OUR COLLECTIVE VOICE

Orchestrating

the Future of Regulatory Excellence

CELEBRATING 30 years
1978–2008
NCSBN
Leading in Nursing Regulation

NASHVILLE
AUGUST 5-8, 2008

2008 ANNUAL MEETING

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Membership

The National Council of State Boards of Nursing, Inc. (NCSBN) is a not-for-profit organization whose membership comprises the boards of nursing in the 50 states, the District of Columbia, and four United States territories—American Samoa, Guam, Northern Mariana Islands and the Virgin Islands.

Mission

The National Council of State Boards of Nursing (NCSBN), composed of Member Boards, provides leadership to advance regulatory excellence for public protection.

Vision

Building regulatory expertise worldwide.

Values

Integrity: Doing the right thing for the right reason through informed, open and ethical debate.

Accountability: Taking ownership and responsibility for organizational processes and outcomes.

Quality: Pursuing excellence in all endeavors.

Vision: Using the power of imagination and creative thought to foresee the potential and create the future.

Collaboration: Forging solutions through the collective strength of internal and external stakeholders.

Purpose

The purpose of NCSBN is to provide an organization through which boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

NCSBN's programs and services include developing the NCLEX-RN® and NCLEX-PN® examinations, performing policy analysis and promoting uniformity in relationship to the regulation of nursing practice, disseminating data related to the licensure of nurses, conducting research pertinent to NCSBN's purpose, and serving as a forum for information exchange for members.

Section I

2008 NCSBN Annual Meeting

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Business Agenda of the 2008 Delegate Assembly

Tuesday, Aug. 5, 2008

8:30–10:00 am

OPENING CEREMONIES

- Introductions
- Announcements

OPENING REPORTS

- Credentials Committee
- Adoption of Standing Rules

ADOPTION OF AGENDA

REPORT OF THE COMMITTEE ON NOMINATIONS

- Presentation of the 2008 Slate of Candidates
- Nominations from Floor
- Approval of the 2008 Slate of Candidates

PRESIDENT'S ADDRESS

CHIEF EXECUTIVE OFFICER'S ADDRESS

Thursday, Aug. 9, 2008

9:00 am–3:30 pm

BOARD OF DIRECTORS' RECOMMENDATIONS

- Adopt the proposed APRN Model Act and Rules.
- Adopt the proposed revisions to the Education Model Rules.
- Adopt the proposed associate membership fee.

NEW BUSINESS

- Accept new advanced practice board of nursing membership applications
- Accept new associate member membership applications

CLOSING CEREMONY

ADJOURNMENT

Special Note

Business conducted during the Delegate Assembly will be continuous, advancing through the agenda as time and discussion permit.

Standing Rules of the Delegate Assembly

1. Credentialing Procedures and Reports

   A. The president shall appoint the Credentials Committee, which is responsible for registering and accrediting delegates and alternate delegates.

   B. Upon registration, each delegate and alternate shall receive a badge and the appropriate number of voting cards authorized for that delegate. Delegates authorized to cast one vote shall receive one voting card. Delegates authorized to cast two votes shall receive two voting cards. Any transfer of voting cards must be made through the Credentials Committee.

   C. A registered alternate may substitute for a delegate provided the delegate turns in the delegate badge and voting card(s) to the Credentials Committee at which time the alternate is issued a delegate badge. The initial delegate may resume delegate status by the same process.

   D. The Credentials Committee shall give a report at the first business meeting. The report will contain the number of delegates and alternates registered as present with proper credentials and the number of delegate votes present. At the beginning of each subsequent business meeting, the committee shall present an updated report listing all properly credentialed delegates and alternate delegates present, and the number of delegate votes present.

2. Meeting Conduct

   A. Delegates must wear badges and sit in the section reserved for them.

   B. All attendees shall be in their seats at least five minutes before the scheduled meeting time.

   C. There shall be no smoking in the meeting room.

   D. All cellular telephones and pagers shall be turned off or turned to silent vibrating mode. An attendee must leave the meeting room to answer a telephone.

   E. A delegate's conversations with non-delegates during a business meeting must take place outside the designated delegate area.

   F. All attendees have a right to be treated respectfully.

   G. There shall be no videotaping, audio recording or photographing of the sessions without the written permission of NCSBN.

3. Agenda

   A. Business

      1. The Business Agenda is prepared by the president in consultation with the executive director and approved by the Board of Directors.

   B. Consent

      1. The Consent Agenda contains agenda items that do not recommend actions.

      2. The Board of Directors may place items on the Consent Agenda that may be considered received without discussion or vote.

      3. An item will be removed from the Consent Agenda for discussion or vote at the request of any delegate.

4. All items remaining on the Consent Agenda will be considered received without discussion or vote.

4. Motions or Resolutions

A. Only delegates, members of the Board of Directors, and the Examination Committee may present motions or resolutions to the Delegate Assembly. Resolutions or motions made by the Examination Committee are limited to those to approve test plans pursuant to Article X, Section 1(a) of the bylaws of the National Council.

