While planning for course innovation,
Our mantra for nurse education
Is, "Please be aware
That face-to-face care
Is vital for nurses' formation."
Introduction
Because U.S. states, territories, and the District of Columbia approve nursing programs, it is important for educators to understand the regulatory perspective on clinical education in nursing prelicensure programs. This chapter will explore in detail the regulatory perspective on clinical education and why boards of nursing take the position that nursing programs need to provide supervised clinical experiences for their students. Some of the myths about regulatory barriers are dispelled, and some of the differences among boards of nursing are discussed. Current issues, such as the regulatory perspective on the use of simulation in prelicensure programs and the use of exit exams, are also explored. Lastly, the importance of collaboration between education, practice, and regulation is integrated throughout the chapter.

Background of Regulation in Nursing Education
In 1903, North Carolina enacted the first registration law for nursing, followed by New York, New Jersey, and Virginia (Dorsey & Schwalter, 2008). Soon thereafter, boards of nursing began to regulate nursing. The mission of all 60 boards of nursing in the United States is to protect the public. Boards of nursing accomplish this through four major domains: (1) approving and enforcing educational standards, (2) licensing on the basis of psychometrically and legally defensible testing, (3) monitoring and decision making related to practice issues, and (4) using the disciplinary process to remove from practice those nurses who fail to maintain standards (Hudspeth, 2008).

By 1906, inspectors of schools or hospitals with nurse training programs began making program visits for regulatory approval. As boards of nursing developed, they began approving nursing education programs as part of their mission to protect the public. Currently 58 of the 60 boards of nursing approve nursing education in their jurisdiction. Furthermore, in the other two states (Mississippi and New York), approval is done through the Board of Higher Education by nurses who hold an earned doctorate. A more detailed history of the regulation of nursing education programs in the United States, and the processes used when approving programs, can be found elsewhere (NCSBN, 2004b; Spector, in press).

Approval of nursing programs ensures that nursing is practiced by minimally competent licensed nurses within an authorized scope of practice. With the Institute of Medicine’s (IOM) report on medical errors (Kohn, Corrigan & Donaldson, 1999), followed by other IOM and national reports on safety in health care, national attention has been directed to patient safety issues. While nurse leaders assert that there is a direct relationship between safe patient care and the quality of nursing programs (ICN, 1997), nurse researchers need to conduct studies that document this relationship between nursing education and patient outcomes.

It is also important for educators to remember that the licensure examinations, the NCLEX-RN® and NCLEX-PN®, are not designed as stand-alone assessments of the ability to practice nursing. Passage of the licensing examination is predicated on the nurse graduate successfully

1 The boards of nursing reside in the 50 states; four states have a registered nurse board and a practical nursing board; one state has an APRN board; the District of Columbia and four territories each have a board.
CLINICAL EDUCATION AND REGULATION

completing a board-approved nursing education program. Therefore, while regulators have the responsibility for approving nursing programs, educators have the responsibility for deciding whether the student should graduate, thereby affirming that the student is safe, clinically competent, and eligible to take the NCLEX®. This decision by faculty members should not be taken lightly.

Another regulatory principle that is important to nurse educators is that nurse licensure is for general nursing practice. In other words, nurses who graduate from prelicensure programs are not licensed for specialties, such as obstetrics or medical-surgical nursing. Thus, when boards of nursing review nursing programs, many of them look for learning experiences across the lifespan. Educators sometimes argue that students should be able to specialize in a field of their choice, especially during these times when clinical experiences are hard to find. However, because licensure covers a broad practice, such an option is not feasible for regulation. Educators, therefore, need to explore creative clinical experiences, such as using day care centers, physician or nurse practitioner offices, or schools for pediatrics experiences. There are some excellent innovative clinical models available (Gubrud-Howe & Schoessler, 2008).

How Regulation of Nursing Education Varies Across the Jurisdictions

Educators often complain about the inconsistency in nursing regulation of education programs across the United States. There is no doubt that this inconsistency exists, and it is particularly the case for practical nursing programs. Processes of approval vary across the country, so that educators, particularly administrators, often find it difficult when they move from one state to another and take a new position. In the fall issue of NCSBN’s Leader to Leader, Hobbs (2007) discusses the implications of these inconsistencies when educators move to other states and offers some tips to effectively manage the differences (see Box 12-1). For example, one state might require 500 hours of clinical experience and limit the faculty-student ratio in the clinical setting to 1:10, while another state may have no minimal requirements for clinical hours but allow only a 1:8 ratio in clinical; still another might have no requirements for either of those situations.

