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LEADER TO LEADER

SPRING 2022

Next Generation NCLEX® is Less Than a Year Away!

By Jason Schwartz, MS, Director, Outreach, Marketing & Advocacy, NCSBN

Jason Schwartz, MS

While clinical judgment skills tend to improve over time as nurses become more experienced, an important finding here was that a nurse cannot begin at zero.

While many educators first heard about the Next Generation NCLEX (NGN) in 2017, timed with or just ahead of the launch of the NCLEX-RN Special Research Section, our work here at NCSBN began in earnest a full decade ago. The origin of the NGN came at the January 2012 meeting of the NCLEX Examination Committee, a forum in which nurse regulators provide oversight and guidance on current and upcoming matters related to the NCLEX-RN and NCLEX-PN exams, when Texas Board of Nursing education consultant Janice Hooper, PhD, RN, FRE, CNE, FAAN posed an astute and ultimately pivotal question:

"Is the NCLEX measuring the right things?"

This is a question so foundational to any exam that it's often taken for granted. Furthermore, the triennial Practice Analyses NCSBN conducts were designed specifically to ensure the answer to this very question was always a resounding "Yes!" Nonetheless, Hooper's question was hardly perfunctory. In truth, all assessments are limited by the testing models and technology available. Just as a reading language arts teacher with only a multiple-choice test would be unable to test essay writing, we recognized there were certainly aspects of entry-level nursing concepts largely untenable through our computer-based testing environment. Principal among these was clinical judgment.

We had two choices. One was to explain why comprehensive, valid and direct measurement of clinical judgment was not possible on a large scale, high stakes, computer- based exam. The other considered exactly what successful measurement of clinical judgment would require. NCSBN opted for this latter approach, focusing not on the barriers themselves but on how to overcome them.

As our measurement and testing experts considered the creative and technological advances needed to assess clinical judgment, we also conducted two studies, a literature review and a strategic practice analysis, ascertaining the criticality of clinical judgment to competent entry-level

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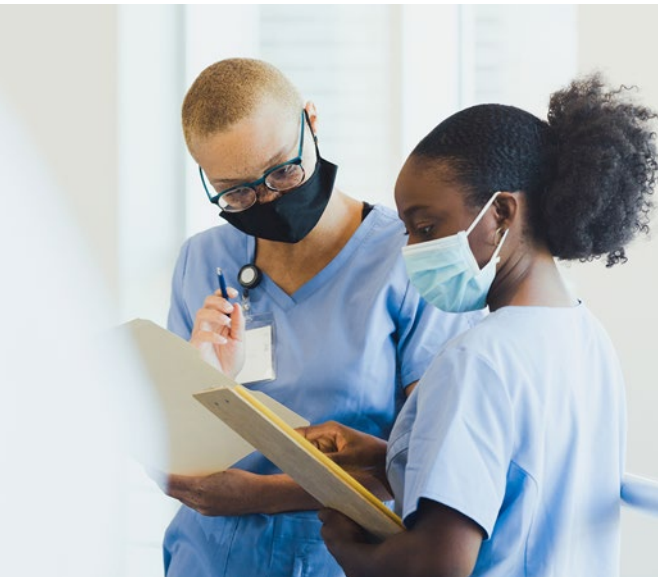
nursing practice. While clinical judgment skills tend to improve over time as nurses become more experienced, an important finding here was that a nurse cannot begin at zero. Some baseline level of clinical judgment is required to provide safe and effective care, even at the entry level.

Finally, a fresh approach to testing accommodations was required, recognizing that not all NGN item types would be accessible to our full testing population.

The lingering question following these studies was not whether or why clinical judgment should be part of the NCLEX, but how? How could clinical judgment be measured? Fundamentally, our early work was focused on two areas:

- Building a measurement framework that formulated clinical judgment as a collection of interconnected and testable skills; and
- Devising new item types specifically designed to measure these skills.

The first of these endeavors led to the NCSBN Clinical Judgment Measurement Model (NCJMM) while the second led to a variety of novel item formats such as extended multiple response, matrix/grid and "bowtie" drag-and-drop.



As our NCJMM and corresponding item prototypes advanced and evolved, including through usability studies, we began to believe that we had cracked the code. However, the rigors of the NCLEX demanded more than simply opinion. Evidence in the form of real candidate data would be needed, hence the genesis of the NCLEX-RN Special Research Section® in July 2017, with the corresponding NCLEX-PN Special Research Section® launching in October 2020. As candidate responses came in literally by the tens of thousands, we had something of a checklist, dubbed our validity framework, comprised of various questions that needed answers.