B. All motions, resolutions and amendments shall be in writing and on triplicate motion paper signed by the maker and a second. All motions, resolutions and amendments must be submitted to the Delegate Assembly chair and the parliamentarian. All resolutions and non-procedural main motions must also be submitted to the chair of the Resolutions Committee before being presented to the Delegate Assembly.

C. The Resolutions Committee, according to its Operating Policies and Procedures, shall review motions and resolutions submitted before Wednesday, Aug. 8, 2007, at 4:30 pm. Resolution or motion-makers are encouraged to submit motions and resolutions to the Resolutions Committee for review before this deadline.

D. The Resolutions Committee will convene its meeting on Wednesday, Aug. 8, 2007, at 4:30 pm and schedule a mutually agreeable time during the meeting to meet with each resolution or motion-maker. The Resolutions Committee shall meet with the resolution or motion-maker to prepare resolutions or motions for presentation to the Delegate Assembly and to evaluate the resolution or motion in accordance with the criteria in its operating policies and procedures. The Committee shall submit a summary report to the Delegate Assembly of the Committee's review, analysis, and evaluation of each resolution and motion referred to the Committee. The Committee report shall precede the resolution or motion by the maker to the Delegate Assembly.

E. If a member of the Delegate Assembly wishes to introduce a non-procedural main motion or resolution after the deadline of 4:30 pm on Wednesday, Aug. 8, 2007, the request shall be submitted under New Business; provided that the maker first submits the resolution or motion to the chair of the Resolutions Committee. All motions or resolutions submitted after the deadline must be presented with a written analysis that addresses the motion or resolution's consistency with established review criteria, including, but not limited to, the NCSBN mission, purpose and/or functions, strategic initiatives and outcomes; preliminary assessment of fiscal impact; and potential legal implications. The member submitting such a motion or resolution shall provide written copies of the motion or resolution to all delegates. A majority vote of the delegates shall be required to grant the request to introduce this item of business. [The Resolutions Committee shall advise the Delegate Assembly where the required analyses have not been performed and/or recommend deferral of a vote on the motion pending further analysis.]

5. Debate at Business Meetings

A. Order of Debate: Delegates shall have the first right to speak. Non-delegate members and employees of Member Boards including members of the Board of Directors may speak only after all delegates have spoken.

B. Any person who wishes to speak shall go to a microphone. When recognized by the chair, the speaker shall state his or her name and Member Board or organization.

C. No person may speak in debate more than twice on the same question on the same day, or longer than four minutes per speech, without permission of the Delegate Assembly, granted by a majority vote without debate.

D. A red card raised at a microphone interrupts business for the purpose of a point of order, a question of privilege, orders of the day, a parliamentary inquiry or an appeal. Any of these motions takes priority over regular debate.

E. A timekeeper will signal when the speaker has one minute remaining, and when the allotted time has expired.

F. The Delegate Assembly may by a majority vote go into executive session. The enacting motion shall specify those permitted to attend.

6. Nominations and Elections

A. A delegate making a nomination from the floor shall have two minutes to list the qualifications of the nominee. Written consent of the nominee and a written statement of qualifications must be submitted to the Committee on Nominations at the time of the nomination from the floor.

B. Electioneering for candidates is prohibited except during the candidate forum.

C. The voting strength for the election shall be determined by those registered by 5:00 pm on Wednesday, Aug. 8, 2007.

D. Election for officers, directors, and members of the Committee on Nominations shall be held Thursday, Aug. 9, 2007, from 7:45 to 8:45 am.

E. If no candidate receives the required vote for an office and repeated balloting is required, the president shall immediately announce run-off candidates and the time for the run-off balloting.

1. If no candidate for officer or area director receives a majority on the first ballot, the run-off shall be limited to the two candidates receiving the highest number of votes.

2. If no candidate for director-at-large receives a majority on the first ballot, the run-off shall be limited to the four candidates receiving the highest number of votes. If no candidate receives a majority on the second ballot, another run-off shall be limited to the three candidates receiving the highest number of votes.

3. If, on the initial ballot, one candidate for director-at-large receives a majority, a run-off shall be limited to the two candidates receiving the next highest number of votes.

7. Forums

A. *Scheduled*: The purpose of scheduled forums is to provide information helpful for decisions and to encourage dialogue among all delegates on the issues presented at the forum. All delegates are encouraged to attend forums to prepare for voting during the Delegate Assembly. Forum facilitators will give preference to voting delegates who wish to raise questions and/or discuss an issue. Guests may be recognized by the chair to speak after all delegates, non-delegate members and employees of Member Boards have spoken.

