NCSBN

Bringing Nursing Regulation & Education Together

LEADER TO LEADER

SUMMER 2023

Prepared to Pivot:
When Unexpected Events Interrupt Your Teaching and Learning Plans

By Mary Ann Jessee, PhD, MSN, RN, Assistant Dean for Academics, Generalist Nursing Practice Associate Professor, Vanderbilt University School of Nursing

Photo credit: Vanderbilt University School of Nursing

Mary Ann Jessee, PhD, MSN, RN

As experienced nurses, we are equipped to navigate sudden changes in patient condition, rapidly modifying our actions to restore homeostasis and achieve a positive patient outcome. As academic nurse educators, loss of the in-person teaching option during the pandemic forced many of us to fundamentally change how we taught. As a result, many of us struggled to maintain our students' learning and foster their preparedness for practice. As our graduates affected by pandemic-related educational changes transitioned to nursing practice, they did so with a lack of confidence. This was due in part to minimal experience with common nursing practice skillsets such as responding to patient condition changes, making decisions about what to do in new situations and communicating with the health care team. Interestingly, these experiences were not altogether different than those of pre-pandemic graduates—and that should make us think! We strive to prepare graduates capable of using their acquired knowledge, skill and professional comportment to provide safe, holistic nursing care, but do our methods match that desired outcome? If so, we will be well-equipped to pivot if our best prepared teaching plans are thwarted by something as small as an instructor illness, or as significant as a worldwide pandemic.

Our graduates should enter practice with extensive experience thinking and acting like the nurses they will *be* in practice, yet our teaching and their learning is often skewed toward knowledge gain rather than fostering the cognitive skills needed to identify priorities, recognize change and act with good judgment. Content knowledge and conceptual understanding is the essential foundation of nursing practice, but our students must become accustomed to using that knowledge during their education as they will be expected to

continued

IN THIS ISSUE ...

- **Q&A:** Students ask where they will need to be licensed if they live and work in different states.
- The Impact of COVID on Nursing Education
- Welcoming Nurses Back to the Workforce: Nurse Refresher Courses in Texas
- NCSBN Research Projects Significant Nursing Workforce Shortages and Potential Crisis
- An Update on the NCSBN ID Nurse Identifier

... and more

do in practice. How our students learn should mirror how nurses practice: actively engaged with the patient (e.g., individual, family, community or population), in the context of that patient's individual situation (e.g., diagnosis, treatments, social determinants of health), within the scope of the nursing role in a specific sphere of care (e.g., primary, subacute, acute, community). The nurse educator, rather than the setting, should be the catalyst to student learning and preparedness for practice. Specifically, the educator should be:

1) using ***active teaching and learning strategies*** while,
2) situating content and conceptual teaching in ***patient-focused context-specific nursing care delivery,*** and
3) employing ***clinical coaching*** to foster students' clinical reasoning and judgment.

When faculty teach with these strategies, a sudden unexpected pivot in setting or delivery method will be much less daunting.

Shifting from in-person teaching and learning to a virtual platform, or to low-tech written assignments, need not reduce the quality of teaching, the depth of student learning or educator ability to assess that learning. However, successful implementation of active learning strategies and patient-focused context-rich teaching in any setting or delivery method requires that the educator be a great coach who uses active learning in the context of patient care. Let's take a look at these three strategies.

Clinical coaching

Clinical coaching is the verbal questioning, teaching and feedback behaviors used by a faculty member with a student or students situated in the context of patient care (Jessee, 2018). Described elsewhere as coaching for salience (Benner et al., 2010), the goal is the same—assessing how students' background, knowledge and reasoning processes influence their decisions in clinical situations, and providing essential feedback to promote the capacity to make safe judgments in practice. With the right questions based on a clinical judgment teaching model (e.g. Tanner's Clinical Judgment Model), the clinical coach can determine: 1) the influence of ***background:*** how does a student's foundational knowledge level, previous experiences and expectations influence what they 2) ***notice*** in a situation; the 3) reasoning patterns they use to ***interpret*** the situation; 4) how they choose to ***respond;*** and 5) how meaningfully they can ***reflect*** for practice improvement (Tanner, 2006). When a deficit is noted, the coach teaches "just enough" to push thinking and decision-making to the next step, then asks another question or provides specific feedback to correct misunderstandings and guide self-assessment for deep learning and practice improvement (see sidebar at left). Successful clinical coaching depends on educator practice of the skill.

CHALLENGE: Start with just a few key questions this week in class, clinical, on your discussion board or in simulation. Continue to build your ability to modify those questions in the moment, recognize when you need to teach "just enough" to get the student to the next step and share specific feedback about how they can work toward improvement.

Example Questioning in Clinical Coaching

Noticing: What do you notice as most important in this situation?

Background/Expectations: What factors may have influenced why you noticed what you did?

Interpretation: What does that finding mean for the patient and your nursing care in this situation?

If there is missing **Foundational Knowledge:** What additional knowledge or information do you need to determine the answer?

Responding: What actions are appropriate, and which is best for this patient in this situation?

