

## **Essentials Implementation Webinar Series**

### **Chat Box Questions and Responses**

*November 2021*

#### **1. Can you define simulation per the new *Essentials*?**

Simulation experiences provide an effective, safe environment for learning and demonstrating competencies serving to augment direct and indirect care within healthcare settings. However, simulation cannot substitute for all direct care practice experiences in any one sphere of care or for any one age group. While simulation experiences represent an important component of clinical education, care experiences with actual individuals or groups continue to be the most important component of clinical education. Simulation learning experiences should align with best practice standards such as those developed by the International Nursing Association for Clinical Simulation and Learning (INACSL) or the Society for Simulation in Healthcare (SSH). The use of simulation in the curriculum as a replacement of direct patient clinical/practice hours or experiences is also determined by requirements of regulatory entities (i.e., licensing and accrediting bodies) (p.21).

#### **2. There is a huge focus on “skills” when it comes to competencies. Can you please talk about competencies in didactic (not clinical) courses?**

Didactic, simulated, laboratory, and clinical learning experiences prepare nurses to practice in diverse settings. Theoretical learning becomes a reality as students are coached to make cognitive connections between the cases or situations presented in the classroom, simulation, or laboratory and in actual practice settings. Practice experiences should integrate didactic learning, promote innovative thinking, and test new potential solutions to clinical practice or system issues. Programs are responsible for informing clinical educators or preceptors about the specific learning that is expected and occurring in didactic settings and provide appropriate learning opportunities across settings to reinforce learning and achievement of competencies across the 10 Essentials domains (p. 19).

One example would be, clinical judgement and decision-making as a skill can be developed in clinical practice, simulation, group discussions, written examinations, and self-assessment. Snap-shot summative assessments in practice environments, using a multi-level observational rubric has been suggested as a valid approach to

assessing clinical decision making as students transition to practice-ready nurses (Clemett & Raleigh 2021).

**3. How are institutions supposed to differentiate Level 2 competencies between master's and DNP programs? How does a program delineate what a master's student needs to accomplish to meet the competency versus a DNP student if the expected sub-competencies are the same?**

Although the new *Essentials* Level 2 sub-competencies have been written with doctoral education in mind, the actual differentiator for the degree attained does not lie within the sub-competencies themselves, but rather how the competencies are demonstrated, the contexts in which they are demonstrated, and the degree/program requirements – such as the DNP scholarly project, role/ specialty requirements, and other requirements set by the faculty and institution (p. 21). By program's end, DNP students will demonstrate the attainment and integration of the Level 1 sub-competencies, Level 2 sub-competencies, and advanced specialty/role competencies into one's practice (p. 24).

**4. For RN-BSN programs, how is prior learning assessed and what are the expectations for clinical learning experiences?**

Programs preparing nurses to enter professional nursing practice (either through pre-licensure preparation or a degree completion pathway for nursing with initial preparation with an associate or diploma degree) will use the Level 1 sub-competencies to design the curriculum. These programs prepare graduates as a generalist for practice across the lifespan and with diverse populations and in all four spheres of practice (p. 19).

Because learners in these programs are already licensed registered nurses, the Level 1 sub-competencies build on knowledge and skills acquired in their initial nursing education program. Content learned within prerequisite courses is incorporated into the learning and assessment of the sub-competencies as applicable. Verification of prior competency achievement in some domains may result in a shorter timeframe needed to prepare learners in these programs (p. 19).

All learners in entry-level professional nursing education programs are required to engage in direct patient care learning activities in all four spheres of care and across the lifespan (p. 19). Graduates of all entry-level professional nursing education programs need sufficient practice experiences (direct and indirect care experiences) to demonstrate end-of-program learning outcomes which includes the Level 1 sub-competencies. All learners in entry-level professional nursing education programs

will engage in direct patient care learning activities in all four spheres of care and across the lifespan and provide clear evidence of student (Level 1) competency in multiple contexts and settings, not one and done, and may use multiple methods, including through simulation, laboratory and clinical practice (p. 20).