Other differences are that at least one board (Louisiana-RN) regulates nursing students in that jurisdiction. In most states, practicing nursing as a student who is enrolled in an approved nursing program is an “exempted” or “excepted” practice in the practice act (see the discussion below under Myth #3). However, in the Louisiana-RN board, while students are not licensed, they are under the jurisdiction of the board and can be disciplined for violating their provisions.

Other states require that the board of nursing be notified in writing of any change in faculty and program administrator positions (Hobbs, 2007). A comparison of nursing education requirements across the boards of nursing can be found in the National Council of State Boards of Nursing’s (NCSBN) Member Board Profiles (NCSBN, 2007). This document can be valuable

2 The National Council of State Boards of Nursing (NCSBN) is a national organization, composed of the boards of nursing, and its mission is to provide leadership to advance regulatory excellence for public protection.
Box 12-1
Regulatory Tips When Educators Move (Hobbs, 2007)

For All Faculty
- Once contracts are finalized, initiate licensure by endorsement. This can take months in some states; others might be able to provide a temporary work permit.
- Read new jurisdiction’s nurse practice act and education administrative rules (often available on the Web). Most have curricular requirements, such as student-faculty ratios.
- Is there oversight of RN to BSN programs or MSN programs?
- Texas requires a jurisprudence exam (assessment of knowledge of the nurse practice act and administrative rules) for all nurses who it endorses; see http://www.bon.state.tx.us/olje.html. Other states may follow.
- Board may have an orientation course for faculty.
- Some states require that the board be notified of any faculty changes.

For Administrators
- Contact the education consultant at the board of nursing for developing a line of communication.
- Attend dean and director meetings as the board of nursing may be represented.
- Find out required faculty qualifications for that jurisdiction.
- Find out when annual reports are due and how site visits are conducted. A template for approval processes is available on NCSBN’s website (NCSBN, 2004b).
- Know what your jurisdiction’s requirements are for the NCLEX® pass rates.

for educators to analyze similarities and differences among how boards regulate nursing education. If the educator would like to suggest rule changes to the board, this document could provide convincing evidence by showing what the other boards are doing.

Because of these differences, it is incumbent upon each faculty member to read the nurse practice act and administrative education rules of the state(s) in which she/he is teaching to fully understand the requirements of each jurisdiction. Many states now have their current rules posted on their website (Hobbs, 2007). Some boards of nursing have started orientation programs for new administrators to highlight the educational rules, and, in many jurisdictions, deans and directors invite a representative from the board of nursing to their regular meetings to discuss any regulatory issues related to nursing education. This is an excellent way to improve communication between educators and regulators. Furthermore, nursing program administrators are encouraged to contact the board of nursing’s education consultant, or the person who is assigned to program approval in that state, if there are any questions about the approval requirements.

3 Rules and regulations are consistent with The Nurse Practice Act. The rules cannot go beyond the law, and once enacted, they have the force of the law. Some states refer to these as the regulations (Spector, in press).
4 Statutes that authorize the board of nursing to promulgate rules that are necessary for the implementation of The Nurse Practice Act (Spector, in press).
NCSBN is often asked why all these inconsistencies exist, and stakeholders ask our organization to “mandate” more consistency. However, it is not that simple. Licensure and the state-based regulatory system in the United States are founded in the 10th Amendment of the US Constitution, thus falling under “individual state jurisdiction with its inevitable variations and uniqueness” (Poe, 2008, p. 268). Therefore, each jurisdiction has its own laws and administrative rules, and these laws/rules differ across jurisdictions. In an attempt to provide some regulatory guidelines and consistency to boards of nursing as they promulgate rules and revise their Nurse Practice Acts, NCSBN, through committees of its membership, maintains a model Nurse Practice Act and model administrative rules (NCSBN, 2004a). The model Act and rules are a living document that is regularly reviewed by experts in nursing regulation. However, NCSBN can only provide recommendations to the boards of nursing; it cannot mandate legislative language because of our state-based regulatory system. In addition, NCSBN has provided its members with Evidence-Based Nursing Education for Regulation (EBNER) (NCSBN, 2006a), which is evidence upon which the Boards can base their administrative rules. This document will be discussed in more detail later.

Regulatory Position on Clinical Experiences: The Evidence

These are exciting times in nursing education. There has been a call for transforming how we teach clinical education (Benner, Surphean, Leonard-Kahn & Day, 2008; Greiner & Knebel, 2003; Gubrud-Howe & Schoessler, 2008; NLN, 2003). At the same time there a major focus on evidence-based nursing education (Oermann, 2007), and journals are seeing more nursing education research being submitted (Tanner, Bellack & Harker, 2009). Regulation welcomes innovation in nursing education and evidence upon which to base their rules for nursing curricula and teaching strategies.