Reflecting: How has your experience today helped you determine additional knowledge or experience you need to improve your practice and your patient's experience next time?

continued

Active learning

An educator's use of clinical coaching is inherently active, but having a variety of active teaching and learning strategies will keep students engaged in all delivery methods. Active learning strategies foster collaborative interaction between the educator and student, as well as among the students themselves, to facilitate achievement of the desired learning outcomes. For example, think-pair-share is an excellent tool for in-person, virtual, discussion board or, if necessary, even phone or email—when all else fails! Whether confirming understanding of the pathophysiology of sepsis, determining the best evidence for an intervention or making a decision in an ethical dilemma, engaging students in the reasoning process individually, followed by discussion in pairs or groups, will maximize their learning. Followed by individual student reflection on their reasoning through a clinical situation, this simple strategy engages students in meaningful consideration of how their peers' and their own background, knowledge and experiences influence their expectations for a patient situation. These expectations influence their capacity to notice what is most important, understand its meaning, take the best actions and reflect on the experience to improve their future practice.

Active learning strategies foster collaborative interaction between the educator and student, as well as among the students themselves, to facilitate achievement of the desired learning outcomes.

CHALLENGE: Try this in your next class and be the clinical coach.

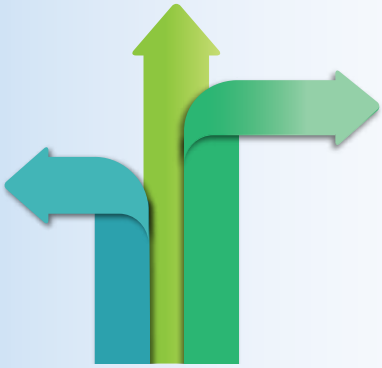
Patient-focused, context-specific delivery of nursing care

Inclusion of a context-rich, patient-focused situation in every class session fosters students' understanding of the value of the topic at hand to their role as a nurse in practice. For example, students often miss the value of nursing research to their practice as a new registered nurse. However, putting that concept in the context of a patient-focused situation shifts the narrative from content to practice. Have students consider a cluster of cancer diagnoses in a community where they are working at an ambulatory clinic. Ask students to explore how qualitative and quantitative methods would each contribute to their understanding of the community members' fears about the situation and devise a research plan. When using this strategy, the complexity of the clinical situation should be driven by the educational level of the student and what you expect them to know, how you expect them to think and how you expect them to take action.

Since we are often unable to predict or standardize the patient situations students will experience in the clinical setting, we must design clinical learning experiences to facilitate student practice with the essential cognitive skills they will need to use when they enter practice. Educators can design and coach students through experiences discerning the most important findings in clinical situations with one or multiple patients, prioritizing individual patient needs or those of a group of patients, weighing value and making decisions on the best actions, recognizing condition changes and responding safely, and communicating effectively with the health care team. In my work with the International Consortium for Outcomes of Nursing Education (ICONed), nurse educators in practice who work with new graduate nurses stress the need for students to have practice recognizing patient decline and taking the first appropriate action. Recognizing decline is only half of the equation. While the new graduate is not expected to always know the detailed cause of a patient decline, or to have a complete understanding of what should be done, it is critical that they know the first step—and take it—in addition to calling for help. In practice,

continued

These types of activities foster preparedness for practice by engaging students in the essential cognitive work of nursing while exposing them to various contextual pressures they will experience in practice.



unexpected findings and events that force immediate action or quick reprioritization of care can be paralyzing for graduates who have not practiced navigating those situations. As academic educators, we can easily pose a sudden change in a clinical situation—while students are working through it. We can impose time pressure and distractors such as sounds or malfunctioning equipment, as they will inevitably face in practice. For further complexity, unfold the situation based on their decisions, to maximize the learning from the situation. Whether an in-person clinical experience, a high-fidelity simulation or a complex patient situation done virtually or on paper, these types of activities foster preparedness for practice by engaging students in the essential cognitive work of nursing while exposing them to various contextual pressures they will experience in practice.

CHALLENGE: Surprise students with a sudden change that requires a shift in priority as they are working through a patient situation. Give them a practice-realistic timeframe to respond, then coach them through their reasoning processes.

In conclusion, let's take a few steps now to prevent the significant stress and additional workload we experienced at the start of the pandemic in 2020. We can begin with critical reflection on how our traditional, pre-pandemic and inter-pandemic teaching and learning strategies prepared, or failed to prepare, our graduates for practice and consider how some of the strategies described here may better support meaningful student learning in future unexpected situations. You do not need to do this alone! Reach out to your colleagues, share experiences, brainstorm options and transform your teaching now to create active learners in any setting or delivery method, so you are prepared to pivot when needed in the future. ◆

REFERENCES:

Benner, P., Sutphen, M., Leonard, V., & Day. L. (2010). Educating nurses: A call for radical transformation. San Francisco, CA: Jossey-Bass.

Jessee, M.A. (2018). Pursuing improvement in clinical reasoning: The integrated clinical education theory. Journal of Nursing Education, 57(1), 7-13. doi:10.3928/01484834-20180102-03.

Tanner, C.A. (2006). Thinking like a nurse: A research-based model of clinical judgment. *Journal of Nursing Education,* 45(6), 204-211. doi: 10.3928/01484834-20060601-04.

Q & A

Q: Our students often ask us where they will need to be licensed if they live and work in different states. Is there a resource on NCSBN's website that explains where they should be licensed?