First and most foundational among them was the issue of dimensionality, a testing concept that in our case considered whether clinical judgment was different enough from the rest of the NCLEX as to require its own scale. A familiar example is a college entrance exam containing two sections: one on mathematical reasoning and one on verbal reasoning. Here the constructs are different enough that such an exam would need to generate two separate scores, presenting decision makers with possibly nontrivial decisions on how to combine or weight the different results. Specific to the NCLEX, our dimensionality studies verified that clinical judgment was not a separate dimension from what was already being measured. On the contrary, it was simply an important aspect of the existing nursing domain. In practical terms this result meant that the NCLEX could continue with a single estimate of candidate ability, a single passing standard and a single pass/fail outcome.

Subsequent studies looked specifically at item prototypes (some of which fared extremely well and others of which were ultimately discarded or revised), new partial credit scoring models, and overall test design (e.g., the optimal number of case studies to include). Meanwhile, existing test development activities such as item writing workshops, bias/sensitivity review, and standard setting were adapted to ensure appropriateness to the multitude of changes in content, format and focus. Notably, French translations were required as well to support the continuing use of the NCLEX-RN by Canadian regulatory bodies. Finally, a fresh approach to testing accommodations was required, recognizing that not all NGN item types would be accessible to our full testing population.

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Today, with the April 1, 2023, launch of the NGN less than a year away, our technical focus is on the refinement and quality assurance of the software and data reporting systems, including "beta" and end-to-end testing, while a second equally strong focus is on communication and outreach. Through conference presentations, webinars and website resources, we want to be sure that educators, candidates and other stakeholders all have real-time access to the most current and accurate information about the exam. As the countdown to launch is now measured in months and weeks rather than years, we can look back on the significant body of research that brought us here. Or we can look ahead, recognizing that excellence in testing and public protection will continue to demand fresh insights and innovations, not just in 2023 but always. ◆

Q & A How has COVID-19 impacted nursing education?

Many nurse educators have asked the same question. You may be aware of continuing NCSBN research on this question: NCSBN's National Prelicensure Study: Assessing the Impact of COVID-19 on Nursing Education. In this longitudinal study, we are looking at outcome measures related to the changes in education that were made during the pandemic. A unique feature of this study is that not only are we measuring the outcomes from the fall of 2020 through the spring of 2022, but we will also follow a cohort of these new graduates into their first three months of practice. *Leader to Leader* will alert readers when the results of this study are published in the *Journal of Nursing Regulation (JNR)*. Stay tuned!

In the free January *JNR* supplement, NCSBN published a comprehensive environmental scan of the current state of nursing, health care and regulation in the year 2022, with information on the nursing workforce, nursing education, health care delivery, legislation and policy issues. The section on nursing education highlights the research and literature available on the impact of COVID-19 on nursing education, which include:

- Students graduating during the pandemic felt unprepared to practice.
- Students expressed concerns about lacking in-person clinical experiences.
- Some students had a difficult adjustment to online learning.
- Future nursing education planning should include how disasters may affect students, their clinical preparedness, collaborative agreements and regulatory requirements.
- New graduate employment in 2020 showed a slight decrease.
- There were unique changes to new graduates' transition into practice because of the alternative nursing education teaching-learning strategies that were used in their programs.
- More rigorous research is needed on the use of one hour of simulation to replace two hours of clinical experiences, the use of virtual reality to replace clinical experiences, and on what constitutes quality clinical experiences.

For more detail, please access *JNR*'s 2022 Environmental Scan. There are some excellent data in *JNR*'s supplements (such as our environmental scans, national workforce data, nursing education evidence-based quality indicators, etc.), and they are always free of charge to the public. ◆

Infusing Clinical Judgment into the Curriculum: Gearing up for the Next Generation NCLEX®

By Lisa Gonzalez, MSN, RN, CNE, CCRN-K, Professor in Nursing, College of Southern Maryland

Lisa Gonzalez, MSN, RN, CNE, CCRN-K

With the Next Generation NCLEX (NGN) only a year away, *Leader To Leader* asked Lisa Gonzalez to provide educators with practical tips on how they can integrate clinical judgment into their curricula.

A recent national survey demonstrates methods nurse educators are taking to improve teaching and learning for the development of students' clinical judgment (Jessee, et. al., in press). Many programs have already begun integrating or are planning to integrate a clinical judgment model into their nursing curricula, such as the well-known Tanner's Clinical Judgment Model (2006). Teaching strategies, including simulation, case studies, questioning, and reflection, are frequently used to facilitate students' clinical judgment (Gonzalez et. al., 2021b). However, implementing teaching strategies as per usual is not enough to adequately develop students' clinical judgment (Tyo & McCurry, 2019). We must transform our current approaches, infusing the evidence to make the greatest impact.