**5. There is some confusion with the designation of RN to BSN programs as entry level. Please confirm that the guidelines for a competency-based curriculum. Are RN-BSN students required to return to clinical site preceptorship?**

All learners in entry-level professional nursing education programs (pre-licensure and postlicensure [degree-completion] programs) are required to engage in direct patient care learning activities in all four spheres of care and across the lifespan (p.19). How this is done and whether the student is placed with a clinical site preceptor or oversight is provided by the faculty is determined by the type of learning experience and the curriculum design.

**6. What about the PhD? You only mention the DNP. Who will do the research and add to our knowledge base if you ignore the role of the PhD?**

The *Essentials* do not apply directly to the preparation of nurse researchers in a PhD (or other nursing research-focused) program. However, the Level 2 sub-competencies could be used by PhD programs to guide core courses for doctoral nursing, particularly for programs offering baccalaureate to PhD degrees. Additionally, for nursing programs offering both DNP and PhD degrees and/or PhD to DNP or DNP to PhD options, the Level 2 sub-competencies could form the basis for shared core courses between the two doctoral degree programs – representing efficiencies in program delivery as well as for more seamless pathways from one degree to the other (p. 17).

AACN's Board of Directors created the Task Force on the Research-Focused Doctoral Program Pathways to Excellence to develop a new vision for PhD programs and graduates. The task force was charged with revising AACN's 2010 position statement on the Research-Focused Doctoral Program in Nursing. The revised position statement is expected to be released in Spring 2022.

**7. Does adopting the new *Essentials* mean that DNP students will no longer need to complete at least 1,000 clinical hours? Are only 500 clinical hours needed?**

All advanced nursing education programs must prepare graduates with the Level 2 sub-competencies. A minimum of 500 practice hours (direct and indirect practice) in

the discipline of nursing, post entry-level education, and attainment of Level 1 sub-competencies are required for the demonstration of the advanced level sub-competencies (Level 2). These practice hours apply to both master's and DNP programs and are considered a foundation for the additional time-based requirements for preparation in any advanced nursing specialty or advanced nursing practice role. The specific clinical/practice experiences and total number of practice hours required includes the minimum 500 hours expected to demonstrate the Level 2 sub-competencies, as well as the advanced nursing practice specialty or advanced nursing practice role requirements and regulatory standards for specialty certifications and licensure. Some specialty areas of practice have separate requirements for those earning a master's degree or a DNP degree. Some of the practice hours for the Level 2 competencies may overlap with those of the specialty or role, but not all will overlap or occur at the same time. Therefore, the total number of hours for a program will vary based on the institution's degree requirements, how the curriculum is designed, and the specialty/role requirements (p. 23).

**8. How do you fit the four spheres of caring into your curriculum? How does acute care fit into the spheres? In which of the four spheres do you see "Acute Care Management" fitting best?**

Acute care is encompassed in sphere 3: "regenerative or restorative care, which includes critical/trauma care, complex acute care, acute exacerbations of chronic conditions, and treatment of physiologically unstable patients that generally requires care in a mega-acute care institution" (p. 6).

How the four spheres of care are addressed and integrated across the curriculum will be determined by the curricular design developed by the program. Historically, nursing education has emphasized clinical education in acute care. While acute care remains an important sphere of professional nursing care, it is increasingly evident that the future of healthcare delivery will occur within four spheres of care: 1) disease prevention/promotion of health and wellbeing, 2) chronic disease care, 3) regenerative or restorative care, and 4) hospice/palliative/supportive care. The workforce of the future needs to attract and retain registered nurses who choose to practice in diverse settings, including community settings to sustain the nation's health. Entry-level professional nursing education programs need to provide rich and varied opportunities for practice experiences (both direct and indirect care experiences) across all four spheres of care, designed to assist the graduate to be able to demonstrate the Level 1 sub-competencies in multiple spheres. Clinical experiences should provide opportunities for students to care for a variety of individuals, families, groups, and populations across the lifespan and across the four

spheres of care. Clinical learning also needs to provide opportunities for students to gain the skills needed to be an effective member of an interprofessional team; thus, interprofessional experiences in a variety of practice settings are essential.