B. *Open*: Open forum time will be scheduled to promote dialogue and discussion on issues by all attendees. Attendee participation determines the topics discussed during an Open Forum. The president will facilitate the Open Forum.

C. To ensure fair participation in forums, the forum facilitators may, at their discretion, impose rules of debate.

Annual Meeting Schedule

Monday, Aug. 4, 2008

6:00–7:30 pm

NCSBN Reception and Delegate Orientation Education Session

Are you representing your state as a delegate? Please join us for a review of the parliamentary procedures followed when debating and voting on Delegate Assembly business. All registered attendees and delegates are invited to attend this orientation education session.

Tuesday, Aug. 5, 2008

7:30 am–5:00 pm

NCSBN Product Showcase

Stop by the Exhibit Showcase to learn of products and information pertinent to the work of boards of nursing.

7:30–8:30 am

Registration/Continental Breakfast

8:30–10:00 am

Delegate Assembly: Opening Ceremony

Welcome from the Tennessee Board of Nursing

- Opening Ceremony
  - Introductions
  - Announcements
- Opening Reports
  - Credentials
  - Adoption of Standing Rules
- Adoption of Agenda
- Report of the Committee on Nominations
  - Presentation of the 2008 Slate of Candidates
  - Nominations from Floor
  - Approval of the 2008 Slate of Candidates

President's Address

Faith A. Fields, MSN, RN, NCSBN Board President

Chief Executive Officer's Address

Kathy Apple, MS, RN, CAE, NCSBN CEO

10:00–10:30 am

Break

10:30–12:00 pm

Candidate Forum

Emmaline Woodson, MS, RN, Area IV, Chair, NCSBN Committee on Nominations

Support NCSBN and your fellow NCSBN members: Come to the Candidate Forum to hear from the nominees for NCSBN elected office.

12:00–1:15 pm

Lunch

Lunch will be held in two separate rooms. (McGavocks ABC & Evergreen)

SCHEDULE SUBJECT TO CHANGE.

1:15–2:15 pm — **Keynote Speaker: Motivational/Inspirational**

Ann Bancroft

2:15–3:15 pm — **APRN Committee Forum**

Ann O'Sullivan, PhD, MSN, CRNP, CPNP, FAAN, Area IV, Chair, Advanced Practice Committee (APRN)

The APRN legislative language developed by the APRN Committee which parallels the APRN Consensus Report will be discussed.

3:15–4:00 pm — **Faculty Qualifications Committee Forum**

Susan Odom, PhD, RN, CCRM, Area I, Chair, Faculty Qualifications Committee

Presentation and discussion related to the work of the Faculty Qualifications Committee and the proposed model rule changes.

6:00–7:30 pm — **Tennessee Board of Nursing Reception – Country Music Hall of Fame**

The Tennessee Board of Nursing would like to welcome all attendees to Nashville for the Annual Meeting and Delegate Assembly. Please join us at the Country Music Hall of Fame for a networking reception and tour.

Wednesday, Aug. 6, 2008

7:30 am–5:00 pm — **NCSBN Product Showcase**

Stop by the Exhibit Showcase to learn of products and information pertinent to the work of boards of nursing.

7:30–8:30 am — **Registration**

8:30–10:15 am — **Area Breakfast Meeting**

NCSBN Area breakfasts are open to NCSBN members and staff only. Breakfasts will be served outside designated meeting rooms from 7:30-9:00 am. Meetings will start at 8:30 am.

The purpose of NCSBN Area Meetings is to facilitate communication and encourage regional dialogue on issues important to NCSBN and its members.

- Area I members include: Alaska, American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Northern Mariana Islands, Oregon, Utah, Washington, and Wyoming
- Area II members include: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, West Virginia, and Wisconsin
- Area III members include: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, and Virginia
- Area IV members include: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont and Virgin Islands

External Organizations Breakfast Meeting

Guests are invited to attend this breakfast meeting to discuss issues of mutual concern with NCSBN staff.

10:15–10:30 am — **Break**

10:30–11:30 am — **Board of Directors Forum**

Faith A. Fields, MSN, RN, NCSBN Board of Directors President

NCSBN President, Faith Fields, will present and discuss Board of Directors issues, the Associate membership Fee and Advanced Practice Board of Nursing Applicants.