These were found to be essential for implementing effective teaching strategies for clinical judgment development (Gonzalez et. al., 2021a; Tyo & McCurry, 2019):

- Integrating a clinical judgment model into teaching and learning;
- Teaching with intention to cognitive components associated with clinical judgment; and
- Considering evidence-based practices.

Clinical judgment models that guide curriculum design and provide a framework to support learning activities increase focus on clinical judgment. Additionally, aspects of Tanner's Clinical Judgment Model (such as noticing, interpreting, responding and reflecting) can be used in teaching/learning activities for purposes such as to structure reflective writing assignments (Lasater & Nielsen, 2009; Smith, 2021), frame simulation scenarios (Jang & Park, 2021), and for debriefing (Bussard, 2016). The model can also be used for assessment/evaluation, for example, to develop assessment rubrics for concept mapping learning activities (Gerdeman et. al., 2013) and other learning experiences that promote clinical judgment development (Wright & Scardaville, 2021). The Lasater Clinical Judgment Rubric (Lasater, 2007), which expands on Tanner's aspects through the addition of eleven dimensions, is also a useful framework to support teaching and learning (Gonzalez, 2018; Lasater et. al., 2014; Nielsen, et. al., 2016) and assessment/evaluation (Georg, et. al., 2018; Lee, 2021), which is grounded in clinical judgment.

Nurses make clinical judgments as they use clinical reasoning skills to make sense of patient care situations. However, nursing students do not enter our curricula with

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proficiency in these complex skills (Ashley & Stamp, 2014; Hunter & Arthur, 2016), so we must teach them. Educators can raise student awareness by guiding them through the cognitive components involved in noticing, interpreting, responding and reflecting. Individual learning activities could highlight a particular component of clinical reasoning. Here are some examples:

Educators can raise student awareness by guiding them through the cognitive components involved in noticing, interpreting, responding and reflecting.

- You can teach the art of *noticing* with a simulation lab where students identify what is hazardous in the clinical environment.
- Concept mapping strengthens *interpreting* as students establish and explain relationships between aspects of care.
- Learning activities for *responding*, such as SBAR (situation, background, assessment, recommendation) and patient rounding, give students opportunities to practice concise communication of patient-care priorities.
- *Reflective learning* activities such as journaling and debriefing promote metacognition, or awareness of thinking, through reflecting-on-action and revisiting the thinking behind decision-making.

Learning cognitive skills specifically for clinical judgment requires practice and metacognition to become part of a student's repertoire. Concept-based learning offers a promising approach as students and the instructor take time to explore physiologic concepts and key aspects of patient care, integrating theoretical with practical knowledge in order to identify salient features of a patient's presentation (Nielsen, 2016). Cognitive linkages are formed as students identify common threads between patients with similar diagnoses. Concept-based learning is also useful to teach clinical reasoning concepts and structure clinical learning. A new topic grounded in clinical reasoning is unpacked each clinical day through discussions, debriefing and learning activities (Gonzalez, 2018).

Further development of student thinking occurs with the use of high-order questioning inspired by clinical judgment. Instead of listing assessment findings, ask students to choose a focused assessment, describe why they chose the focused assessment and then consider how the focused assessment guides patient care. Focused assessments allow nurses to monitor patients' stability, identify complications and catch early decline (Lavoie et. al., 2020). High-level questioning also teaches students to think abstractly and creatively and encourages them to practice applying their knowledge to patient care (Merisier et. al., 2018; Vacek & Liesveld, 2019). Questioning to promote higher-level thinking utilizes open-ended questions that stimulate thinking rather than closed-ended questions that elicit a one word or simple yes/no response. A high-level questioning strategy is versatile and adaptable across educational settings, including simulation, debriefing, clinical and the classroom (Lasater, et. al., 2014; Gonzalez et. al., 2021a). The possibilities are numerous:

- Create questions that encourage students to notice alarming assessment findings in a case study;
- Present a patient case in class and use interpreting questions to unpack patient care priorities;
- Pause a simulation to ponder questions that help students determine their next best response; and
- Tailor debriefing questions to deeply reflect on action and consider future actions.

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Promoting Confidence

As students become familiar with and gain skill in clinical judgment, we should also consider how to develop students' confidence. A research study by Fagan et. al. (2016) found that clinical judgment and confidence are two characteristics essential to the ability of nurses and students to speak up about patient care situations. Students or new nurses may demonstrate skillful clinical reasoning that leads to sound clinical judgment, but if they do not have the confidence to speak up when problems arise, we have failed to provide safe patient care. Confidence and clinical judgment develop over time through supportive dialogue, meaningful feedback, reflective self-analysis, and by creating safe learning spaces that provides challenges without being threatening (Jessee, 2018; Monagle et. al., 2018; Weimer, 2013; Wright & Scardaville, 2021).

