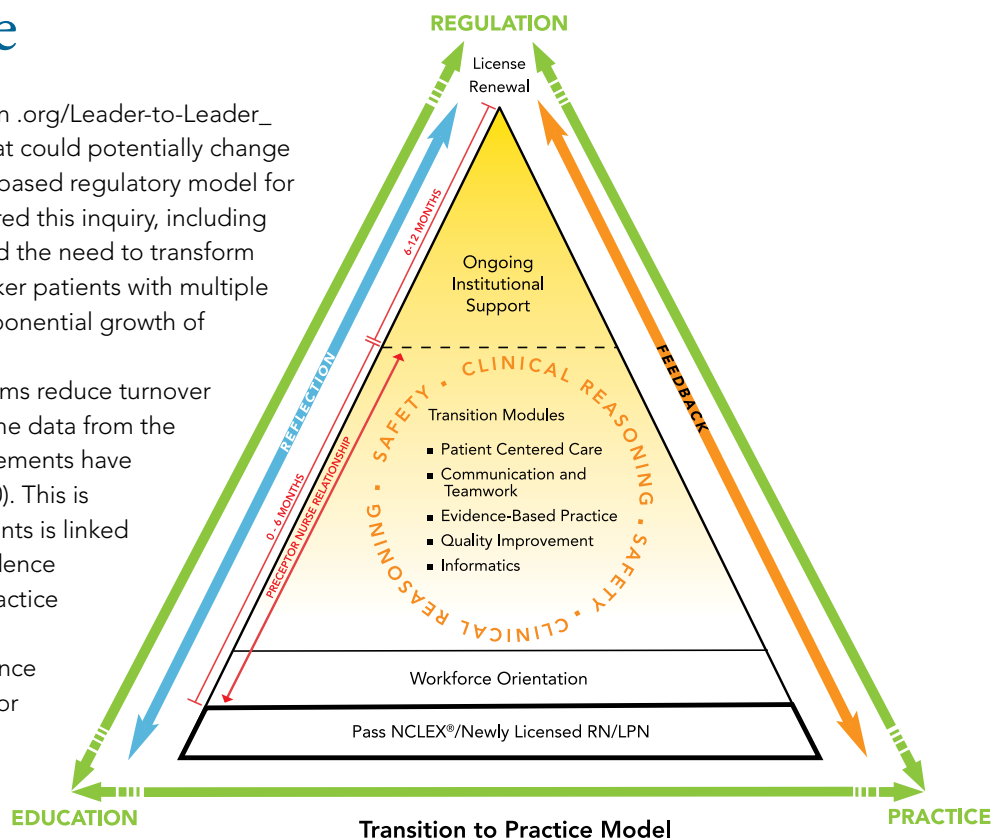
The model is strongly dependent on a well-developed preceptor nurse relationship, which is supported in the research. The preceptors in this model will be trained and the essentials of that module are being established. Preceptors will either work one-on-one with newly licensed nurses or in teams; recent evidence supports that team preceptorships can be very effective (Beecroft, Hernandez & Reid, 2008). NCSBN is planning to offer electronic social networking to connect new nurses to preceptors in those settings or regions of the country where preceptors are in short supply; again so that all novice nurses will have the opportunity to meet this requirement.

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. In many states new drivers have similar requirements for maintaining their license after their first year of driving, and in some states teachers have the same requirement.

NCSBN is looking for funding possibilities to assist practice with developing a transition program that would meet the requirements of our standardized transition program. Since federal monies support medicine, pharmacy and pastoral care residency programs, there might be a possibility that nursing could also receive funding. It should be noted, however, that studies show that well-planned transition programs are associated with positive returns on investment because of the decreased turnover.

Because this is such a big step for nursing, we intend to pilot this model. We will convene national advisory panels of experts to assist us in establishing outcome measures and for advice on implementing the model. Once the pilot data are available, NCSBN's membership will vote on adoption of the model. If adopted, each state or jurisdiction will decide whether or not to implement this model. Jurisdictions could adopt the model as a whole or could adapt it to meet the particular needs of their states or jurisdictions. Our toolkit has more information, including a timeline, and can be accessed by visiting www.ncsbn.org/363.htm.