11:30 am–12:00 pm — **Plenary: The First 25 Years of NCSBN**

Corinne F. Dorsey, MS, RN and Joyce M. Schowalter, MEd, RN

12:00–1:15 pm — **Lunch**

Lunch will be held in two separate rooms. (McGavocks ABC & Evergreen)

1:15–1:30 pm — **Finance Committee Forum**

Ruth Ann Terry, RN, MPH, Area I, Chair, NCSBN Finance Committee, Treasurer, NCSBN Board of Directors

1:30–2:30 pm — **Keynote Speaker: The Regulatory Challenge of the Future**

Jeffrey Bauer, PhD, Healthcare Futurist

2:30–3:30 pm — **Plenary: "Self-Assesement, Self-Direction, Self-Regulation and Other Myths"**

Glenn Regehr, PhD

- Richard and Elizabeth Currie, Chair in Health Professions Education Research
- Professor, Faculty of Medicine, University of Toronto
- Scientist, Toronto General Research Institute, University Health Network
- Associate Director, The Wilson Centre

3:30–4:30 pm — **Resolutions Committee Meeting**

6:00–9:30 pm — **NCSBN 30th Anniversary Gala**

Celebrate 30 years of regulatory excellence! Join us at the General Jackson Showboat for a dinner cruise with dancing and an awards ceremony celebrating NCSBN membership. Semi-formal/cocktail attire. Shuttles depart the Sheraton Music City hotel at 5:30 pm.

Thursday, Aug. 7, 2008

7:45–8:45 am — **Election of Candidates**

8:00–9:00 am — **Pearson VUE Sponsored Breakfast and Registration**

9:00–10:00 am — **Delegate Assembly**

- Adopt proposed APRN Regulatory Model Act and Rules

10:00–10:15 am — **Break**

10:15 am–12:00 pm — **Delegate Assembly Resumes**

- Adopt the proposed revisions to Education Model Rules
- Adopt the proposed associate member fee

12:00–1:15 pm — **Lunch**

Lunch will be held in two separate rooms. (McGavocks ABC & Evergreen)

SCHEDULE SUBJECT TO CHANGE.

1:15–3:30 pm **Delegate Assembly Resumes**

New Business

- Accept new advanced practice board of nursing membership applications
- Accept new Associate Member membership applications

Closing Ceremony

Friday, Aug. 8, 2008

7:30–8:30 am **Continental Breakfast**

8:30–10:00 am **Knowledge Networks**

NCSBN Knowledge Networks are brainstorming discussions regarding industry issues. Participants will be asked to brainstorm a list of the top five industry topics with the top three selected for discussion/exploration.

Choose from the following options:

- NCSBN Executive Officers
- NCSBN Board Presidents
- NCSBN Board Members
- Discipline
- Practice
- Education
- Licensed Practical/Vocational Nurses

10:00–10:15 am **Break**

10:15–11:30 am **Breakout Sessions**

NCSBN is pleased to offer the following breakout sessions (more information to be provided, soon).

- NCSBN Research
- Nur*sys*®/HIPDB
- TERCAP™
- CORE
- IRE

11:30 am **Boxed Lunches**

SCHEDULE SUBJECT TO CHANGE.

Summary of Recommendations to the 2008 Delegate Assembly with Rationale

This document provides a summary of recommendations that the NCSBN Board of Directors and the Committee on Nominations propose to the 2008 Delegate Assembly. Additional recommendations may be brought forward during the 2008 Annual Meeting.

Board of Directors' Recommendations

1. ***Adopt the proposed APRN Model Act and Rules.***

   Rationale:
   The purpose of the proposed APRN model act and rules is to promote the homogeneity of Advanced Practice Registered Nurse regulation across the country. The proposed model was written to reflect the consensus results of the national dialogue on changes to advanced practice education, accreditation, certification and licensure.

   Fiscal Impact:

   The future Board of Directors will determine what support services may be developed to assist Member Boards with the implementation of this model should the model be adopted by the Delegate Assembly.

2. ***Adopt the proposed revisions to the Education Model Rules.***

   Rationale:
   The Faculty Qualifications Committee reviewed the literature and received feedback from Member Boards and educators and concluded that the NCSBN Model Education Rules should be revised to include stronger language for requiring graduate level clinical practice and education. Further, given the complexity in nursing practice and nursing education today, the education level for practical nurse educators should be increased from a baccalaureate degree with a major in nursing to a master's degree with a major in nursing.

   Fiscal Impact:
   None

3. ***Adopt the proposed membership fee of $1,500 per year for Associate Members.***

   Rationale:
   The 2007 revisions to the NCSBN Bylaws created an Associate Member category for a nursing regulatory body or empowered regulatory authority from another country or territory. The bylaw revision requires approval of the membership fee by the full membership of the Delegate Assembly. Due diligence was used to assess comparable associate membership fees of similar organizations along with the level of services and products provided to associate members.

   Fiscal Impact:
   Revenue generated of $1,500 per year per Associate Member.

Committee on Nominations Recommendation

1. ***Adopt the 2008 Slate of Candidates.***

Rationale:
The Committee on Nominations has prepared the 2008 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of the NCSBN. Full biographical information and personal statement for each candidate is posted in the Business Book under the Report of the Committee on Nominations. Candidates will present himself or herself at the Candidate's Forum on Tuesday, Aug. 5, 2008.