A: That is a great question. Licensure can be complex for new graduates. In an increasingly mobile workforce, initiatives such as the Nurse Licensure Compact (NLC), which 41 jurisdictions have enacted in the U.S., can be extremely useful, but it's important to understand how licensure works. If nurses live in an NLC state and have a multistate license, they can practice in any of the 41 jurisdictions that have implemented the NLC Learn more about the NLC here. If nurses live in a non-NLC state, they will need a license in each state where they practice. When practice is via telehealth, the state where the patient is located is the state where you need to hold a license. To assist nurses, and especially new graduates, in learning where they would need a license, we have developed the Nurse Licensure Guidance tool. Once a nurse submits their information, the tool quickly displays where they would need licenses and points to helpful resources of how to move forward. This user-friendly tool has become very popular worldwide, with nurses from more than 95 countries using it. With this in mind, we recommend that faculty highlight this tool for their graduating seniors. ◆

NLC NURSE LICENSURE COMPACT

The Impact of COVID on Nursing Education

In the Fall 2022 issue of *Leader to Leader,* we highlighted NCSBN's Annual Report Program (ARP), along with the aggregate report of data collected from 2020–2021. As a part of the nursing program approval process, many nursing regulatory bodies (NRBs) collect annual reports from nursing programs to keep updated on the quality indicators and outcomes of their schools of nursing. The process can be very time-consuming for our very busy NRBs.

Therefore, NCSBN developed an evidence-based Annual Report survey, based on our large, mixed methods study of nursing program quality indicators (Spector et al., 2020) for NRBs to send to their programs. We then collect the data and develop a final report for each participating NRB. Additionally, each year we analyze the data in the aggregate and upload that report on our website (NCSBN, 2022). That aggregate report is a good way for nursing programs to compare their activities and outcomes to national data.

In the first two years of NCSBN's Annual Report Program (2020 and 2021), we collected data on the impact of COVID-19 on nursing education by adding 16 questions. This article will present the key findings from those questions.

The final sample participating in the COVID-19 impact survey included 17 NRBs (n=798 programs) in 2020 and 19 NRBs (n=929 programs) in 2021. Two NRBs had collected their own surveys on the impact of COVID-19 on their nursing education programs, so their programs did not participate in these questions.

A significant finding was that the pandemic caused a major disruption for nursing education programs in 2020 especially. As can be seen from Table 1, nearly half the programs considered the impact to be a major disruption to their programs in 2020, though that decreased significantly in 2021.

> ... nearly half the programs considered the impact to be a major disruption to their programs in 2020, though that decreased significantly in 2021.

Table 1. Overall Effect of COVID-19 on the Nursing Program

	2020	2021
N	**798**	**929**
	n%	**n%**
Overall Effect of COVID-19 on the Nursing Program		
Major disruption	382 (47.9%)	208 (22.4%)
Quite a bit	276 (34.6%)	336 (36.2%)
Somewhat	120 (15%)	288 (31%)
A little	12 (1.5%)	80 (8.6%)
Not at all	8 (1%)	17 (1.8%)

The improvement in 2021 could be because more of the students had clinical experiences with patients and in-person didactic classes. It also might be that nursing programs developed ways to adapt to the new environment with COVID-19.

continued

At the beginning of the pandemic in 2020, most nursing programs reported that COVID-19 greatly impacted didactic education and clinical experiences with patients in clinical sites, as illustrated in Table 2. Likewise, COVID-19 continued to affect didactic education and clinical experiences in most programs into 2021. Simulation and skills labs were also greatly affected at the beginning of the pandemic, but the effects on these parts of the program seemed to ease some by 2021. However, effects were still seen in a majority of the programs.

Table 2. Effect of COVID-19 on Specific Aspects of the Program

	2020	2021
N	**798**	**929**
	n%	**n%**
Effect of COVID-19 on Specific Aspects of the Program		
Didactic Education		
Yes	740 (92.7%)	774 (83.3%)
No	58 (7.3%)	155 (16.7%)
Clinical Experiences with Patients in Clinical Sites		
Yes	778 (97.5%)	858 (92.4%)
No	20 (2.5%)	71 (7.6%)
Simulation in the Simulation Lab		
Yes	691 (86.6%)	550 (59.2%)
No	107 (13.4%)	379 (40.8%)
Skills Lab		
Yes	669 (83.8%)	592 (63.7%)
No	129 (16.2%)	337 (36.3%)
Other Parts of the Program		
Yes	104 (13%)	114 (12.3%)
No	694 (87%)	815 (87.7%)

The specific changes made to didactic education included moving to 100% online education, moving to partial online education and implementing smaller class sizes.

The specific changes made to didactic education included moving to 100% online education, moving to partial online education and implementing smaller class sizes. Approximately 23% of nursing programs implemented smaller class sizes in 2020 while 36.4% of programs implemented smaller classes in 2021. A very small percentage of programs (2.4%) made no changes to didactic education at the start of the pandemic in 2020. Some programs (22.8%) reported making other adaptations at the start of the pandemic, such as conducting online exams and using remote exam proctoring. By 2021, 32.5% of programs reported using masking and social distancing for reinstituting in-person classes.

In addition to ceasing in-person didactic education at the start of the pandemic, the majority (54%) of nursing programs reported that face-to-face clinical experiences with patients at all sites were canceled, while the remaining programs canceled in-person clinical experiences to some extent. These cancellations were primarily due to restrictions set by the clinical settings. Only 1.4% of nursing programs had not canceled in-person

continued

clinical experiences at the start of the pandemic in 2020. In 2021, 16% of nursing programs were still reporting cancellations of in-person clinicals at all sites. Interestingly, when students were in clinical experiences and caring for patients with COVID-19, only 29.7% of the health care facilities provided them with PPE in 2020, and this increased to 36.85% in 2021. The students or their nursing programs provided the PPE when the health care facilities did not. Nursing needs to collaborate with practice facilities and public health agencies to prevent this from happening in the future.