However, one point that regulation is quite firm on is that all prelicensure students should have sufficient supervised clinical experiences with actual patients, at the scope of practice to which the students are aspiring, to meet the program’s outcomes. Nursing is a practice discipline, so actual contact with patients is an essential component of prelicensure nursing education. All other health professions require supervised clinical experiences, and nursing should be no exception. Yet, from time to time, programs have presented boards of nursing with curricula that incorporate minimal or no clinical experiences. Therefore, the following discussion will provide rationale for why nursing regulation has taken this position.

At NCSBN’s 2004 annual meeting, the membership presented the organization with a resolution asking NCSBN to develop a position statement that provides boards with guidance on evaluating clinical experiences in both traditional and alternative nursing education programs (NCSBN, 2005). An NCSBN committee was established to look at this question, and its members spent a year investigating the evidence as to whether supervised clinical experiences, at the aspired level of licensure, were an essential component of a nursing education program. To accomplish this goal, the committee members took several steps. They reviewed the available literature and research, surveyed boards of nursing, surveyed education organizations, consulted with renowned simulation experts, participated in simulated scenarios at a simulation center, and sought input from practice.
Box 12 – 2
Recommendations from NCSBN’s Position Paper on Clinical Experiences in Prelicensure Nursing Programs (NCSBN, 2005)

Prelicensure nursing educational experiences should be across the lifespan.
Prelicensure nursing education programs shall include clinical experiences with actual patients; they might also include innovative teaching strategies that complement clinical experiences for entry into practice competency.
Prelicensure clinical education should be supervised by qualified faculty who provide feedback and facilitate reflection.
Faculty members retain the responsibility to demonstrate that programs have clinical experiences with actual patients that are sufficient to meet program outcomes.
Additional research needs to be conducted on prelicensure nursing education and the development of clinical competency.

The committee findings and recommendations were presented in a position paper at NCSBN’s 2005 annual meeting, and the membership nearly unanimously adopted the statement (NCSBN, 2005). This position paper calls for supervised clinical experiences, at the level of licensure that the graduates are seeking, to be an essential component of prelicensure education. The specific recommendations of this paper are highlighted in Box 12-2.

While NCSBN’s position paper on clinical experiences was released in 2005, the American Organization of Nurse Executives (AONE) released a similar position statement in 2004 (AONE, 2004). See Box 12-3 for that position statement.

Furthermore, both national nursing accreditation organizations (i.e., CCNE and NLNAC) provide expert opinions that prelicensure nursing students should have supervised clinical experiences in their standards and criteria. Standard 4.8 from the 2008 National League for Nursing Accrediting Commission (NLNAC) Standards and Criteria (NLNAC, 2008) addresses

Box 12 – 3
AONE Position Statement on Prelicensure Clinical Experiences (AONE, 2004)

AONE firmly believes that solutions to the nursing shortage require innovation and creative approaches to education, practice and the delivery of systems of care. We strongly support efforts to address the shortage that align with the guiding principles that have been developed by the AONE Board to describe the future work of the nurse. Such initiatives are critical to our ability to secure a competent, professional workforce that can deliver safe, quality care to populations in our communities.

AONE also believes that the education programs for the nurses of the future will require a balance of didactic content and supervised clinical instruction.

Although innovative approaches may be developed, it is the position of AONE that all prelicensure nursing education programs must contain structured and supervised clinical instruction and that the clinical instruction must be provided by appropriately prepared registered nurses.
clinical education, and Standard 4.8.1 specifically states that "Student clinical experiences reflect current best practices and nationally established patient health and safety goals." Similarly, the Commission on Collegiate Nursing Education (CCNE) uses the 2008 Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008) as a guiding document when accrediting baccalaureate programs. Throughout this document, the essentiality of supervised clinical experiences in baccalaureate programs is highlighted, as evidenced by the following example (p. 4): "Learning opportunities, including direct clinical experiences, must be sufficient in breadth and depth to ensure the baccalaureate graduate attains these practice focused outcomes and integrates the delineated knowledge and skills into the graduate's professional nursing practice."

Boards of nursing, however, are vested in basing their administrative rules on research findings, as well as consensus statements of experts, and, as NCSBN’s recommendation number five stated, there is the need for additional research on this subject. For that reason, NCSBN conducted a study to identify evidence-based elements of nursing education. In this study, a sample of 410 education programs provided information on the characteristics of their programs. Then a sample of 7,497 graduates from those programs was obtained and graduates were matched to the program from which they graduated; at least five graduates had to graduate from a particular program in order for that program to be included. The two outcomes measures explored were the new nurses’ self-reports of (a) adequacy of preparation and (b) difficulty with client care assignments. Whereas these were only self-reports, the last outcome measure is closely related to actual patient outcomes. If nurses are having difficulty with their current workplace assignments, it is likely that will affect patient outcomes. Content validity and reliability (Cronbach’s alpha scores ranged from 0.87 to 0.91) were established on the research tools; separate tools were used for new graduates and nursing programs. Multiple regression, when the data were continuous, and logistic regression, when the data were dichotomous, analyses were used to link the curriculum elements and outcomes. Significant results are summarized in Table 12-1.