Fiscal Impact:
Costs for the new Leadership Succession Committee will be incorporated into the FY09 budget, approximately $33,000.

Report of the Committee on Nominations

Recommendation to the Delegate Assembly

1. ***Adopt the 2009 Slate of Candidates.***

   Rationale:
   The Committee on Nominations has prepared the 2009 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of NCSBN. Full biographical information for each candidate follows. Each candidate will present himself or herself at the Candidate's Forum on Tuesday, Aug. 5, 2008.

Background

Per the bylaws, the Committee on Nominations considers the qualifications of all nominees for officers and directors and presents a qualified slate of candidates for vote at the Annual Meeting. The Committee's report is read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name is placed in nomination without the written consent of the nominee.

Once members are elected to the new Leadership Succession Committee, the Committee on Nominations will be discontinued.

Highlights of FY08 Activities

- The Committee reviewed the 2007 Committee evaluations and the 2007 Delegate Assembly evaluation comments related to the candidate forum and election process.
- The Committee reviewed the NCSBN Bylaws, Policy 3.1, Role of the Board, the NCSBN mission, vision, and values and the strategic initiatives for 2008-2010.
- The Committee reviewed the special proviso from the bylaw changes adopted at the 2007 Delegate Assembly for the Board of Directors and the Leadership Succession Committee.
- The Committee reviewed the Committee on Nomination policies 1.1, 1.2, and 1.3.
- Policy 1.3 was revised to allow for four minute speeches for candidates running for Board of Director positions and two minute speeches for candidates running for the Leadership Succession Committee.
- From a conference call with the Board of Directors, the need for all aspects of diversity was identified as important for the next slate of candidates. The Board of Directors emphasized the need for candidates to clearly understand the time needed to fulfill the commitments of officer and director positions.
- The Committee discussed various campaign strategies, the initial campaign letter and the recruitment brochure.
- The Committee discussed methods of increasing awareness of positions open for nomination.
- The Committee discussed various methods of providing more information about candidates to the membership. The Committee will implement an audio stream of candidate responses (two minutes for each candidate) to the following questions along with their photo at a display table at Delegate Assembly.
  - What have been your contributions to your state board and/or to NCSBN?

Committee Members

Emmaline Woodson, MS, RN
Maryland, Area IV, Chair

Paula Meyer, MSN, RN
Washington, Area I

Mary Blubaugh, MSN, RN
Kansas, Area II

Janice Hooper, PhD, CS, RN
Texas, Area III

Staff

Kathy Apple, RN, MS, CAE
Chief Executive Officer

Kate Jones
Coordinator, Executive Office and Meetings

Meeting Dates

- Dec. 10, 2007
- March 12, 2008 (Conference Call)
- April 23, 2008
- May 13 & 15, 2008 (Conference Call)

  - Describe your current and/or previous nursing or professional experiences.
  - Describe your current and/or previous leadership experiences.
- The 2008 Midyear PowerPoint presentation were reviewed, revised and presented at the 2008 Midyear Meeting.
- The Committee met with Member Board presidents during the 2008 Midyear Presidents Networking session.
- Three nomination e-mail reminders were sent to the membership on March 13, 24 and April 7, 2008.

Attachments

A. 2008 Slate of Candidates

Attachment A

2008 Slate of Candidates

The following is the slate of candidates developed and adopted by the Committee on Nominations. Each candidate profile is taken directly from the candidate's nomination form. The Candidate Forum will provide the opportunity for candidates to address the 2008 Delegate Assembly.

Board of Directors

President

Kathy Malloch, Arizona, Area I 22

Laura Rhodes, West Virginia, Area II 23

Vice President

Lepaine McHenry, Arkansas, Area III 25

Treasurer

Ruth Ann Terry, California, Area I 26

Director-at-Large (two-year term) (two positions)

Randall Hudspeth, Idaho, Area I 27

Rene Cronquist, Minnesota, Area II 28

Patricia Lane, Virginia, Area III 29

Katherine Thomas, Texas, Area III 30

New Director-at-Large (one-year term) (two positions)

Catherine Giessel, Alaska, Area I 31

Lynda Narwold, Indiana, Area II 32

Leadership Succession Committee

Area I

Barbara Swehla, Montana, Area I 33

Area II

Nancy Bohr, South Dakota, Area II 34

Area III

Rick Garcia, Florida, Area III 35

Richard Gibbs, Texas, Area III 36

Area IV

None

Designated Member (Current or Former Chair) (one-year term)

None

Designated Member (Board Member of Member Board) (one-year term)

Alexis Welch, North Carolina, Area III 37

Detailed Information on Candidates

Information is taken directly from nomination forms and organized as follows:

1. Name, jurisdiction and area.
2. Present board position, board name.
3. Date of term expirations and eligibility for reappointment.
4. List all relevant professional/regulatory/community involvement including service on National Council committee(s).
5. What do you see as a challenge to nursing regulation and how would you propose resolving the challenge?
6. Describe how you will advance the mission, vision and strategic initiatives of the NCSBN.