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Debriefing is one strategy that can be used to promote confidence and clinical judgment. Debriefing is a student-centered approach that extends thinking about and reflecting on the patient care experience (Sabei & Lasater, 2016). Although debriefing is commonly associated with simulation, given time and space, the strategy is beneficial in a variety of educational settings including clinical and classroom (Driefuerst, 2015). For example, adding a mid-shift clinical conference allows time to debrief patient care experiences and offers the additional benefit for students to immediately apply new knowledge back to the patient care experience during the second part of the clinical shift (Gonzalez 2018). One student's patient becomes a learning experience for all.

As nurse educators continue the work of teaching to develop students' clinical judgment, we must consider how we infuse current evidence into our teaching strategies. Do strategies intended to promote student development of clinical judgment produce desirable results? Intentional and empathetic use of a clinical judgment model to frame teaching and learning strategies that foster development of the cognitive components of clinical judgment, including thought-provoking questions, conceptual learning activities, and debriefing, demonstrates promise for facilitating student learning of clinical judgment.

The author would like to acknowledge the expertise and feedback of Janet Monagle, PhD, RN; Mary Ann Jessee PhD, RN; Kathie Lasater, EdD, RN, ANEF, FAAN; and Ann Nielsen, PhD, RN.

A complete list of references can be found on page 17. ◆

Take-home points for faculty when integrating clinical reasoning into their curricula:

1. **Think of clinical judgment as a set of clinical reasoning skills that you can teach.**
2. **Consider adapting a currently used learning activity into a clinical judgment framework (e.g., turn a narrative journaling assignment into a structured reflective exercise).**
3. **Introduce clinical judgment early in the program and thread clinical judgment model terminology throughout nursing curricula to improve familiarity and alignment.**
4. **Create safe learning environments to grow students' confidence and clinical judgment.**

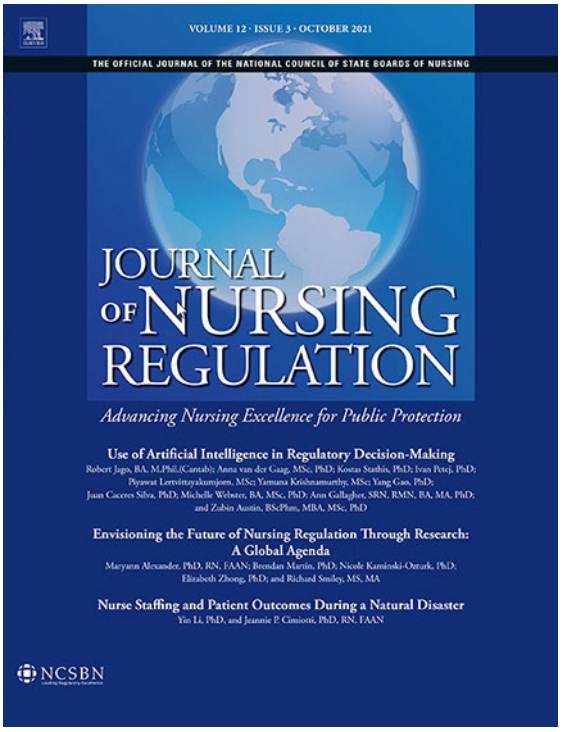
From the *Journal of Nursing Regulation*:

"An Update on Clinical Judgment in Nursing and Implications for Education, Practice, and Regulation"

By Nancy Spector, PhD, RN, FAAN , Director, Regulatory Innovations, NCSBN

Nancy Spector, PhD, RN, FAAN

Periodically in *Leader to Leader,* we will highlight articles from the *Journal of Nursing Regulation (JNR)* that are of interest to our readers. *JNR* is published quarterly and has cutting-edge articles and research on the regulatory/policy perspective of education and practice. For example, faculty across the world are familiar with *JNR*'s seminal "The National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Education," by Hayden et al. (2014). This study was first published in a *JNR* supplement, and it has been cited in Scopus by 492. Of note, all JNR supplements are free to the public. Other *JNR* articles include those on evidence-based quality indicators of nursing education programs; nursing workforce data; the current state of nursing, health care and regulation, just to name a few.



Because this issue of *Leader To Leader* focuses on the impending launch in one year of the Next Generation NCLEX, we thought our readers would be interested in Mary Ann Jesse's article in the October 2021 issue of *JNR,* entitled, "An Update on Clinical Judgment in Nursing and Implications for Education, Practice, and Regulation." In this article, Jesse first provides an update on the science of clinical judgment. As part of this, she clearly delineates the differences among critical thinking, clinical reasoning and clinical judgment. Jesse writes how Tanner's (2006) analysis of clinical judgment "disrupted" nursing education's reliance on the nursing process and provided a framework for how nurses can make decisions about care. In Tanner's framework, the background knowledge and experience of the nurse is crucial. Jesse explains, therefore, how "noticing" is different from "assessment," in that it is influenced by the nurse's past experiences. Similarly, she explains how "interpreting" expands upon "analysis and planning;" "responding" expands upon "implementation;" and "reflection," rather than "evaluation," allows the nurse to evaluate the patient response in real time. Jesse encourages nursing programs to use a clinical judgment model (she references several) to inform the curriculum so that clinical judgment can be consistently integrated. Jesse provides current best practices when teaching clinical judgment, including teaching and learning strategies, clinical coaching, simulation and debriefing, and during clinical experiences with patients.