Alternative strategies for clinical experiences included programs either using in-person simulation (19.2% in 2020; 45% in 2021) or simulation with mandated social distancing (34.6% in 2020; 57.9% in 2021). Additionally, in 2020 most programs (96.1%) used virtual simulation (though this decreased to 73.5% in 2021). To date, the research has not supported virtual simulation to replace clinical experiences (Foronda et al., 2020). Some schools decreased the number of clinical hours that were required for students to graduate (22.9% in 2020; 8.4% in 2021), while others changed their grading criteria (19% in 2020; 9% in 2021). This lowering of requirements is concerning and should be explored for future crises situations.

A surprising finding of this survey related to attrition of faculty and students during 2020 and 2021. Student attrition was higher than faculty attrition, with 32% in 2020 and 47.3% in 2021.

The decision to close and cease in-person classes was primarily made by governor proclamation (73.8%, n=589) and administration at the university, college or educational organization (95.1%, n=759). Faculty had some say in closing programs (20.3% in 2020; 18.3% in 2021), but not a lot. Particularly in nursing, when administrators make decisions about whether or not to close programs during a pandemic or a disaster, they should listen intently to nursing faculty because it is a health profession where clinical experiences are essential for applying the content learned in class and preparing the professional nurse (Spector et al., 2020).

A surprising finding of this survey related to attrition of faculty and students during 2020 and 2021. Student attrition was higher than faculty attrition, with 32% in 2020 and 47.3% in 2021. Some of the reasons students reported that they left their programs included difficulties in not adapting to the online or virtual formats, having personal responsibilities at home and financial hardships. Faculty attrition was smaller, but still a major concern in nursing education today with our faculty shortage. In 2020, 11.4% of faculty left their positions, while it was 19.2% in 2021. Some of the reasons faculty gave for leaving their jobs were worries about their health and safety, as well as difficulty adapting to online education.

This survey reveals how severely nursing education was impacted during the pandemic. Nursing education would benefit from a national meeting on what happened during the pandemic and how we might plan for future crisis events. A document could be developed where suggested and evidence-based alternative teaching strategies could be provided when clinical or didactic classes can't be held. Additionally, information on emergency preparedness to be added to curricula could be made available. This pandemic has opened our eyes to how important it is for nursing to take some steps to prevent the chaos that ensued during the pandemic from ever happening again. ◆

REFERENCES:

Foronda, C.L., Fernandez-Bergos, M., Nadeau, C., Kelley, C.N., & Henry, M.N. Virtual simulation in nursing education: A systematic review spanning 1996–2018. *Simulation in Healthcare,* 15(1), 46-54. DOI: 10.1097/SIH.0000000000000411.

National Council of State Boards of Nursing (NCSBN). (2022). National nursing education aggregate report: 2020–2021 aggregate data. https://www.ncsbn.org/public-files/AnnualProgramReport-AggregateData-2022.pdf

Spector, N., Silvestre, J., Alexander, M., Martin, B., Hooper, J., Squires, A., & Ojemeni, M. (2020). NCSBN regulatory guidelines and evidence-based quality indicators for nursing education programs. *Journal of Nursing Regulation,* 11(2), S1-S64.


2023 NCSBN
NCLEX® Conference
Sept. 21, 2023 | Virtual
This conference provides nurse educators with NCLEX program updates from the experts who develop and administer the exam.
Registration Deadline: Sept. 7
REGISTER TODAY

Welcoming Nurses Back to the Workforce:
Nurse Refresher Courses in Texas

By Virginia Ayars, EdD, MS, RN, CNE, Nursing Consultant for Education, Texas Board of Nursing; and Janice Hooper, PhD, RN, FRE, CNE, FAAN, Nursing Consultant for Education, Texas Board of Nursing

During the summer of 2022, Texas Board of Nursing staff noted an increased number of inquiries from nurses with lapsed licenses who wanted to return to active practice and were requesting detailed information about how to do so. Anecdotal comments indicated financial needs were the driving force for these individuals to reactivate their vocational or professional nursing license to rejoin the Texas nursing workforce.

Data points have been collected since mid-August 2022 to document the number of calls and email communications from individuals seeking clarification about the process of reactivating their nursing license, specifically about the process of completing a Nurse Refresher Course (NRC). The inquiries were from nurses throughout the United States as well as Canada and Europe. These data demonstrate a 33.33% increase over a six-month period, as the 26 inquiries received in September 2022 rose to 39 inquiries received in February 2023 (Ayars & Hooper, 2023).

> In order to facilitate the effort, academic settings and employers supported the idea of providing refresher courses to prepare returning nurses to re-enter the workforce.
> (Yancy & Handley, 2004)

Based on multiple database searches, a scarcity of current literature about NRCs was located. However, authors of available NRC articles independently set forth that a nursing shortage emerging during the 1980s created interest for health care facilities in recruiting non-practicing nurses back into practice to meet staffing needs. In order to facilitate the effort, academic settings and employers supported the idea of providing refresher courses to prepare returning nurses to re-enter the workforce (Yancy & Handley, 2004).

According to the Texas Center for Nursing Workforce Studies' (TCNWS) *Updated Nurse Supply and Demand Projections 2018–2032,* Texas will experience a significant shortage of all types of nurses (vocational, professional and advanced practice) by 2032. Based on current data, there is an expected deficit of 57,012 full-time equivalent registered nurses (RNs) and an expected deficit of 12,572 full-time equivalent licensed vocational nurses (LVNs) by 2032 (TCNWS, 2022). Considering this predicted shortage of nurses, it is a relevant time to review the process in Texas for reactivating expired licenses of nurses who have been away from nursing practice for four or more years.