Date of expiration of term:
June 30, 2012

Eligible for reappointment:
No

President

Kathy Malloch, PhD, MBA, RN, FAAN

Board Member, Arizona, Area I

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Arizona State Board of Nursing (1998-present); I have served as member, vice-president and president. NCSBN: Practice Breakdown: I have served as member, and chair; Governance and Leadership Task Force, member: Board of Directors; I have served as Director at Large and currently serve as Area I Director. I am a member of the American Academy of Nursing, American Nurses Association, American Organization of Nurse Executives, Sigma Theta Tau: Beta Upsilon chapter, Arizona Nurses Association, Member of Arizona Governor's Nursing Shortage Task Force, and Arizona Organization of Nurse Executives. I have served on numerous committees of these organizations including finance, informatics expert panel, research committee, and evidence based practice.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

The work of the NCSBN Board of Directors is to actively be involved in identifying and addressing current member board challenges and looking around the corner to identify future regulatory challenges. The Board of Directors is accountable to ensure that these challenges are clearly identified and become the core initiatives of the NCSBN strategic plan. The strategic plan must also include a research agenda that meets the needs of Member Boards in creating and transferring knowledge to support evidence based regulation. The specific challenges/ opportunities for the next three years are: 1) assuring that the member board core competencies have been identified and that education and expediential learning is ongoing through NCSBN offerings; 2) exploring new ways to increase the transparency of the NCSBN "glass house" through member board access to information, involvement and influence in decisions that impact state board effectiveness; 3) exploring new methods.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

Nursing regulation of the future will need to be responsive, evidence-based and tightly linked to the protection of the public. As an experienced nursing leader and current member of NCSBN Board of Directors, I will use my knowledge, education, experience, networking expertise and passion for excellence to continue the established pathway of NCSBN. My ten years of experience as a Board Member in nursing regulation and over 35 years experience in patient care operations, nursing education and self-employment provide a broad range of experiences and perspectives that will assist me in this role. Specifically, I will support efforts to accelerate the work of determining continuing competency mechanisms, to continue to assure testing excellence and security in the electronic world, support the ongoing creation of evidence-based regulatory practices and contribute to the science of regulation through a disciplined research program.

President

Laura Rhodes, RN, MSN

Board Staff, West Virginia, Area II

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

NCSBN

Vice President; Board of Directors

Liaison to the Bylaws Committee

Transition to Practice Committee

Faculty Qualifications Committee

Bylaws Task Force, 1999

Bylaws Chairperson, 2000-2006

Governance and Leadership Task Force, 2004-2005

Governance and Leadership Advisory Council, 2005-2006

Professional Involvement

American Red Cross, 1980

Sigma Theta Tau, 1983

Assistant Troop Leader for West Virginia Black Diamond Girl Scout Council Troop 2126

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

One challenge to nursing regulation is "process". By this I mean the steps that must occur to go from the birth of an idea to its implementation. We have some excellent ideas and expectations for regulation. Moving these ideas through all stages of development to implementation is sometimes a challenge for us in our various roles as Member Boards, whether as individual agencies or as the membership of NCSBN. There are many legitimate reasons the process may take a while. At both the local and national levels it takes time to garner support for an idea, gather evidence, evaluate information, draw conclusions, develop feasible recommendations, pass laws, educate, evaluate and begin again. Unified success is the goal. And, when unified success is not the result, we are more often able to agree to disagree when the process meets our needs. The results of the most recent Member Board Assessment reports that "75% or more of the Member Boards identified the following issues as being important for NCSBN to focus on: 1) Providing more data for evidence based regulation so that hard facts support best practices; 2) Global issues and changes to ensure NCSBN remains a resource for cutting-edge information; 3) Developing a program to educate administrators and members on how to identify fraudulent documents; and 4) Determining facts involved in nursing incidents that require disciplinary or remediation action". As president of NCSBN I will accept these membership identified issues as my own. I will: work toward resolving the challenge of "process" by including in all deliberations and activities the perspective of the membership; work with the Chief Executive Officer to assure our thoughts and plans are in sync with membership and organization needs; lead the Board in their work to determine viable options; and keep a constant watch on the "process" to assure our communications are timely and clear. It is the collective wisdom, intellect and commitment of the membership and staff that will result in the development of feasible solutions to these issues.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

Being prepared and current on issues of interest to the membership and assuring the organization's presence during discussions with related stakeholders are foundations to advancing the mission, vision and strategic initiatives. My previous leadership roles, regulatory experience and service on the NCSBN Board of Directors have all prepared me to effectively represent the positions of NCSBN in both national and international arenas. As president I will continue to support the current atmosphere of fairness and open communication in all NCSBN activities.