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ADDITIONAL SUPPORT MATERIAL

Quality and Safety in Nursing Education. www.qsen.org.

NCSBN Publications

NCSBN announces the release of **Nursing Pathways for Patient Safety**, a new book which advocates an innovative approach to examining instances of nursing practice breakdown.

Published by Elsevier Mosby, *Nursing Pathways for Patient Safety* is written by a distinguished panel of NCSBN experts seeking to create a change in the current state of health care safety management. The book examines the issues surrounding practice breakdown in a way that looks beyond individual errors and instead, examines practice breakdown from a systems perspective.

One of the book's editors, Patricia Benner, PhD, RN, FAAN, Visiting Professor, University of Pennsylvania, and Senior Scholar for the Carnegie Foundation for the Advancement of Teaching, comments, "This book is a 'must read' for all undergraduate and graduate nursing students, as well as all practicing nurses, and nurse educators and administrators. It clarifies and exemplifies the nurse's central role in patient safety. Nurses are the patient's first and last defense in today's complex health care system. Central to their work is the prevention of safety hazards to patients as a result of hospitalization or encounters with all health care institutions."

A culmination of NCSBN's Practice Breakdown Initiative, the book describes the TERCAP® (Taxonomy of Error Root Cause Analysis and Practice-responsibility) data collection instrument and provides a systematic review of eight types of practice breakdowns. Factors that may contribute to practice breakdown have been identified, including:

- Patient Profile;
- Patient Outcome;
- Setting;
- System Issues;
- Health Care Team;
- Nurse Profile; and
- Intentional Misconduct or Criminal Behavior.

Coverage of each type of practice breakdown, such as clinical reasoning or judgment, prevention and intervention, is systematically explored.

The book provides compelling case studies in each chapter based on actual instances of practice breakdown. Chapters on mandatory reporting and implementation of a whole systems approach offer practical information on understanding TERCAP and provide a helpful framework for grasping the scope of problems, along with NCSBN's approach to addressing them.

The book is priced at $39.95 and is available from Elsevier at www.us.elsevierhealth.com/index.jsp or by calling 1.800.545.2522.
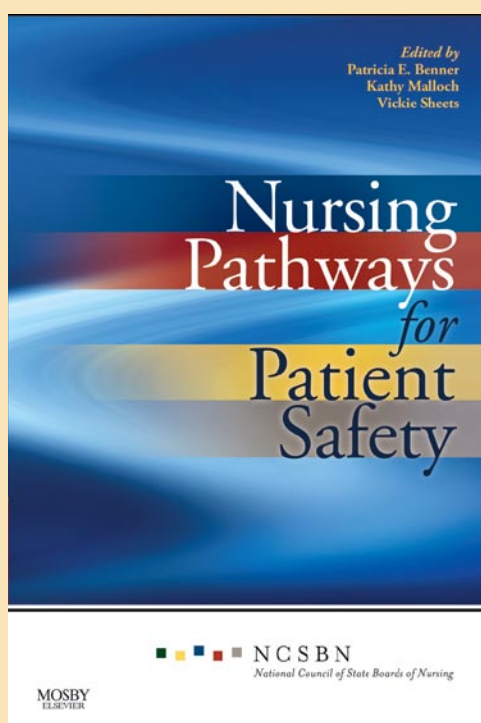
Leader to Leader

Available Only Online in 2010

Throughout the last five years **Leader to Leader** has successfully brought nursing regulation and education together in a publication that challenged its readers to look at the issues surrounding these two disciplines with a fresh perspective. Now, in an effort to be more environmentally-friendly, provide easier and wider accessibility to our current readers, and expand our readership base, *Leader to Leader* will no longer be a printed publication. The online publication allows for a greater diversity of readers that bring with them new questions and feedback, as well as innovative ideas for stories. This new input coupled with the ongoing comments we receive will enable the editors to bring you a richer and more valuable newsletter.