Data from the NCSBN Member Board Profiles (2022) indicated that 51% of boards responding to the survey reported they require a refresher course for nurses to reactivate their nursing license. Further, 22% of boards responding to the survey reported they do not require a refresher course, while 27% responded that a refresher program is one option for reinstatement (NCSBN, 2022).

continued

In Fall 2022, an online survey was distributed to all board-approved Texas professional nursing education programs to collect data about the numbers of colleges/universities offering NRCs. The first question, "Does your college/university currently offer a Nurse Refresher Course?" brought a total of 96 responses; eight programs (8.33%) stated they offer NRCs while 88 programs (91.67%) stated they do not. Of the eight positive responses, seven (87.50%) indicated the course is currently active. Of the 84 programs responding to the question about the possibility of offering an NRC in the future, 71 programs (84.52%) stated that, although they do not currently offer an NRC, the program would be interested in doing so in the future if a demonstrated need from the community arose.

Board Rule 217.6 (Failure to Renew License) provides requirements for renewal of an expired nursing license in Texas. The process for renewal requires successful completion of the nursing jurisprudence examination as well as evidence of fulfillment of continuing education requirements (Texas Board of Nursing [TBON]a, 2023).

Applicants for licensure renewal who have not practiced nursing for four or more years are required to complete one of the following: a board-approved refresher course, an extensive orientation, or a nursing program of study. This discussion focuses on aspects and processes of NRCs as the increased number of inquiries were specific to those courses.

In Texas, the *Verification of Successful Completion of Nursing Refresher Course/Extensive Orientation/Academic Nursing Course(s)* is required to be submitted as evidence of completion of the essential elements needed for licensure reactivation (TBONb, 2023). Extensive orientations at a clinical facility may be offered to refresher nurses as a method to ensure the nurse who has not actively practiced nursing in four or more years is safe and competent to return to the provision of direct patient care. These orientations require the reentry nurse to complete at least 80 hours of clinical learning experiences, and offers the reentry nurse (as well as clinical nursing staff) the opportunity to evaluate one another and determine if permanent employment would be beneficial for both. However, the board does not have purview to mandate a chief nursing officer or director of nursing to open their clinical facility as a clinical learning experience for refresher nurses. Individuals seeking to reactive their nursing license are a potential rich source of new staff members.

For nurses who have expired licenses and have not practiced for four or more years, the completion of specific areas of study for each type of program (LVN and RN) ***plus*** 80 hours of supervised clinical practice are required. Specified content areas for each educational level are provided in the table below (TBONb, 2023):

Knowledge/Skill for LVN	Knowledge/Skill for RN	Percent of Content
Review of NPA, Rules, Position Statements	Review of NPA, Rules, Position Statements	15%
Determining Individual Scope of Practice and role in patient safety	Determination of Individual Scope of Practice and role in patient safety	5%
Review of the clinical problem-solving process for the provision of individualized, goal-directed nursing care to include: a) Collecting data & performing focused nursing assessments; b) Participating in the planning of nursing care needs for clients; c) Participating in the development & modification of the comprehensive nursing care plan for assigned clients. d) Implementing appropriate aspects of care within the LVN's scope of practice; e) Assisting in the evaluation of the client's responses to nursing interventions and the identification of client needs.	Review of the nursing process to include assessment, planning, implementation and evaluation.	30%
Pharmacology Review	Pharmacology Review	20%
Medication Administration	Medication Administration	20%
Documentation principles/practices	Documentation, quality assurance and legal implication for nursing practice	10%
Documentation of current CPR certification prior to beginning precepted clinical experience	Documentation of current CPR certification prior to beginning precepted clinical learning experience	NA
Supervised clinical experience providing precepted clinical experience	Supervised clinical experience providing direct patient care (minimum of 80 hours)	80 hours
Documentation of successful completion of Didactic Content of the Refresher Course	Documentation of successful completion of Didactic Content of the Refresher Course	NA

continued

The rules are not prescriptive as to the specific setting in which the clinical hours must be completed; however, the optimal setting would offer a wide variety of direct patient care experiences. Since the clinical learning objectives direct the activities, any setting that would allow learners to meet the course objectives would be appropriate. It is recommended that any nursing functions carried out by the learner (under the supervision of the instructor or preceptor) shall be in alignment with the clinical facility's policies and procedures.

Although the board does not have specific requirements for the number of preceptors assigned to the learner during the 80 hours of clinical learning experiences, the board recommends that one preceptor for each learner is preferred. The use of one preceptor provides greater opportunity to observe and evaluate any weaknesses or need for immediate remediation as the refresher nurse progresses throughout the experience.

... providing effective refresher programs offers an opportunity to increase the nursing workforce by calling on the human resources already available.

Further, the board does not establish a schedule for learner completion of the 80 hours of clinical learning experiences. Learners may accomplish the required 80 hours by working 40 hours per week for two weeks, 20 hours per week for four weeks, or develop any configuration to total 80 hours that is mutually agreed upon by the learner, the preceptor, and the clinical facility.