**9. I see how to get going when it comes to the clinically based courses, but do you have suggestions on how to think about competency-based education related to other courses such as pharmacology, pathophysiology, etc.?**

Courses taught outside the nursing program may not be considered competency-based. Content from the sciences or any support/prerequisite courses should be integrated as appropriate across the curriculum. Assessment of the application of the knowledge gained in these courses, e.g., pharmacology, physiology, pathophysiology, genetics, epidemiology, should be incorporated into the “nursing courses” across the curriculum. See Domain 1, Knowledge for Nursing Practice for the expected competencies (p. 27).

**10. Are the “3 P’s” or other separate courses in any of the sciences required for advanced- level nursing programs?**

Physical assessment, physiology and pathophysiology, and pharmacology (commonly referred to as the 3 P’s) are framed within the science of the nursing as a discipline and have varied applications across specialty or practice areas.

The new *Essentials* does not change the requirement that programs preparing graduates for one of the four APRN roles (CRNA, CNM, CNS, NP) must include three separate graduate courses in physical assessment, physiology/pathophysiology, and pharmacology as defined and required in the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education, 2008.

Regardless of the emphasis area of study in an advanced level nursing program, professional nursing leadership, making informed decisions, and guiding practice (regardless of setting) must be informed by the science of the discipline including biophysical principles fundamental to health for patients, families, communities, and populations and available research evidence.

Advanced level (Level 2) sub-competencies across all the Domains of competence are foundational for any pursuit of advanced-level nursing education regardless of practice specialty or advanced nursing practice role. A strong foundation in multiple areas of science ( e.g., physiology, pathophysiology, pharmacology, epidemiology,

genetics) is needed to form the basis for clinical judgment in all areas of nursing practice and to demonstrate the Level 2 sub-competencies.

The science of the discipline may be operationalized differently for different areas of study or specialty areas other than the four APRN roles. The core areas of physiology/pathophysiology, pharmacology, and assessment have varied applications across specialty or practice areas. In addition to the areas of advanced knowledge referenced above, courses or content in other areas of science (e.g., epidemiology, genomics) will be necessary for preparation and attainment/demonstration of the Level 2 competencies. See Domain 1, Knowledge for Nursing Practice, for the expected competencies (p. 27).

Examples of how a student pursuing an advanced nursing degree in Health Systems Leadership might apply scientific knowledge in one's practice are included below.

### **Health Systems Leadership Exemplars**

- A student pursuing an advanced nursing degree in Health Systems Leadership might apply advanced knowledge in pathophysiology of disease within the context of managing a pandemic response across multiple practice settings within a health system including:
  - resource management and staff deployment
  - patient safety
  - care quality
  - modes of transmission
    - associated need for targeted personal protective equipment
    - employee health services management; work- related exposures, vaccination data, etc.
- The Health Systems Leadership student may also apply advanced knowledge of pharmacology to oversight and management of pharmacy services at a systems level including:

Reduction in inpatient pharmacy costs, for example:

  - Evaluation of pharmacologic options for management of deep vein thrombosis (DVT) prophylaxis, including risks, benefits, and comparative cost.
  - To make fully informed decisions, the Health Systems Leader needs to understand pharmacologic agents and their actions on living systems - "how the drug works in the body".

- What a drug is, its physiologic effect, the type of drug being used, modes of administration, how the drug is absorbed.

Allocation of outpatient pharmacy revenue with the goal of improving quality of patient care, for example:

- There are various intravenous and oral therapies to prevent chemotherapy-induced nausea and vomiting (CINV). The choice of pharmaceutical agent is directly related to the emetogenic potential of the chemotherapy regimen. The cost varies for each pharmacologic agent.
- Higher cost is not always associated with more effective prevention and treatment of CINV
  - A clear understanding of pharmacologic principles and concepts, including mechanism of action, is imperative to adequately optimize allocation of pharmacy resources and ensure quality of care.

Clemett, V. J., & Raleigh, M. (2021). The validity and reliability of clinical judgement and decision-making skills assessment in nursing: A systematic literature review. *Nurse Education Today*, 102, 104885. <https://doi.org/10.1016/j.nedt.2021.10488>