The first electronic only edition of *Leader to Leader* will start with the Spring 2010 issue. To ensure that you receive this publication, **join the *Leader to Leader* mailing list by visiting www.ncsbn.org/epushprofilecreate.html.** The latest issues will be sent directly to your inbox the moment they are available.

Join the *Leader to Leader* mailing list today and encourage your colleagues to do so as well in order to continue learning about nursing regulation and education topics, such as simulation, innovations in education, transition to practice and much more.

For more information, contact communications@ncsbn.org.

2010 NCLEX-RN® Test Plan

NCSBN reviews the test plans for the NCLEX-RN® every three years. Changes to the *2010 NCLEX-RN® Test Plan* are based upon empirical data collected from newly licensed nurses, as well as the expert opinions of the NCLEX® Examination Committee, NCSBN content staff and boards of nursing. The *2010 NCLEX-RN® Test Plan* will become effective in April 2010, and has been posted on the NCSBN Web site. The *2010 NCLEX-RN® Detailed Test Plan* is also available, offering a more 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 *2010 NCLEX-RN® Detailed Test Plan*; a Candidate version and an Item Writer/Item Reviewer/Nurse Educator version. Answers to frequently asked questions about the *2010 NCLEX-RN® Test Plan* can be found at www.ncsbn.org/1287.htm.

In order to provide the public with important NCLEX information, the NCLEX® Examinations department has created the official **NCSBN NCLEX-RN® & NCLEX-PN® Examinations Facebook page (http://bit.ly/a4hPg) and the NCLEXInfo Twitter page (www.twitter.com/NCLEXInfo)**. Facebook users can now become a fan of NCLEX examinations and Twitter users can follow NCLEXInfo to find current information about the examination, updates and direct links to the NCLEX examinations Web site.

Development of Guidance Documents within Nursing Education Regulation

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During the past several years, the Virginia Board of Nursing (VA BON) has heard from various stakeholders about the increasing complexity of the nursing care required to assist Virginians in a variety of health care settings, and the need for an increase in the numbers of qualified registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) in these settings. At the same time, the VA BON heard from nursing faculty and nursing students about the challenges that new nurses face in being prepared to care for their patients in this complex health care environment. Because the mission of the VA BON is to protect the public and enhance the delivery of safe and competent health care by licensing qualified nurses (and regulating nursing programs), the VA BON discussed ways to assist schools of nursing in educating their students to prepare their graduates for their roles as RNs or LPN/VNs. This assistance includes the use of innovative approaches in nursing education without jeopardizing the quality of the education, and remaining within the bounds of Virginia law and VA BON regulations.

These documents will assist schools of nursing in the preparation of qualified nursing graduates, while staying within the bounds of VA BON regulations.

As a result of discussions and correspondences with these groups, the VA BON promulgated regulations that became effective in April 2008 requiring all nursing education programs approved in Virginia to have a minimum number of direct client care clinical hours; RN programs must have a minimum of 500 direct client care hours and LPN programs must have a minimum of 400 direct client care hours. The change in the regulation requiring a specific number of clinical hours led to additional discussions about the use of simulation in nursing education programs, LPN to RN bridge programs and clinical hours in distance learning programs.