Hawley and Foley (2004) reported that providing effective refresher programs offers an opportunity to increase the nursing workforce by calling on the human resources already available. The anticipated outcome for nurses completing an NRC is they will be fully integrated into the culture of the current nursing workforce. Further, it is critical the participants be welcomed as part of the decision-making process when identifying specific learner needs, learner experiences, and evaluating learner outcomes. The NRC cohorts most likely will be comprised of learners of varying ages, as well as learners with differences in educational backgrounds, levels of licensure, and professional experiences (Hammer & Craig, 2008).

Randolph (2013) and Hawley and Foley (2004) cited completion of NRCs as benefits to both healthcare facilities and individual reentry nurses. The cost of preparing a reentry nurse compared to the cost of preparing a new graduate nurse is by far a more cost-effective measure (Randolph, 2013). Nurses who complete an NRC would experience

continued

increased confidence and personal comfort in their professional life. Further, these nurses would be offered a greater variety of employment opportunities (Cundall et al., 2004).

An exploration of the Texas Board's process to facilitate a safe return to practice for nurses who have not utilized their nursing knowledge, skills, or abilities in four or more years may assist other boards of nursing in their efforts to ensure patient safety while increasing the nursing workforce. Inactive nurses are a potentially rich resource and could serve to address the projected nursing workforce shortage. Further, a critical examination of current NRC curricula and long-term outcomes could assist other NRC coordinators to consider one state's process to develop additional options for refresher courses for those interested in returning to the nursing workforce. ◆

... a critical examination of current NRC curricula and long-term outcomes could assist other NRC coordinators to consider one state's process to develop additional options for refresher courses for those interested in returning to the nursing workforce.

REFERENCES:

Ayars, V. D., & Hooper, J. I. (2023). *Report of the Status of Nurse Refresher Courses in Texas* (Agenda Item 3.2.6). Texas Board of Nursing. https://www.bon.texas.gov/meetings_board_meetings_2023_Jan.asp.html

Cundall, R., Emert, B., Gowens, D., Hedrick, C., Phillips, M., Schulze, B., & Sredl, D. (2004).

Designing a nurse refresher course curriculum. *The Journal of Continuing Education in Nursing, 35*(4), 164-167.

Hammer, V. R., & Craig, G. P. (2008). The experiences of inactive nurses returned to nursing completing a refresher course. *The Journal of Continuing Education in Nursing, 39*(8), 358-367.

Hawley, J. M., & Foley, B. J. (2004). Being refreshed: evaluation of a nurse refresher course. *The Journal of Continuing Education in Nursing, 35*(2), 84-88.

National Council of State Boards of Nursing. (2022). *Member Board Profiles.* NCSBN Member Board Profiles

Randolph, P. (2013). Employment patterns in RN refresher graduates: a 4-year follow-up. *Journal of Nursing Regulation, 3*(4), 60-61.

Texas Board of Nursing. (2023a). *Rules and Regulations relating to Nurse Education, Licensure and Practice Rule 217.6.* https://www.bon.texas.gov/rr_current/217-6.asp.html

Texas Board of Nursing. (2023b). *Application forms – six month limited permits.* https://www.bon.texas.gov/applications_six_month_permits_and_temporary_licenses.asp.html

Texas Center for Nursing Workforce Studies. (2023). *Updated Nurse Supply and Demand Projections, 2018-2032.* https://www.dshs.texas.gov/texas-center-nursing-workforce-studies/nursing-supply-demand-projections

Yancy, P., & Handley, A. (2004). Can everyone be refreshed? *The Journal of Continuing Education in Nursing, 35*(2), 80-83.

NCSBN Research Projects Significant Nursing Workforce Shortages and Potential Crisis

In the recently published *Journal of Nursing Regulation* 2022 National Nursing Workforce Study, and an article using a subset of the data, "Examining the Impact of the COVID-19 Pandemic on Burnout and Stress Among U.S. Nurses," it was revealed that 100,000 registered nurses left the workforce during the pandemic. Even more alarmingly, by 2027 almost 800,000, or almost one-fifth of 4.5 million total registered nurses, intend to leave the workforce.

The study is considered to be the most comprehensive and only research in existence, uncovering the data points which have far-reaching implications for the health care system at large and for patient populations.

While NCSBN and the National Forum of State Nursing Workforce Centers have conducted a comprehensive biennial nursing workforce study since 2013, this research also investigated and quantified the personal and professional characteristics of nurses experiencing heightened workplace burnout and stress due to the COVID-19 pandemic.

NCSBN Director of Research Brendan Martin, PhD, comments, "Although many of the difficulties facing nurses that were identified in the study did not come as a surprise to researchers, we were astonished by the extent that an already volatile environment was made exponentially worse by the pandemic."

The study found that a quarter to half of nurses reported feeling emotionally drained (50.8%), used up (56.4%), fatigued (49.7%), burned out (45.1%), or at the end of their rope (29.4%) "a few times a week" or "every day." What is especially disturbing is that these issues are most prevalent amongst nurses with 10 or fewer years of experience, driving an overall 3.3% decline in the U.S. nursing workforce in the past two years. The exodus of this population of nurses can have a devastating impact on patient care and safety in the years ahead.

> "The loss of any nurse that chooses to leave the profession has an impact, but when a nurse who is essentially just beginning their career does so, the health care system loses decades of practice."
>
> – Maryann Alexander, PhD, RN, FAAN
> NCSBN Chief Officer of Nursing Regulation

"The loss of any nurse that chooses to leave the profession has an impact, but when a nurse who is essentially just beginning their career does so, the health care system loses decades of practice," says NCSBN Chief Officer of Nursing Regulation Maryann Alexander, PhD, RN, FAAN. "We lose not only their service but their potential leadership and mentorship of those who follow them."