Jesse illustrates how clinical judgment is critical to patient safety, and the lack of it contributes to the often-cited practice-education gap. She writes about how the

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expanding nursing curriculum and the changing context of practice add to the complexity of what students must learn. Therefore, Jesse emphasizes that, while an understanding of prevalent disease processes and associated nursing interventions is important, this must be coupled with the development of clinical judgment.

Jesse calls for "collaborative, novel actions" to establish a national model for improving clinical judgment.

Jesse highlights the challenges with providing optimal clinical experiences, such as scarcity of experiences, lack of access to medical records, and the focus on "task completion," rather than on demonstrating practice competencies. We must, she says, accept the reality that the lack of meaningful clinical experiences hampers the development of competencies needed for safe practice, and she encourages academia, practice and regulation to collaborate to establish a realistic expectation for new graduates so that they can provide safe and competent nursing care.

Jesse concludes with recommendations for education, practice, regulation and accreditation. She calls for "collaborative, novel actions" to establish a national model for improving clinical judgment. I highly recommend this article to educators. ◆

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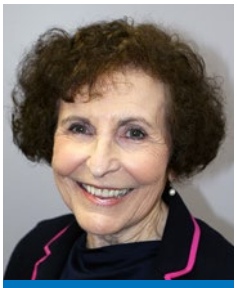
What is a "Quality" Nursing Education Program?

By Janice Hooper, PhD, RN, FRE, CNE, FAAN, Nursing Consultant for Education, Texas Board of Nursing



Janice Hooper, PhD, RN, FRE, CNE, FAAN

Every nursing program wants to be known as a quality program, but there was no evidence about what constitutes quality before an NCSBN study published in 2020 (Spector et al., 2020). The large mixed-methods study that began in 2017 collected nationwide quantitative (five years of annual reports) and qualitative (five years of site visit documents) data from nursing regulatory bodies (NRBs) and surveyed education consultants, nursing faculty and practicing nurses using a Delphi method for analysis. Additionally, an integrative literature review was completed. A panel of experts, including representatives from the American Association of Colleges of Nursing, the National League for Nursing and the Organization for Associate Degree Nursing, convened to establish evidence-based regulatory guidelines and quality indicators for nursing education programs.

The Texas Board of Nursing uses the NCSBN quality indicators to assess their nursing programs, either during a review of a self-study report or a survey visit. These are not administrative rules, but they do represent goals to which programs may aspire.

These quality indicators have been presented to a very interested audience of Texas program deans and directors at various meetings. When the quality indicators have been validated during a survey visit, the education consultant acknowledges the evidence of their presence during the exit interview that includes school officials and administrators. This leads to an opportunity to discuss all of the quality indicators, as well as warning signs. Here are some examples of the quality indicators and the discussions that ensue:

ADMINISTRATION AND PROGRAM

1. **Administrative support of the nursing program:** It is evident that the school administration expresses and provides positive support of the program with adequate resources for a successful program.
2. **Consistent leadership in the nursing program:** The program director has served in the role as leader of the program for a number of years with the intent of providing ongoing excellence in the position.
3. **Administrative support for ongoing faculty development:** There should be a plan for the ongoing development of each faculty member with funding to support the process. Continuing education not only educates faculty but energizes them for better teaching.
4. **National nursing accreditation:** Nursing programs that hold national nursing accreditation have a history of better educational outcomes for graduation rates and NCLEX results. Standards for accreditation often require a nursing program to move to a higher level of educational quality, whereas Texas Board rule requirements focus on preparing the graduate for entry-level practice.
5. **Consistent NCLEX pass rates:** The consistency of the annual pass rates is more important than each pass rate. If a program's pass rate fluctuates widely each year, it is matter of concern.
6. **Ongoing systematic evaluation of the nursing program:** A total evaluation plan is the heart of a nursing program. Ongoing systematic evaluation will identify weak areas so that improvements can be made to keep a program strong, current and exciting.

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7. **Comprehensive student support services:** When this is missing, the school often relies on nursing faculty to be the counselors, advisors, tutors and admission coordinators. This takes away from their main purpose to facilitate the curriculum and learning.

