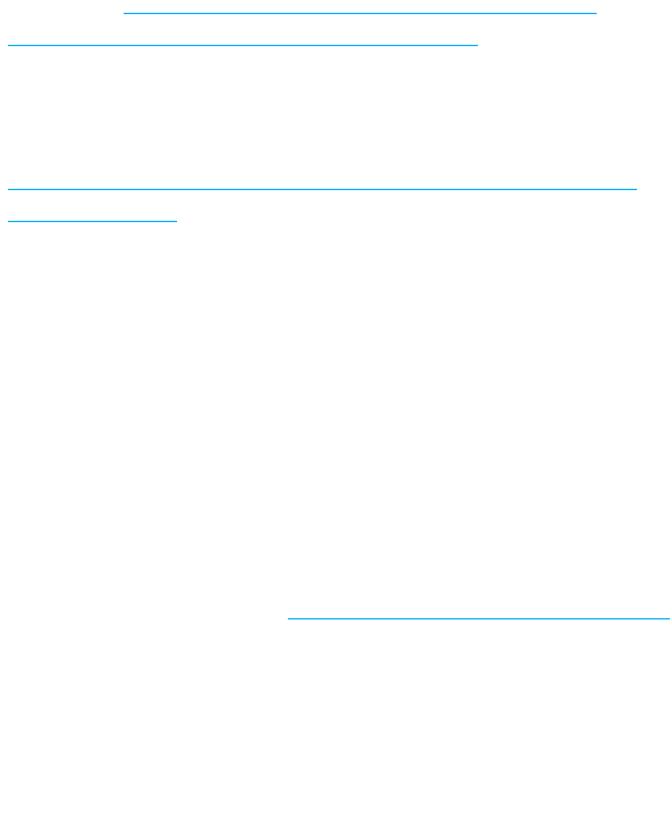


Leader Leader

A Day in the Life of a
Nursing Regulator

Practical Guidelines for Boards of Nursing on Sexual Misconduct Cases provides BONs with realistic guidelines to assist in the decision-making process in sexual misconduct cases. This



continued from page 1

on my feet when new issues (if any) present themselves during hearings, and the overall adrenaline rush I feel in a board room and courtroom knowing that my duty to protect the public is always on the line. I also love being an administrator. Team building is important, and I recognize the value of not

for eligibility, we are nearly at our goal of requiring graduate or postgraduate level education for practice. There are still two states, however, that do not require the advanced level certification, so NCSBN will focus its efforts there.

Progress has been made in several jurisdictions. In 2012, three jurisdictions expanded role recognition, two changed the title to "APRN" and two corrected role titles. One jurisdiction added the requirement of "national, advanced certification" and also required both RN and APRN licensure. One jurisdiction added independent prescribing and practice to one of the roles and another changed from supervised to collaborative practice and prescribing.

Communication Tools

NCSBN provides a variety of resources to assist jurisdictions with APRN Consensus, including maps, videos and marketing materials. Adding to its arsenal of information is the newly published

[A Health Care Consumer's Guide to Advanced Practice Registered Nursing](#) brochure, which explains the importance of APRNs in health care; how access to care could be increased if APRNs are allowed to practice to the full extent of their education and training; and how the APRN Consensus Model, if adopted, would reduce barriers to care in all jurisdictions. As with all NCSBN materials, this brochure is available free of charge.

Patience and Persistence

Several jurisdictions are anticipating the introduction of legislative attempts in 2013 to move closer to consensus and some jurisdictions have made huge efforts in past legislative sessions only to see them stalled or rejected. These jurisdictions and their action coalitions and grassroots efforts deserve a special mention. Movement on consensus rarely occurs in leaps and bounds; instead, it occurs after multiple attempts, much negotiation and, most of all, relentless communication with stakeholders, legislators, advocates, advisors, payers, planners and practitioners.

There is a great amount of admiration for those who learn from each attempt and regroup to try again. The maps don't display their efforts. The points, once earned, will tell their story of success, but they will be the ones to remind others of the depth of their efforts and the time devoted to it. They are the champions of APRN Consensus. Their relentless communication is not just within jurisdictions, but across borders asr stort3ub(-)Tj commu51Tāsus

Competition for clinical sites among nursing schools in the same regional area, faculty shortages, patient acuity and increasing technology in health care facilities has required educators to design innovative strategies to recreate clinical environments within the educational laboratory setting (Nehring, 2008; Glasgow, Niederhauser, Dumphy, & Mainous, 2010). Simulation experiences mimic the reality of clinical environments in a nonthreatening environment, providing students active involvement in learning, leading to increased self-confidence in their critical-thinking and problem solving abilities (Jeffries & Rizzolo, 2006). Regulatory standards and guidelines from national boards of nursing for the use of clinical simulation as an adjunct for clinical learning experiences provide a framework for the development and definition of simulation experiences within schools of nursing (Nehring, 2008). The current U.S. health care environment of change and complexity, along with the call for quality and safety, presents the opportunity to expose the next generation of nursing leaders to the professional commitment of providing patient-centered high quality care.