Of additional concern is the fact that disruptions in prelicensure nursing programs have affected the supply and clinical preparedness of new nurse graduates. NCSBN has also published Assessing the Impact of the COVID-19 Pandemic on Nursing Education: A National Study of Prelicensure RN Programs, a mixed-methods longitudinal study focused on prelicensure registered nurse (RN) students entering the core of their didactic and clinical nursing coursework during the pandemic. Early career data for new entrants into the profession suggest decreased practice and assessment proficiency.

continued

Above: The panel of experts gathered in Washington, D.C. on April 13, 2023 for, "Nursing at the Crossroads: Workforce Shortages Risk the Health of the Nation."

Recognizing that the data from these studies indicate that the future of nursing and the health of the nation is at risk, NCSBN convened an esteemed panel of experts to review the results of this startling new research. The group gathered in Washington, D.C. on April 13 to not only discuss these studies but also explore solutions that will transform nursing, retain nurses in the workforce and attract a more diverse group of individuals into the profession.

Alexander asserts, "Given what has already happened and that this has the potential to become increasingly more dire with even more nurses saying they want to leave the profession, action needs to be taken immediately. However, the positive note is that there is a unique opportunity for health care systems, policymakers, regulators and academic leaders to collaborate and enact solutions that will spur positive systemic evolution to address these challenges and maximize patient protection in care into the future."

> "One thing that is important to realize is that our survey uncovered an intention by nurses to leave, they haven't left yet ... We must work to reverse their decision and make the improvements necessary to keep them engaged and supported"
>
> – Brendan Martin, PhD
> NCSBN Director of Research

Martin adds, "One thing that is important to realize is that our survey uncovered an intention by nurses to leave, they haven't left yet. Most nurses enter the profession out of desire to help people and make a difference. We must work to reverse their decision and make the improvements necessary to keep them engaged and supported."

The panel discussed that supporting nurses needs to start when they are students with initiatives such as:

- Academic practice partnerships being increased to provide clinical affiliations for nursing schools allowing for enriched real-world experiences for students.
- Nurse residency programs supported and funded across the nation to ease the transition from student to working professional.
- Attracting a more diverse workforce by encouraging non-traditional and minority students to pursue nursing. Providing financial funding for their education.
- Bringing nurses back into the workforce in a virtual capacity to serve as mentors and preceptors.

"Fundamentally, the health care system must undergo a paradigm shift into an environment that is more supportive, more flexible and safer for nurses and other health care professionals," Alexander concludes. "These changes will not occur overnight, and it will take the collaboration of health systems, policymakers, educators and regulators to make it happen. NCSBN has provided the evidence, the first steps need to begin now." ◆

An Update on the NCSBN ID Unique Nurse Identifier

By Susan Alexander, DNP, ANP-BC, ADM-BC, Professor, College of Nursing, University of Alabama in Huntsville; Whende Carroll, MSN, RN-BC, FHIMSS; Nancy Beale, PhD, MSN, RN-BC; and Nur Rajwany, MS, Chief Information Officer, NCSBN

As the work of nursing has become more complex, technology is playing an increasingly important role in care delivery. Using a unique nurse identifier (or UNI, a distinct numeric code unique for each nurse) across technologies and systems can enhance communication between technologies while also capturing nursing contributions to patient outcomes.

An important part of the 21st Century Cures Act is focused on interoperability, or the exchange of health information between systems[1]. Promoting the use of a UNI can facilitate accurate communication between systems. Additionally, the communication of data between systems, enabled by integration of a UNI, will generate new and actionable insights, such as revealing patterns between staffing, skill sets and patient outcomes[2].

Understanding the NCBSN ID and Data Flow

The NCSBN ID is a unique number assigned to every U.S. nurse upon registration for the NCLEX. It is the only UNI for all nurses and allows concise communication among systems while protecting a nurse's personally identifiable information (PII). An NCSBN ID is free to obtain and available exclusively through the NCSBN's Nursys® system. Additionally, since all licensure data is in Nursys, the Nursys team was able to reconcile and assign a unique NCSBN ID to every single nurse who became licensed before the NCLEX was created (pre-1994). When this was accomplished, a unique NCSBN ID was assigned.

Organizations can now incorporate the NCSBN ID into their data sets, and researchers and institutions can exchange their nurse data sets without the need to use PII for identification.

Creating and leveraging a UNI was originally suggested almost a decade ago during a Nursys® Committee discussion, and significant efforts by nursing regulatory bodies have furthered NCSBN ID adoption. These efforts include targeted education and partnerships with informatics, nursing, other health organizations, and technology system vendors to implement and operationalize the UNI in clinical practice and administration. Organizations can now incorporate the NCSBN ID into their data sets, and researchers and institutions can exchange their nurse data sets without the need to use PII for identification.

Data from the nursing regulatory bodies' licensing systems flow into NCSBN's primary source equivalent Nursys® system (see Figure 1, page 16). The Nursys system generates and manages the NCSBN ID, providing a continuous update with licensure, discipline and practice privileges information.