8. **Admission criteria that emphasize a background in the sciences:** A requirement for studies in the sciences, as an admission criterion, has been shown to increase the likelihood that an applicant will be successful in a nursing program.

FACULTY

9. **Consistent full-time faculty as opposed to reliance on adjunct faculty:** Nursing faculty who maintain a commitment to a program gain experience not only as faculty, but also with the particular curriculum. It may be necessary to hire some adjunct faculty, but their familiarity with the curriculum and the students is not as strong as full-time faculty and often adjunct faculty have no stake in the program.

10. **Faculty with current clinical competence:** Faculty should be allowed and expected to maintain their clinical skills through actual practice, shadowing nurses in the affiliating agencies, supervising students in the clinical area and maintaining currency through continuing education.

11. **Faculty are able to role model professional behaviors:** It has been said that students learn to be just like their faculty because of the modeling. Students learn skills from the faculty, but they also learn how to act in the role and how to interact with patients, patients' families, nurses and other members of the health care team.

CURRICULUM

12. **Evidence-based curriculum that emphasizes critical thinking and clinical reasoning skills:** The curriculum should focus on teaching students to critically think through patient situations and make clinical judgment based upon their knowledge and skills. This is especially important in preparation for the Next Generation NCLEX.

13. **Evidence-based curriculum that emphasizes quality and safety for patient care:** The faculty should conscientiously and continuously emphasize quality and safety, and question students about their interventions to advocate for patient safety.

CLINICAL EXPERIENCES

14. **Clinical experiences with actual patients that prepare students for the reality of clinical practice:** Hands-on experiences occur where there are patients receiving nursing care and these learning opportunities are essential in a nursing program. A balance of clinical learning includes skills labs, a variety of simulation experiences and nursing care of actual patients.

15. **Opportunities for a variety of clinical experiences with diverse populations:** This is best done by allowing students practice experiences in a number of different clinical or community areas. A mixture of clinical settings will promote meeting this quality indicator.

16. **Quality simulation to augment clinical experiences:** This refers to the use of high-fidelity simulation experiences under the supervision of trained faculty and including debriefing and feedback. These promote student readiness for hands-on experiences with actual patients in clinical settings, and also allow experiences not always available in the clinical setting.

17. **A systematic process to address and remediate student practice errors:** This indicator requires that faculty carefully assess students in the clinical area and provide remediation for practice errors or near misses, thus promoting safe and skillful practice.

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18. **Collaboration between education and practice when planning clinical experiences:** The literature stresses, and research supports, that students' clinical experiences are more valuable when there are good relationships between the program and the clinical setting. This takes effort on the part of everyone involved: nursing director, faculty, students, and practicing nurses on the unit. Faculty should be able to discuss how this is done and its effectiveness.

Programs are not recognized for possessing quality indicators unless there is specific evidence of their presence through conversations, documents and demonstration. Few programs will possess all of these quality indicators. Quality indicators are not board requirements, but represent measures of excellence in performance, policy and process. Programs can use them to measure their quality and identify areas for quality improvement.

The NCSBN study provides additional guidelines in the publication, including recommendations for nursing education programs. ◆

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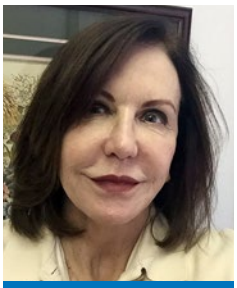
Faculty Assist with Internationally Educated Nurse Licensure: An Exemplar

By Virginia Ayars, EdD, MS, RN, CNE, Nursing Consultant for Education, Texas Board of Nursing and Kimberley Kelly, DNP, MSN, RN, LNC, President/VN Program Director, Vocational Nursing Institute, Inc.



Virginia Ayars, EdD, MS, RN, CNE

Kimberley Kelly, DNP, MSN, RN, LNC

The nursing shortage in Texas, and in the U.S., continues to increase. Predicted shortfalls indicate a deficit of 12,572 licensed vocational nurse (LVN) full-time employees (FTEs) and 57,012 registered nurse (RN) FTEs in Texas by 2032 (TCNWS, 2020). As a result, health care facilities are recruiting internationally educated nurses (IENs) to address the shortage. The Texas Board of Nursing (BON) is the third largest approver of international candidates' applications to take the NCLEX, behind New York and Illinois (M. Majek, personal communication, August 13, 2021). According to the Texas BON database, the 463,013 licensed nurses in Texas include 105,610 LVNs (362 internationally educated) and 357,403 RNs (30,919 internationally educated); therefore, IENs make up a total of 6.76% of licensed nurses in Texas (D. Fletcher, personal communication, August 30, 2021).