Since promulgation of regulations in Virginia may be a lengthy process, the VA BON wanted to be responsive to the nursing education community and the public, so they prepared three guidance documents in 2009. These documents assist schools of nursing in the preparation of qualified nursing graduates, while staying within the bounds of VA BON regulations. The VA BON will look closely at the nursing graduate outcomes to guide regulatory changes as a result of the success or failure of the implementation of these guidance documents (see reference to guidance documents at the end of this article).
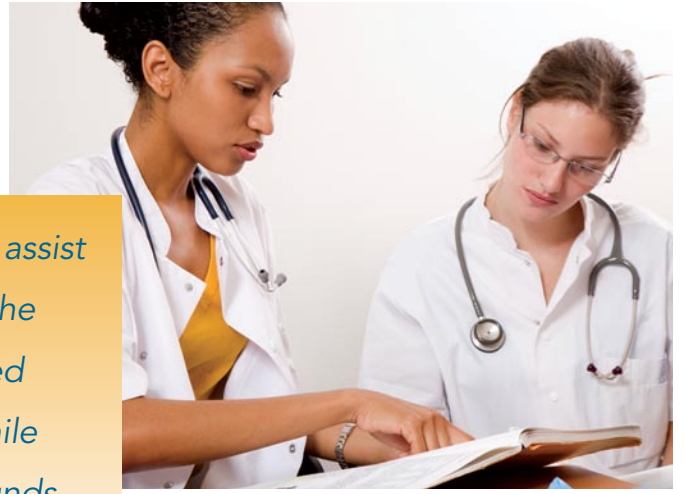
In developing the guidance documents, the VA BON communicated with nursing education programs through e-mail, speaking engagements and an annual survey. The VA BON also had feedback from stakeholders, employers and consumers.

There has been much discussion nationally about innovative approaches in nursing education as a means of increasing the capacity of education programs, and the number of nursing graduates and licensees. One such innovation that has been defined and implemented in Virginia is the use of simulation in nursing education programs. The VA BON is supportive of the use of simulation and developed simulation guidelines in lieu of a percentage of direct client care hours. The use of simulation in nursing education is consistent with the *Model Rules for Innovative Approaches in Nursing Education Programs* adopted by the NCSBN Delegate Assembly in August 2009. As indicated in the model rules, these innovative approaches allow for complexity in health care by introducing the nursing student to new technologies, critical thinking, a more diverse population with multiple chronic illnesses, and a focus on patient safety and preventing errors. The guidance document developed by the VA BON outlines the essential components and major concepts that are necessary when using simulation in lieu of direct client care. The VA BON stated that one hour of simulated client care, including the debriefing time, is equal to one hour of direct client care. Further, no more than 20 percent of direct patient contact hours may be simulation. For prelicensure RN programs, the total of simulated patient care hours cannot exceed 100 hours (20 percent of the required 500 hours); for prelicensure LPN programs, the total of simulated patient care hours cannot exceed 80 hours (20 percent of the required 400 hours). No more than 50 percent of the total clinical hours for any course may be used as simulation. Skills acquisition and task training alone, as in the traditional use of a skills lab, do not qualify as simulated client care and therefore do not meet the requirements for direct client care hours. Clinical simulation must be led by faculty as defined by the VA BON regulations.

The VA BON also consulted with the Virginia State Simulation Alliance (VASSA) in the development of the guidance document that has been well received by schools of nursing and VASSA. As more nursing schools use simulation as an innovation to teaching nursing and more research to support the use of simulation in nursing education becomes available, the VA BON will consider this information as they refine the regulations for nursing education programs.

The second guidance document that was developed by the VA BON this year pertains to LPN to RN transition or bridge programs. In an effort to assist schools with transitioning LPN to RN programs, this guidance document gives parameters for schools of nursing to use when offering credit for an LPN education without jeopardizing the quality of the RN program and remaining within the bounds of the VA BON regulations for RN programs.

In general, it is the position of the VA BON that an LPN transitioning into a prelicensure RN program may be awarded no more than 150 clinical hours from their LPN program. The remaining 350 hours must "encompass the attainment and maintenance of physical and mental health and the prevention of illness for individuals and groups throughout the life cycle in a variety of clinical settings" [18VAC90-20-120.B.1], which shall include RN clinical experiences in obstetrics, pediatrics, mental health and medical/surgical nursing.