NCSBN’s National Study of Elements of Nursing Education was a beginning effort toward describing the evidence-based elements of nursing education. The findings on clinical education provide evidence that clinical education is important to student learning outcomes and the ability to practice. For example, the finding on faculty members being available to assist with clinical skills during clinical experiences found that those graduates were 1.4 times more likely to report having no difficulty with their current assignment.

One limitation of this study is that it relies on student reports of being prepared or of having difficulty with assignments. Future studies might look at actual patient outcomes. There are no studies that link nursing education to actual patient outcomes, and that would be a next step.

After reviewing the results of the National Survey of Elements of Nursing Education, NCSBN conducted a systematic review of nursing education outcomes (NCSBN, 2006c), which found 25 studies that met the study criteria. The studies were categorized as to strength of study design. Five studies in this review provided evidence that clinical experiences improve students’ abilities to think critically when caring for patients, though no study investigated numbers of clinical hours that are necessary for quality education. Since clinical experiences are so variable
Table 12 – 1
Summary of Significant Results from NCSBN's Elements of Nursing Education Study (NCSBN, 2006b)

Graduates were more likely to report they were adequately prepared (multiple regression analysis) when their nursing program:

- Had a higher percentage of faculty who taught both didactic and clinical courses ($\beta=0.34$).
- Taught use of information technology ($\beta=0.42$) and evidence-based practice ($\beta=0.44$).
- Integrated pathophysiology ($\beta=0.33$) and critical thinking ($\beta=0.34$) throughout the curriculum.
- Taught content related to specific client populations (such as medical surgical ($\beta=0.20$), care of clients with psychiatric disorders ($\beta=0.24$), and women’s health ($\beta=0.41$) as separate courses.

Graduates were more likely (multiple regression analysis) to report they were adequately prepared when their faculty were able to:

- Demonstrate clinical skills ($\beta=1.15$)
- Assist with classroom projects ($\beta=0.84$)
- Provide current information in the classroom ($\beta=1.15$)
- Assist with clinical skills ($\beta=0.67$)
- Require students to demonstrate skills ($\beta=0.51$)
- Answer questions during clinical ($\beta=0.73$)
- Answer questions about content ($\beta=0.33$)

- Availability of faculty to assist with clinical skills is also predictive of difficulty with current care assignments (Odds Ratio OR)=1.44

Relationship between perceived adequacy of education preparation and difficulty with client care assignments (logistic regression analysis):

- Work effectively within the health care team (OR=2.2)
- Understand the pathophysiology underlying a client’s condition (OR=1.5)
- Delegate tasks to others (OR=1.4)
- Analyze multiple types of data when making decisions (OR=1.3)
- Administer medications to groups of patients (OR=1.3)

(Gubrud-Howe & Schoessler, 2008) and since educators have many different strategies for teaching clinical education, it is not likely that specific numbers of clinical hours will ever be supported by research findings. It is the quality of clinical learning experiences that researchers should be addressing, as well as their relationship to patient outcomes.

NCSBN’s National Survey of Elements of Nursing Education (NCSBN, 2006b) and the systematic review of nursing education outcomes (NCSBN, 2006c) were used to develop
### Box 12 – 4
EBNER Recommendations Related to Clinical Education (NCSBN, 2006a)

<table>
<thead>
<tr>
<th>Assimilation to the role of nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide experiences for relationship-building with professionals</td>
</tr>
<tr>
<td>• Provide experiences for students to gain comfort in nursing role</td>
</tr>
<tr>
<td>• Provide experiences for students to work effectively in a team</td>
</tr>
<tr>
<td>• Provide transition programs</td>
</tr>
<tr>
<td>• Deliberate practice with actual patients</td>
</tr>
<tr>
<td>• Provide experiences for relation-building with patients</td>
</tr>
<tr>
<td>• Provide clinical experiences with actual patients</td>
</tr>
<tr>
<td>• Provide experiences for gaining confidence</td>
</tr>
<tr>
<td>• Provide opportunities for reflection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Faculty-student relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Faculty teach clinical and didactic courses</td>
</tr>
<tr>
<td>• Faculty are available to demonstrate and assist with skills in clinical activities</td>
</tr>
<tr>
<td>• Faculty are available to answer questions during clinical activities</td>
</tr>
<tr>
<td>• Faculty provide current information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teaching methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Integrate critical thinking into the curriculum</td>
</tr>
<tr>
<td>• Use critical thinking strategies</td>
</tr>
<tr>
<td>• Integrate evidence-based practice into the curriculum</td>
</tr>
<tr>
<td>• Integrate information technology into the curriculum</td>
</tr>
<tr>
<td>• Integrate pathophysiology into the curriculum</td>
</tr>
<tr>
<td>• Teach population courses separately</td>
</tr>
<tr>
<td>• Require students to demonstrate skills before performing them on patients</td>
</tr>
</tbody>
</table>