To become licensed as a licensed vocational nurse (LVN) or registered nurse (RN) in Texas, an IEN must have graduated from an accredited nursing program within the last four years, or if the individual graduated from an approved foreign nursing education program more than four years ago, must have practiced nursing within the past four years. Internationally educated applicants will also need to fulfill the Texas BON's requirements before being considered for licensure. One of these requirements is the completion of a Credentials Evaluation Service (CES) report.

> Often when Texas BON staff evaluate a candidate's CES report, staff identify a deficit in didactic and/or clinical learning experiences in one or more of the mandated content areas.

Often when Texas BON staff evaluate a candidate's CES report, staff identify a deficit in didactic and/or clinical learning experiences in one or more of the mandated content areas. One Texas rule requires that vocational nursing education programs must include content in nursing care of children, maternity nursing, nursing care of the aged, nursing care of adults and nursing care of individuals with mental health problems. Another rule mandates that professional nursing education programs must offer content in the following five areas: medical-surgical, geriatric, maternal/child health, pediatrics and mental health nursing. This is the case for most nursing regulatory bodies (NRBs). If faculty are not sure of their state's rules, they should review their nurse practice act (NPA). When content deficiencies are noted in Texas, the staff notifies the applicant to locate a Texas BON-approved nursing education program that would accept the applicant as a nondegree seeking student to complete the required didactic and/or clinical learning experiences. This article provides a few tips to faculty who might be able to assist international applicants who need additional content.

Although the candidate's NCLEX results are not considered as part of the program's pass rates, it is often difficult for a candidate to secure these opportunities. In particular, many program directors are reluctant to allow international graduates to actively

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engage in face-to-face clinical learning experiences. However, in July 2021, Kimberley Kelly, DNP, MSN, RN, LNC, president/director of the Vocational Nursing Institute, Inc. (VNI) Vocational Nursing Education Program in Houston, agreed to assist a Canadian LVN, Jensen Carne (in the Village of Glennloch Farm's skilled unit), whose application indicated Carne had completed a pediatric didactic course, but was provided no pediatric clinical learning experiences in her Canadian prelicensure vocational nursing education program.

Kelly began by assessing Carne's knowledge, skills and abilities, and subsequently designed a targeted plan to ensure her competency prior to providing direct hands-on patient care. The pediatric course for Carne included the following learning activities:

Jamie Marshall, DC, and Jensen Carne at a Community Clinic

- Clinical schedule with pediatric opportunities;
- Journal entries for each daily experience;
- Self-reflection activities;
- Use of Swift River simulation (med pass, pediatric client care);
- Use of Shadow Health simulation (virtual pediatric module);
- Direct supervision by VNI staff in clinical settings;
- Clinical canvas entries documenting student experiences;
- Textbook issuance;
- Enrollment as any other student, however limited to this eight-week course;
- Grading 90% performance-based, 10% paperwork based per VNI syllabus;
- Pediatric camp clinical experience (assessments, med pass, med reconciliation);
- Transcript provided at the end of course for pediatric clinical;
- Recommended enrolling in an NCLEX-PN review course; and
- Recommended Assessment Technologies Institute (ATI) review and contacting them for NCLEX prep in the U.S.

Kelly designed a customized pediatric clinical enrollment agreement, syllabus, clinical canvas and workable schedule for Carne. She also ensured that VNI issued a school name badge and uniform patch for clinical to facilitate Carne feeling that she is a part of VNI and a valued team member.

The timing of this request was fortunate in that VNI offered a pediatric clinic in mid-August at an elementary school where the school nurse may see up to 45 children per day. A preceptor supervised Carne in this setting. Further, Kelly serves as the health director for an equestrian pediatric camp and, under her supervision, Carne was able to participate in nursing assessments for check-in, medication reconciliation, medication passes, as well as being on call for emergencies 24 hours per day, seven days per week, for the four-week duration of the camp. Observation activities were scheduled for Carne in community clinics.

This exemplary model demonstrates how Nursing Program Directors can assist IENs who wish to enter the nursing workforce yet need additional education to validate competency and meet NRB licensure requirements. Careful management (including awareness of cultural differences, workplace values and individual support) is required to successfully integrate IENs into the nursing workforce.

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This exemplary model demonstrates how Nursing Program Directors can assist IENs who wish to enter the nursing workforce yet need additional education to validate competency and meet NRB licensure requirements.

"It is important for our program directors and deans in our Texas schools of nursing to assist the IENs to complete their required clinical hours so that they may become a part of our Texas workforce and help provide care to our Texan citizens," says Kelly. "We will all need the help, especially with the nursing shortage we are facing, the pandemic, and overall need of our citizens." ◆

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Graduates of the ICRS certificate program at the ICRS Advanced Leadership Institute April 6-7, 2022, in Washington, D.C.