These innovative approaches and guidance documents are permissible within the current laws and regulations of the VA BON. Guidance documents, however, do not have the force and effect of law, and therefore are advisory only. As the VA BON gains more data on the outcomes of these two approaches, it will consider developing regulations that will further define the use of innovative approaches in nursing education. As the regulations are reviewed, it is the practice of the VA BON to include educators, stakeholders, the public and any other interested party to be part of an advisory team during the regulatory review process.

The third document refined in 2009 pertains to clinical hours in distance learning programs. As a result of changes to the Regulations Governing the Practice of Nursing (18 VAC 90-20-10 et seq.) effective April 2, 2008, the VA BON voted on May 20, 2008, that any student enrolled in a distance learning education program that does not meet the clinical requirements on or before April 2, 2008, must complete his/her program by Dec. 31, 2009, in order to be eligible to take the NCLEX-PN® or NCLEX-RN® and be licensed in Virginia. After Dec. 31, 2009, graduates of the above programs will not be eligible for licensure in Virginia by examination or endorsement. As a result of questions related to people endorsing into Virginia from other jurisdictions, the VA BON began a fast-track Notice of Intended Regulatory Action in 2009 to allow endorsement into Virginia (after Dec. 31, 2009) for those RNs and LPN/VNs who graduate from an approved program that did not meet the VA BON's requirement for clinical hours. The VA BON regulation allowing those RNs and LPN/VNs to endorse into Virginia with an unencumbered license and 960 hours of licensed clinical practice will become effective Dec. 31, 2009. While this guidance document specifically addresses the clinical hours for distance learning programs, all graduates applying for licensure in Virginia are required to meet the clinical requirements, as well as the curriculum content specified in VA BON regulations.

The VA BON's work with nursing schools and stakeholders in developing communication and solutions to regulatory and practice concerns is an example of effective collaboration in the process of developing evidence-based regulation.

For details and copies of the Virginia Board of Nursing Guidance Documents, visit www.dhp.virginia.gov/nursing; then choose "guidance documents."

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Regulation Fosters Innovations in Nursing Education

Background

Because of the complexities in nursing and health care delivery, and a national focus on patient safety, nursing organizations and health care organizations are calling for more innovation in nursing and health care education (AACN, 2008; Greiner & Knebel, 2003; IHI, 2003; NCSBN, 2005; NLN, 2003). Therefore, on March 25, 2008, NCSBN held an invitational roundtable where leaders in education, practice and regulation gathered to discuss how nursing can collaborate to innovatively enhance nursing education for the next generation of nurses. The group discussed the meaning and implications of innovation in nursing education. Perceived barriers to educational innovations not only related to regulation were discussed, but also barriers set up by education systems, practice environments and the students themselves. A vision for the future was presented, which focused on improved communication and forming partnerships between education, regulation and practice.

The following day, March 26, 2008, NCSBN's Faculty Qualifications Committee hosted a conference on the faculty shortage that attracted educators, practitioners and regulators from around the country, as well as internationally. At this meeting some exemplar innovations were presented, such as using simulation, piloting nurse faculty internship programs and using robots to extend nurse educators. There was collaboration between nurse regulators, nurse educators, and those in practice about what nursing education innovations are needed and how they could be implemented.

To continue with this endeavor of fostering innovation in education, in May 2008 the NCSBN Board of Directors established a new committee for 2008–09 that was charged with:

- Identifying real and perceived regulatory barriers to education innovations; and
- Developing a regulatory model for innovative education proposals.

Foundational Work

Committee members began by developing the following definitions and premises as a foundation to their work. When devising the definition for innovation, the group recognized that the etymology of the word derives from the Latin word *innovare*, which means "to renew or change" (Online Etymology Dictionary, 2001). Therefore, while an innovation is something very new and different, it doesn't necessarily mean that an innovation is better. Oftentimes, that nuance is not understood. The members of the committee defined *innovation* as "a dynamic, systematic process that envisions new approaches to nursing education." *Regulatory barrier* was defined as "a real or perceived regulatory parameters that hinder innovation in nursing education." Premises were developed as a foundation to this work, and the literature was reviewed. These can be found at www.ncsbn.org in the Innovations Toolkit.