Evidence-based nursing education for regulation (EBNER) (NCSBN, 2006a) for boards of nursing to use as evidence-based guidelines when promulgating education rules. Recommendations that directly related to clinical education are outlined in Box 12-4.

Two studies similar to NCSBN's National Survey of Elements of Nursing Education (NCSBN, 2006b) were conducted more recently. Candela and Bowles (2008) conducted a descriptive study of nurses who were registered in the state of Nevada and had graduated within the past five years. A total of 352 nurses returned the survey with 43 percent being in practice from one to three years and 57 percent practicing from three to five years. The data collection instrument, which was researcher designed, showed adequate reliability (Cronbach's alpha of 0.87). A factor analysis determined that the items were loaded onto three factors: skills for practice, professional development, and clinical performance. As with the NCSBN national study, this statewide study is limited because its outcomes measures are based on student self-reports. Some of the significant findings for clinical education included:
- Need to be better prepared to administer medications
- Need for more clinical hours in the education program
- Need for more management/leadership in the education program
- Need for better preparation in using electronic medical records
- More than half of the respondents believed that their programs prepared them to pass the NCLEX-RN®

The findings support more focused clinical experiences in areas of medication administration, management and leadership, as well as practice with electronic medical records.

The Nursing Executive Center conducted a large national study regarding new graduate nurses. The researchers surveyed 53,000 "frontline" nurse employers, and more than 5,700 responded. An online survey asked employers to rate their satisfaction (from "strongly agree" to "strongly disagree") with new graduates (defined as those with less than 12 months of practice) on 36 mutually-agreed-upon competencies that are essential to safe and competent care (Berkow, Virkstis, Stewart & Conway, 2008). The researchers also surveyed more than 400 nursing school deans/directors/department chairs for relative curricular emphasis on these competencies. Results of the study found that about 25 percent of the employers were fully satisfied with new graduate performance, while more than 25 percent were somewhat dissatisfied or worse. Indeed, new graduates met the expectations of more than 50 percent of their employers on only two competencies: utilization of information technologies and rapport with patients and families (Berkow et al.). In another publication (Advisory Board Company, 2008), the Nursing Executive Center plotted the 36 competencies by relative curriculum emphasis (as reported by the educators) and new graduate proficiency (as reported by employers). See Box 12-5 for the competencies with the least curricular emphasis and the least proficiency in practice.

The national findings by the Nursing Executive Center support the need for focused and well-planned clinical experiences. For example, there is evidence to support more emphasis of delegation in nursing clinical courses. NCSBN's studies have also found delegation and supervision of others to be a weakness reported by new graduates (NCSBN, 2006b). Further,

**Box 12 – 5**

**New Graduate Competencies with Least Curricular Emphasis and Least Practice Proficiency (Advisory Board Company, 2008)**

- Follow-up
- Initiative
- Understanding of quality improvement
- Completion of tasks within expected time frame
- Track multiple responsibilities
- Conflict resolution
- Delegation
when new nurses reported inadequate preparation to delegate, they were 1.4 times more likely to have difficulty with their patient assignments (logistic regression analysis; Odds Ratio of 1.4).

While the report of Carnegie’s national study of nursing education has not been released yet, this study (Benner et al., 2008) also cites the importance of well-planned clinical experiences. In this multi-method national study, the researchers found that clinical and didactic education frequently are taught separately, and they call for an integration of classroom and clinical teaching.

Taken together, all of these studies and expert opinions provide evidence that education for nursing should include supervised experiences with actual patients. Future research should address innovative strategies and relate them to actual outcomes. While boards of nursing take the position that direct patient care is important in prelicensure programs, no board of nursing mandates how this should be done.

Myths and Realities in Regulation of Education Programs

Educators sometimes complain about regulatory barriers that don’t actually exist. The following includes a discussion of some of those myths.

**Myth 1: All Boards of Nursing Require Specific Numbers of Clinical Hours**

At a national meeting, a nurse leader stood up and said, “All boards of nursing require specific numbers of clinical hours, and this limits innovation.” This is a common misunderstanding of faculty, and could easily be dispelled had that leader gone to her/his own board’s administrative rules. Table 12-2 shows how many boards of nursing require specific numbers of hours and makes clear that this practice is more frequent in practical nursing education than in RN education.