ICRS Certificate Program Participants Gather for the First ICRS Advanced Leadership Institute

ICRS
International Center for Regulatory Scholarship

The International Center for Regulatory Scholarship (ICRS) was launched by NCSBN in 2019 to provide nursing regulators, health policy leaders and other professionals from around the world the opportunity to learn, network and discover their leadership potential. ICRS's pinnacle offering is the ICRS certificate program—a pioneering, competency-based online and blended course of study—designed to enrich and inspire those entrusted with patient safety.

The culmination of the ICRS certificate program is the ICRS Advanced Leadership Institute, a conference where ICRS participants hear world-renowned speakers, network with their peers and enjoy a celebratory graduation ceremony and dinner. The first ICRS Advanced Leadership Institute was held April 6-7 in Washington, D.C.

The ICRS certificate program will continue to invest in the educational and professional growth of global health professionals to further NCSBN's mission to empower and support nursing regulators in their mandate to protect the public.

Details on How to Apply to the ICRS Certificate Program ◆

ANNOUNCEMENT:

NCSBN's International Center for Regulatory Scholarship (ICRS) Seeking Academic Partnerships

The ICRS provides unprecedented opportunities for nursing and policy leaders from around the world to learn, network and collaborate.

ICRS is seeking partnerships to offer reciprocal courses toward graduate-level degrees in public or health policy, nursing, public health, health care administration and leadership.

We want to partner with select academic institutions to promote regulatory science and help equip future health care leaders with the knowledge, skills and abilities needed to succeed in the complex and ever-changing fields of nursing, health care delivery and health profession regulation. Students will also have access to NCSBN's Center for Regulatory Excellence (CRE) which offers unique opportunities to serve as paid NCSBN Scholars in Residence for graduate students or faculty, as well as grants to graduate students and seasoned researchers for scientific research projects related to nursing regulation and policy.

We are looking for universities to partner with us to make this opportunity a reality.

RFPs are now being accepted. The application can be accessed at: www.ncsbn.org/16642.htm.
Contact icrs@ncsbn.org for more information. ◆

Proposal Deadline June 16, 2022

Compacts Update:

Nurse Licensure Compact (NLC) Grows to 39 Jurisdictions

On Feb. 1, 2022, Vermont joined 35 other jurisdictions that have implemented the Nurse Licensure Compact (NLC). New Jersey implemented on Nov. 16, 2021. Three jurisdictions — Ohio, Pennsylvania and the U.S. Virgin Islands — have enacted the compact and are awaiting implementation.

The NLC allows registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) to have one multistate license, with the ability to practice in-person or via telehealth, teach via distance education and provide patient consultation in both their primary state of residence and other NLC jurisdictions.

In most states, boards of nursing (BONs) require faculty to be licensed wherever they are teaching students, whether it is a clinical or a didactic course. Therefore, if an educator has a multistate license in an NLC state, and their students are located in other NLC states, they do not need an additional license to teach in those states.

Shiela Boni, MSN, RN, executive officer, Vermont State Board of Nursing, said, "We are thrilled to partner with the other compact states in our shared mission to protect public safety while providing mobility to Vermont nurses, as well as nurses across the nation, who are seeking the lifestyle and collaborative practice environment that Vermont offers."

On Dec. 13, 2021, the U.S. Virgin Islands also enacted the NLC. An implementation process must be completed before its residents will be able to apply for a multistate license and before nurses in other NLC states who hold a multistate license will be able to practice there.

See the map of current NLC states. For more information about the NLC, visit www.nlc.gov, or contact nursecompact@ncsbn.org

Three States have Enacted the APRN Compact

Utah's recent enactment of the APRN Compact on March 24, 2022, brings the total number of enacting jurisdictions to three. Delaware and North Dakota enacted in 2021. The APRN Compact will be implemented when seven states have enacted.

Through the APRN Compact, APRNs will have the ability to travel from state-to-state to deliver care or provide telehealth services across state borders in other compact states without getting additional licenses. This will increase patient access to high-quality care with the assurance that their practitioner has met rigorous uniform standards no matter where that care is provided.

Pamela C. Zickafoose, EdD, MSN, RN, NE-BC, CNE, FRE, executive director, Delaware Board of Nursing, commented, "I would like to thank our General Assembly legislators, Gov. Carney, and Lt. Gov. Hall-Long who supported both bills. In addition, I am very appreciative of the dozens of organizations and APRNs who wrote letters of support, contacted their legislators, and met with various stakeholders to educate them and reinforce the purpose and importance of these bills. The positive results were the product of professional nurses working together and communicating the same message to achieve a common goal. This is an historic event for APRNs in Delaware and I hope other states will follow our lead!"

For more information about the NLC, visit aprncompact.com. ◆

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LEADER TO LEADER

NCSBN

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 www.ncsbn.org

Phone: 312.525.3600

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