Committee members held a collaborative call with nursing education organizations to learn their perspectives about some of the regulatory barriers that boards of nursing (BONs) have in place that hinder innovation in nursing education. Organizations that participated included:

- American Association of Colleges of Nursing;
- Commission on Collegiate Nursing Education;
- National Association for Practical Nurse Education and Service;
- National League for Nursing; and
- The National League for Nursing Accrediting Commission, which was invited and provided their input in writing.

The representatives on the call shared the regulatory barriers reported by their members, and communication seemed to be the biggest challenge between regulators and educators. While some of the barriers they cited were real, some of the perceived barriers identified proved to be myths. The perceived barriers and myths can be found in the Innovations Toolkit. Generally the participants on the collaborative call were very grateful that NCSBN had asked for their input and were eager to continue the dialogue about how to foster innovation in nursing education.

Regulatory Influences on Innovation

Following their initial work, committee members devised a model (see above, center) to describe regulatory influences that have the potential of hindering education innovations.

The laws/rules, processes in the BONs and communication with the educators are all regulatory processes that can hinder innovation.

When the three regulatory influences overlap, the barrier might be even harder to overcome. The influences may be real, though many *perceived* regulatory barriers also exist. That is, while educators think the rules are too prescriptive to allow their innovative strategy, oftentimes they are not.

Fostering Innovation

After reviewing the literature and listening to input from educators and BONs, the members of NCSBN's Innovations in Education Regulation Committee decided that developing model rules would be an excellent way to foster innovation in education. BONs use model rules as a framework and/or language to develop amendments and revisions to state laws and rules. These model rules would provide BONs with the appropriate regulatory language to allow for innovative approaches to nursing education that are outside the current rule structure. This language would be particularly effective for those BONs that do not have a lot of flexibility in their practice act or rules. BONs can adapt the language for their particular jurisdictions. At the August 2009 NCSBN Delegate Assembly, the membership voted unanimously to officially adopt the model rules.

Committee members also designed two handouts for BONs. One identifies some of the real and perceived regulatory barriers and also provides BONs with recommendations on creating a favorable climate for innovations in those nursing programs that are ready to implement them. The other is designed for BONs to disseminate to nursing programs, thus promoting dialogue between BONs and educators. It provides tips for nursing programs on planning innovative approaches to nursing education.

NCSBN will assist BONs in implementing the model rules and will evaluate whether they have fostered innovative approaches in nursing programs. Further, NCSBN has developed an online toolkit that includes the model rule language, a place for BONs to post innovations that have been developed across the country, the handouts that were developed for BONs, and other resources for educators and BONs. This toolkit can be accessed at www.ncsbn.org/1927.htm.

Please contact Nancy Spector at nspector@ncsbn.org if you have any questions.
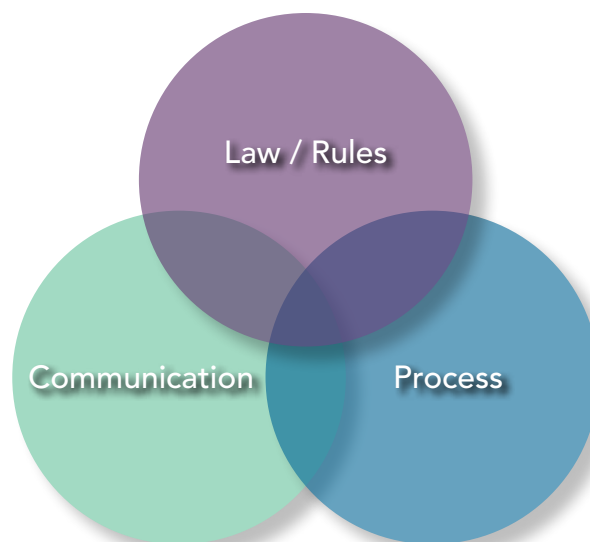
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