**Myth 2: Boards of Nursing Limit Innovation Because of Their Prescriptiveness**

Nursing regulation supports innovations in nursing education. In March 2008, for example, NCSBN hosted a roundtable with leaders from nursing education, regulation and practice. The purposes of that meeting were as follows:

- Analyze possible barriers to implementing innovations in education put in place by education, practice and regulation
- Discuss ways to maintain quality while implementing innovation
- Discuss the future vision of innovation in nursing education

Currently, an NCSBN committee has delivered a document that identifies regulatory parameters that may prevent innovation, though also acknowledging that practice, education, and the students themselves can set up barriers. The committee members developed a flyer for boards of nursing that provides recommendations for breaking down regulatory barriers and another to share with educators for encouraging innovative approaches. It is hoped that these handouts (available online) will promote innovative approaches and that the flyer for educators will stimulate dialogue between the regulators and educators about the myths and realities of implementing innovations, thus enhancing communication. The committee members also developed a model to explain the regulatory influences on innovations in nursing education;
Table 12-2
Number of Boards that Require Numbers of Clinical Hours (NCSBN, 2007)

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Number Requiring Hours</th>
<th>Number Not Requiring Hours</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>PN Certificate or Diploma</td>
<td>17</td>
<td>35</td>
<td>7</td>
</tr>
<tr>
<td>PN Associate Degree</td>
<td>8</td>
<td>36</td>
<td>15</td>
</tr>
<tr>
<td>Associate Degree RN</td>
<td>8</td>
<td>46</td>
<td>5</td>
</tr>
<tr>
<td>Diploma RN</td>
<td>3</td>
<td>35</td>
<td>19</td>
</tr>
<tr>
<td>Baccalaureate RN</td>
<td>7</td>
<td>46</td>
<td>6</td>
</tr>
</tbody>
</table>

these influences include the laws/rules themselves, the board’s approval processes (which can sometimes be lengthy), and communication between faculty and the board of nursing. The final report from this committee work can be found on the NCSBN website: www.ncsbn.org.

Most boards of nursing, however, do not have highly prescriptive administrative rules, and innovations are not limited at present. In fact, three boards (Texas, Minnesota, and North Carolina) have, or have had, specific laws that allow exemptions to rules for innovative projects. Sadly, none of the three boards has received many proposals. In the 15 years Minnesota has had a rule allowing exemptions for innovations in nursing education, they have received no proposals for exemptions. Similarly, North Carolina had an innovation rule from 1984 to 2005, at which time it was repealed because no one used it. Texas’s law and administrative rules that allow programs to be exempted from specific rules for an innovative project is more recent, but there have been very few programs that have applied. To stimulate proposals for innovation, Texas has created a link on their website (http://www.bon.state.tx.us/nursingeducation/innovative.html) where they report on all the innovative projects in that state (whether or not the programs need an exemption for the project). Such an approach might be an exemplar for other boards of nursing, particularly since communication between regulation and education is crucial as more innovations in nursing education are developed.

Myth 3: Clinical Students Work Under the License of Their Faculty Member

A similar question was addressed in the Spring 2005 issue of Leader to Leader (https://www.ncsbn.org/LDR_to_LDR_March_05.pdf), and the comments here mirror the response to that question. Although nurse educators frequently talk about students practicing under their (i.e., the nursing instructor’s) license, the fact is that the only person who works on a nurse’s license is the person named on the license. Nurse practice acts include statutory language that specifies exemptions or exceptions to the requirement for a nursing license. Typically, practicing nursing as a student who is enrolled in an approved nursing program is one of the exempted (or excepted) practices. The nursing student is accountable for nursing actions and behaviors to patients, the instructor, the clinical facility and the nursing program. The accountability for nursing instructors is for their decisions and actions as an instructor. For example, the instructor is accountable for the selection of patients for nursing students’ assignments, supporting students in preparing for the clinical experience, monitoring students’ clinical performance,
and, most critically, intervening as necessary to protect patients when situations are beyond the abilities of students. Instructors must identify "teaching moments" as well as assess and evaluate students' clinical performance. This broader accountability reflects the education, experience and role of the instructor, who is accountable to the patient, the student, the facility, the nursing program and the professional licensing board.

**Myth 4: Boards Require Acute Care Experiences in the Specialties**

As clinical sites become saturated with nursing students, NCSBN often hears complaints from educators that their board is so prescriptive that they must offer acute care obstetric, psychiatric or pediatric experiences, all of which are difficult to find. While the majority of boards do require clinical experiences to be across the lifespan, they do not specify that these be hospital-based experiences. Educators, therefore, are encouraged to be creative about where they will provide specialty experiences. For example, Lamaze classes, children's day care centers, schools, assisted living, ambulatory clinics, community centers, free clinics and homeless shelters are all places where students could have excellent learning experiences to develop assessment and communication skills across the lifespan. If educators are unsure about specific settings, they are encouraged to contact the education consultant at their board of nursing for advice.