Pilot Use Case Examples

Evaluating skills to match patient needs:

At the Center for Medical Interoperability (C4MI), Kelly Aldrich, DNP, MS, RN-BC, FHIMSS, RYT, Chief Clinical Transformation & Digital Officer, and colleagues led a simulation test case to evaluate the use of the NCSBN ID across disparate systems. These connections included a patient monitor, defibrillator, EHR data, human activities and interventions. By implementing the NCSBN ID in the test scenario, C4MI connected data across multiple systems to assess nurses' performance of CPR in a simulated code scenario. With data

continued

1. H.R.34 - 114th congress (2015-2016): 21st Century Cures Act. https://www.congress.gov/bill/114th-congress/house-bill/34. Accessed September 7, 2022.
2. Beale NJ, Rajwany N. Implementation of a Unique Nurse Identifier. Nursing Management. 2022;53(1):6-9. doi:10.1097/01.numa.0000805040.87004.37

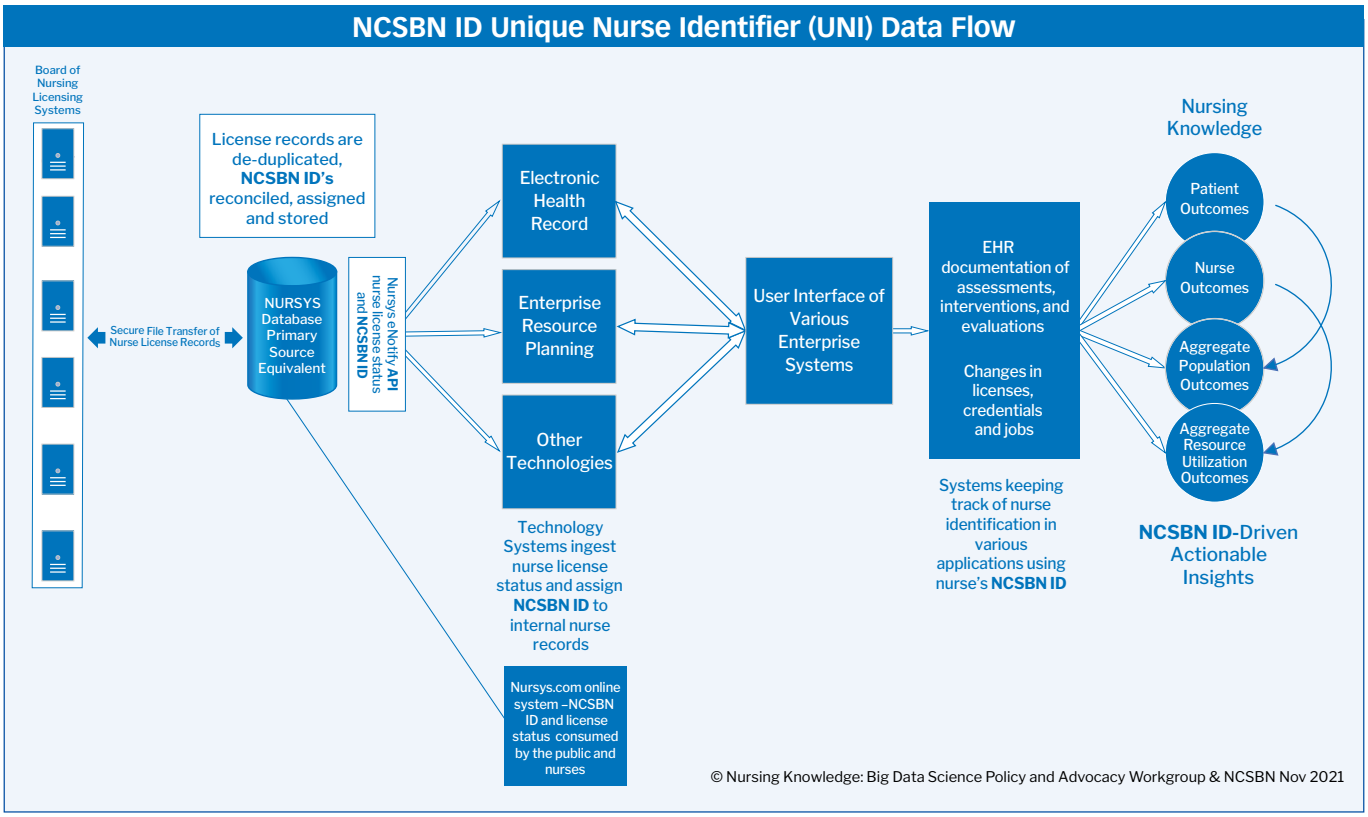


Figure 1

analytics and real-time analysis, clinician performance impact and outcomes assessment were possible.

Looking Ahead

In global unification, the nursing informatics community has facilitated robust informatics education opportunities to bring awareness of the effective use of the NCSBN ID as a UNI. Efforts include print resources, publications, posters, webinars, HIMSS and NCSBN-supported informatics news items, and a social media drive. These campaigns have advanced the national recommendation in the 2020-2030 NAM Future of Nursing Report, which cites a vital need for a UNI to measure nurses' essential contributions to value-based care.

Future NCSBN ID advocacy will include providing tangible technical specifications to health care systems, nursing researchers, institutions of higher learning, the nursing workforce, and health care technology vendors. These defined data workflows and architecture will assist continued proof of concept (POC) pilots. The POCs will promote a better understanding to all practicing nurses and nurse leaders of the benefits of the NCSBN ID as the unique identifier to provide evidence in the movement to quantify the value of nursing practice. ◆

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

Editor: Nancy Spector, PhD, RN, FAAN, Director, Regulatory Innovations, NCSBN nspector@ncsbn.org

NCSBN empowers and supports nursing regulators in their mandate to protect the public.