Vice President

Date of expiration of term:
Dec. 31, 2008

Eligible for reappointment: Yes

Lepaine McHenry, RN, BSN, MS, CNS

Board Member, Arkansas, Area III

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Served on the NCSBN Practice, Regulation, and Education Committee 2005-2007, Currently Serving as Chair of the Transition to Practice Committee 2007- present, Served as NCSBN Delegate to Delegate Assembly in 2006 and 2007, Served on Arkansas State Board of Nursing since 2004, Currently serving as Board President 2007-2008, Served as Board Vice President 2006-2007, Chaired the ASBN Education Committee 2006-2007, Chaired Arkansas Medication Assistive Personnel Taskforce 2005-2006, Chaired Arkansas Consumer Directed Care Task Force 2005, Appointed by Arkansas Governor to serve on the Minority Health Commission and Long Term Care Advisory Board, Founder of the Arkansas Directors of Nursing Administration in LTC Organization, Served on Board in several roles of the National Assoc. of Directors of Nursing Administration for 17 years, Served as Board Chair for the Community Clinic at St. Francis House, Board Member of the Leadership Training Institute of America.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

There are many challenges facing nursing regulation. However, Continued Competence and Transition to Practice are two challenges that face nursing regulators worldwide. These challenges can be best addressed when NCSBN seeks the input of Member Boards; work collaboratively to ensure that quality products and services are provided based on the need of our members that support and enhance their ability to function effectively. Also, dealing with the ever increasing disciplinary caseloads for Member Boards is a challenge. The NCSBN can assist by conducting research of disciplinary data to identify methods to expedite cases and assist Member Boards in this area.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

My diverse background has afforded me the opportunity to gain a front line perspective of nursing education, practice, and regulation. This combination of experiences uniquely prepares me to serve our Member Boards and NCSBN to provide leadership that advances regulatory excellence. My ability to effectively communicate, collaborate, build consensus, problem solve, negotiate, engage discussion, and listen will be instrumental in working with Member Boards and advancing the mission of NCSBN. I will work with all board members to ensure that all initiatives of the NCSBN are mission and vision driven. To accomplish this, I will function as a team player, a voice of Member Boards, and demonstrate support of the delegate assembly approved strategic initiatives. I pledge to maintain as the foundation of my service to the NCSBN to be rooted in its fundamental purpose of public protection.

Date of expiration of term: N/A
Eligible for reappointment: N/A

Treasurer

Ruth Ann Terry, MPH, RN

Board Staff, California, Area I

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

I have served as treasurer for the past two years and I can truthfully say it has been one of the most rewarding experiences I've had. I have been a member of NCSBN since 1985. I have served on a number of committees over the years. The most recent committees include the finance committee of which I served five years before my election as treasurer. I served on the bylaws committee and the resolutions committee. I continue to serve on two 501(c)(3) organizations in my community, which has reinforced the need for a strong board of directors. I feel I will be an asset to the NCSBN Board of Directors if I am re-elected as treasurer.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

One of the major challenges facing nursing education and nursing service today is a need for a more cohesive use of technology to enhance the quality of nursing care that is being provided. There continues to a major disconnect between expectations by nursing educators and nursing service. NCSBN could serve as a pivotal partner in bringing these two groups together to develop a master plan that not only identifies the minimum requirements for specific kinds of technology and core competencies that should be included in every school of nursing and in every direct care RN job description. The outcome could strengthen the continuity of care being provided when everyone starts with a level playing field.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

I would continue to advance the mission, vision and strategic initiatives by continuing to be an advocate for consumers. For the past two years as treasurer of this organization, I have worked diligently to ensure that the fiduciary responsibility is at the forefront of the discussions by the finance committee. I will continue to be mindful of who our customers are and represent board of nursing and our strategic partners with honesty, integrity and a bit of humor. Give this economy; I welcome the opportunity to assist in ensuring the economic viability of this organization.

Director-at-Large

Date of expiration of term:
April 30, 2011

Eligible for reappointment: Yes

Randall Hudspeth, MS, APRN-CNS/NP, FRE

Board Member, Idaho, Area I

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

State Level

Board Member holding Advanced Practice Seat since 2003

Board chairman two terms

Board vice-chairman two terms

Member multidisciplinary APRN Advisory Committee to BON

BON representative to annual AANP Region 10 meetings, 2004- current

National

Mid-year meeting 2004, 2005, 2006

Delegate for Idaho at annual meeting, 2003, 2004, 2005, and 2006

APRN Committee for NCSBN, 2004- current

APRN Round Table 2004- current, presenter 2007

APRN Conference for Board of Nursing – Facilitator, 02/2007.