**Myth 5: Boards of Nursing Regulate Online/Distance Programs Differently from Traditional Programs**

The nurse practice act and education administrative rules in each jurisdiction cite regulations for education programs. All programs must meet the same regulations, whether they are an online/distance learning program or a brick-and-mortar program. For example, if an online/distance program in state A wanted all students in a distant state to have preceptored experiences, but state A's administrative rules dictate that only 50 percent of clinical experiences can be accomplished with a preceptor, then the online/distance program would have to hire clinical faculty in the distant states in order to receive continued approval. There are not separate and different rules for online/distance programs versus traditional programs.

**Myth 6: Annual Education Reports Are Put on the Shelf and Not Used**

At a recent meeting with leaders from nursing education, an educator commented that the annual reports to the board of nursing, which can take a great deal of time to complete, get put on a shelf, never to be seen again. Those reports, however, should serve as very useful resources for nursing education in a state. For example, Arizona's board of nursing notes that their report is quoted by policy makers to establish the need for additional faculty and nursing education funding. For example, Arizona data have been used to:

1. Successfully support and secure $20 million in funding for additional faculty to expand nursing program capacity
2. Inform the media, and others who publish articles on policy, regarding the nursing shortage or nursing education issues
3. Respond to requests for information and data from various stakeholders, including the Governor's office, the Arizona Hospital Association, lobbyists, and the Arizona Nurses Association
4. Provide data utilized by prospective nursing programs to establish the need for a nursing program

Other states report similar uses of the annual data that educators send the board of nursing in most states. Thus, they do not simply "sit on a shelf."

**Myth 7: All Boards Have Rules that Limit the Use of Simulation**

The boards of nursing, like educators, are attempting to understand what role simulation has in nursing education today. In NCSBN's 2005 position paper on clinical experiences (NCSBN, 2005), boards of nursing recognized the importance of simulation in education. In fact, the committee members sought the expertise of Dr. William McGaghie, a co-author of a rigorously conducted, systematic review of simulation (Issenberg, McGaghie, Petrusa, Gordon & Scalese, 2005), to learn about the regulatory perspectives toward simulation. The committee members also participated in high-fidelity simulations at a leading simulation center in Chicago in order to learn how simulation can be best used in nursing education. Further, NCSBN has conducted a randomized controlled trial of simulation, and preliminary results were presented in a poster format at the 2007 ICN conference in Yokohama, Japan (Li, Hicks, & Bosek, 2007) and are available online at NCSBN's website: https://www.ncsbn.org/169. In this study, baccalaureate students were randomized into one of three groups for a critical care course: 1) simulation only (n=19); 2) simulation and clinical experiences (n=19); 3) clinical experiences only (n=20). The outcome measures included knowledge acquisition, confidence scores, and clinical performance with standardized patients. Because of small numbers in each group, the results of this study were inconclusive, though trends favored the combination group. There are plans for replicating the study using multiple sites and including associate degree students. Finally, NCSBN has also funded several studies on simulation through their Center of Regulatory Excellence (https://www.ncsbn.org/389.htm), and our members are awaiting those results.

In summary, while boards of nursing are interested in how simulation is being used, they also are waiting to see the best evidence as to how simulation can or should be used. Therefore, there are few boards that have any rules on simulation. Nehring (2008) has written an excellent review of the use of simulation in nursing in her report of a survey on simulation that she sent to the boards of nursing. In that survey, she found that only one board limited the use of simulation by requiring a percentage of time that it could substitute for actual clinical experiences. Even in that state, simulation can be used when it is not substituting for clinical experiences. In a 2009 NCSBN survey sent to the boards of nursing, of the 48 respondents, only five boards reported limiting simulation to nonclinical course work. Most indicated they were waiting for further evidence on the use of simulation or that they review requests on a case-by-case basis. Yet, it is clear that boards do not want to see 100 percent of the clinical education coming from simulated experiences. Many educators, however, fear that their board will limit the use of simulation by requiring it be used as only a small percentage of actual experiences. Since most boards do not have specific clinical hours in the first place, this seems unlikely. Educators who want to substitute simulation for clinical experiences should contact the education consultant at their board of nursing and discuss the issue. Most boards are waiting for some more definitive answers on simulation before they write anything in their rules.
Other Regulatory Issues