The George Washington University (GWU) School of Nursing embraced clinical simulation with quality competencies as a core teaching methodology in our second degree BSN program. As faculty we chose not only to embrace high-fidelity simulation as a learning technology, but to be inclusive of the Quality and Safety Education for Nurses (QSEN) initiatives and additionally, to add the peer review component in order to enrich the learning experience. Our simulation student experiences were influenced by the Vds andr define the , bu(ace.)18(onmen)111(ves tor nursiadact hours)1 mD,333 TD(oroforoforo-1.h TD 1Jr)1go TDNeexf4 to be facinders

Regulatory Perspective

The VABON, in response to various stakeholders to include health care facilities, faculty and nursing students, acknowledged the increasing complexity of nursing care required to care for patients in Virginia health care facilities by promulgating regulations setting educational direct client care hours. The regulations, effective in April 2008, required all Virginia registered nurse (RN) prelicensure nursing education programs to have a minimum of 500 direct client care hours and licensed practical nurse (LPN) education programs to have 400 direct client care hours. This change in regulation requiring specified nursing care hours led to further discussion and collaboration with stakeholders on the use of simulation in nursing education.

The Virginia Board of Nursing began the task of developing a guidance document to address the use of simulation in nursing education. The simulation guidance document (Guidance Document #90-24) for prelicensure RN programs developed by the VABON went into effect in July 2009. It states that no more than 20 percent of the 500 direct patient contact hours in prelicensure RN programs or the 400 direct patient contact hours in prelicensure LPN programs may be simulation if used in lieu of direct client care. Additionally, no more than 50 percent of the total clinical hours for any one course may be used as simulation in lieu of direct care hours. Clinical simulation is to be facilitated by qualified faculty experienced in simulation education. This document is consistent with the Model Rules for Innovative Approaches in Nursing Education Programs adopted by NCSBN Delegate Assembly in August 2009.

The VABON will monitor nursing graduate outcomes and consider developing regulations that will further define the innovative simulation approach to direct patient contact hours (Saxby, 2009). The simulation experiences developed at GWU follow the key components of this guidance document, including: the simulation experience, debriefing, and evaluation; clearly stated objectives; student preparation for the clinical experience; required orientation to both the simulation technology and the environment; and the educator assumes the role of facilitator.

continued from page 10

QSEN

The QSEN initiative identifies six competencies: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, informatics, and safety. For each competency the knowledge, skills and attitudes (KSAs) necessary for successful nursing performance have been identified (Sullivan, 2010). Our project incorporates the QSEN competencies and KSAs, and includes a student peer reviewer component. Peer review enhances a student's responsibility for learning while developing

the KSAs in the learning objectives. The QSEN competencies observation sheets for the student peer reviewer were developed by the simulation lab director.

Students are well acquainted with the QSEN initiative as it is integrated throughout the curriculum, particularly highlighted during the second semester Quality and Safety course. The use of the peer reviewer tool (Table 1, below) in clinical simulation was an exercise in the clinical application of the QSEN competencies and KSAs.

Students were exposed to the simulation experience beginning with their orientation to the nursing program. Simulation is used as an integral part of the students' learning in the required nursing labs during first and second semesters. Prior to the clinical simulation day, students received clearly stated objectives, background patient information, as well as a preclinical worksheet to guide the students as they prepared for the clinical simulation experience (Tables 2 and 3, page 13). Students are required to wear their clinical uniform and practice with professional comportment while in the clinical simulation environment.

continued from page 12

session, students were first asked to assess their clinical performance in the scenario and identify how the QSEN objectives were met. Next the students were asked to identify missed opportunities and what they would do differently if they could repeat the scenario. The debriefing session concluded with the students identifying how the clinical simulation experience will impact their practice. Students were required to complete an online evaluation of the scenarios and simulation experience. The faculty postscenario evaluation identified if scenario objectives were met and suggestions for improvements.

Conclusions

Student evaluations identified pediatric simulation as a valuable learning experience not only for integrating didactic learning with practice, but also for the knowledge enhancement of the QSEN competencies application to practice. Student evaluations acknowledged that participating as a peer reviewer allowed them to observe the scenario as it unfolded, objectively identifying the application of safe quality nursing care, as well as recognizing their own knowledge areas of strengths and weaknesses. Faculty report that the value of simulation experiences is often illustrated by students in their acute care reflective journals, which describe their confidence and ability to critically think and perform, and increased awareness of patient safety in the clinical setting. The pediatric simulation day with the peer reviewer QSEN integration is a replicable learning experience for undergraduate nursing students.

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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

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