Around the country, boards of nursing are seeing an entrepreneurial response to the nursing shortage. Businesspeople, with no nursing expertise or degrees, are developing nursing programs. Some of these are well done because they hire qualified nurses to plan the program and curriculum. However, other such programs suffer because non-nurses are developing the curricula for nursing programs. Programs that are not well conceived can take up tremendous board resources, thus preventing the board’s work in other areas of public protection. Boards of nursing find that quality nursing programs have nursing administrators who are seasoned, well-educated nurses with the power to make decisions for the program. Quality programs also hire sufficient, qualified faculty members (i.e., those with master’s or doctoral preparation) and have adequate resources to support nursing education, including the supervised clinical component. Sometimes, though, new nursing programs are loosely put together by people who have no experience in nursing education. Their sense of clinical experiences might be to send the students out to find preceptors in local hospitals. When this happens, there is no cohesiveness in the program, and students most likely will not be successful.

Boards of nursing also struggle with programs to maintain a qualified nursing faculty. At the 2008 annual meeting of NCBSN, the member boards voted to strengthen the model administrative rule language regarding faculty qualifications (NCBSN, 2008). The qualifications call for faculty to have a minimum of a master’s in nursing with graduate preparation in clinical practice and in education for teaching in PN and RN programs. There was also a recommendation that the faculty team be balanced, so that faculty with other graduate degrees related to nursing (such as pharmacology and genetics) are encouraged to participate in the education of RNs. Faculty members with a baccalaureate in nursing may be used to assist in the clinical education of PN education. While this position elevates requirements for faculty appointment, the reality is they cannot be met in today’s climate of the faculty shortage. Boards are collaborating with each other and with educators to learn how to successfully educate nurses during this severe faculty shortage. On the February 2009 education consultant conference call facilitated by NCBSN, the member boards discussed creative strategies during this faculty shortage — some are allowing waivers of qualifications, and one is facilitating the development of a pool of qualified educators that programs could use on a temporary basis. Since some areas of the country and certain settings (large urban medical centers) are temporarily no longer experiencing a nursing shortage, the boards suggest that this might be the time for nurses to go to graduate school to become nurse educators.

Boards of nursing are hearing from the nursing programs that clinical spaces for their students are becoming saturated. Programs will often use this as a reason to limit their clinical experiences, and it is a legitimate concern in some areas. When boards or others have recommended the use of clinical placement software, which is a web-based tool designed to match available clinical sites with the needs of the nursing programs in that state or region, oftentimes there has been a satisfactory outcome. One board of nursing’s executive director said that once their state implemented clinical placement software, clinical site saturation, which had previously been a highly ranked problem, was no longer an issue. Boards also encourage the use of more creative clinical sites to meet program outcomes.
Another education issue that some boards of nursing face concerns nursing programs using standardized assessment exams, which are designed for benchmarking and remediation, to increase their percentage of students passing the NCLEX®. If these exams are used throughout the program for remediation, they can be excellent resources for enhancing student learning and the program's NCLEX® pass rates. However, when programs administer such exams at the end of a course or even at the end of the program and provide little or no structured remediation, the standardized tests are being misused. In a 2006 NCSBN survey of boards of nursing, 15 of the 42 respondents reported that exit exams have presented some problems for that board of nursing. Indeed, one state has taken a stance and developed a monitoring policy stating that exit exams should not be used as a bar for graduation when all other program requirements have been met (Spector & Alexander, 2006). Other states have written letters to programs explaining their recommendations for the use of exit exams, while others have counseled students to use the institutional grievance process. Often states have rules that require programs to outline the requirements for graduation and to implement those requirements as written. Therefore, in some states, the use of an exit exam could be a violation of the rules in that state (Spector & Alexander, 2006). When programs do have problems with NCLEX® pass rates, the board of nursing will work with the program and will provide them a reasonable time frame to make appropriate changes.

Conclusion

This chapter provides the regulatory perspective on clinical education in nursing. For more than 100 years, nurse regulators have been approving education programs, and how and why this is done has been explained. Some of the inconsistencies across boards of nursing have been described, as has the rationale for why differences exist. Further, the chapter has highlighted the U.S. regulatory position on the need for supervised clinical experiences, at the level of licensure that the student is seeking, and the evidence supporting this stand.

There are many myths about the regulation of education programs, and seven specific ones have been discussed, pointing out both the facts and the fiction. Issues the boards of nursing continue to struggle with have been presented, along with how the boards are working with each other and with educators to overcome some of these challenges.

While educators bring practice partners to the table when planning for educating the nurse of the future, they often do not think to invite the boards of nursing. Yet, educators and regulators have the same goal, which is to graduate safe and competent nurses in sufficient numbers to meet the needs of the public. When there is collaboration between education and regulation, this goal will be met.
References