Institute of Regulatory Excellence, 2004-2007

FRE – Inducted Fellow of IRE, August 2007

Presenter, Institute of Regulatory Excellence, Jan. 2008

Nursing Regulation Column author, *Nursing Administration Quarterly* since 2006

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

One challenge ahead is the implementation and enforcement of the model statute language and corresponding rule and regulations for APRNs will challenge NCSBN to communicate, explain, reinforce and invest in maintaining national consensus among stakeholders and boards. Development of an effective "roll-out" plan and continued, structured communication will help avoid problems that could negatively impact success. Another potential issue is the continued impact of the nursing shortage and the pressure to lower practice standards to meet staffing needs. For this, education about standards, implementing outcome measurements and breaking down barriers to licensure need to be explored.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

I believe that a consistent presence, messaging and reinforcement are essential to promoting NCSBN mission. As a board member, being a part of the team who engages in the conversation, and supports the outcome decision of the group is essential. I have a strong management background, have worked to learn regulatory principles, demonstrated some level of competence in regulation as a state board member, and I can provide the added perspective as a APRN.

Date of expiration of term: N/A
Eligible for reappointment: N/A

Director-at-Large

Rene Cronquist, JD, RN

Board Staff, Minnesota, Area II

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Discipline Resources Advisory Panel 2003-2006;

Institute for Regulatory Excellence, Participant 2003-2005 Speaker 2005;

Minnesota Intercollegiate Nursing Consortium Advisory Group, 2004-present;

Numerous state nursing practice stakeholder workgroups;

Minnesota Nurses Association Disaster Nursing conference planning committee/ presenter, 2007;

FARB Advocacy Committee, 2008;

Minnesota Society for Health Risk Management 2006.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

Nursing regulation faces numerous, critical challenges. Generally speaking, nursing regulation is faced with a challenge to remain a relevant, significant contributor to the health and welfare of the public, given the fast-paced evolution of health care. This can be addressed, in part, by continued communication and collaboration among boards of nursing regarding the issues of mutual concern. One of the specific challenges nursing regulation must address is ensuring the appropriateness and effectiveness of disciplinary actions and other remedies utilized by boards of nursing. This can be addressed by continuing to conduct, support and disseminate research that provides evidence-based strategies for effectuating improvement in nursing practice.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

I will seek to advance the mission, vision and strategic initiatives of the NCSBN by being an active listener, intentional learner, responsible participant, careful thinker, clear communicator and conscientious collaborator. While I bring extensive experience of working with one board, I recognize and appreciate that NCSBN is comprised of boards with a myriad of structures and a diversity of pressing issues. I will seek to bring a broad vision to my work as a Director-at-Large for NCSBN.

Director-at-Large

Date of expiration of term:
July 1, 2009

Eligible for reappointment:
Yes

Patricia Lane, RN, BS, BSN, MBA, HC

Board Member, Virginia, Area III

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

I was appointed to the Virginia State Board July 2005 for a four year term. Since being on the board I have been on the following committees: Special Education Committee; CORE; Simulation Research Task Force; RFP Task Force for CNA's

Other activities in the community included: Member of Virginia Legislative Coalition; Member of Virginia Partnership for Nursing; Member of ANA – Virginia confirmation 25579, District 8; President of Northern Virginia National Black Nurses Association 2007-2008; Member of American Association of Neuroscience Nurses; Ambassador for the Power to End Stroke Program; AHA/ASA Nursing Representative for Power to End Stroke CME Project; Chair of Greater Washington Area PTES AHA/ASA Task Force; Member of Alpha Kappa Alpha Sorority Incorporated since 1982; Member of Mt. Zion United Methodist Church; Member of Sigma Theta Tau; GMU Alumni Association

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

I believe the most challenging foci of nursing regulation revolve around continuous advocacy of patient safety. At the heart and soul of all regulatory boards is keeping the public safe. Factors that impact nursing regulations incorporate nursing shortages, health policy and last but not least the various entry levels of nursing. It is imperative for nursing to be regulated to keep the public safe. Ideologies such as TERCAP, CORE, continuous competency and strategic alignment amongst various states and international water are imperative to ensure nursing regulations are steadfast. I would propose that it is mandatory for all nursing faculty and those applying for a nursing license take a competency test on the regulations governing the practice of nursing. On-boarding is critical to the maintenance of nursing and I believe will assist with decreasing discipline cases. As we learned in nursing school there is a rationale behind every action.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

I was very impressed by the work that was shared at the Midyear meeting. One of the things I would strive to do would be to share the work of NCSBN and their strategic initiatives with a plethora of stakeholders in nursing, health policy and community entities. I would take a grass roots approach to this methodology by creating quarterly updates of how strategic initiatives developed in NCSBN correlates to the success of nursing practice. The quality outcomes department for NCSBN is robust and I would like to see a stronger link to each state incorporating the initiatives of NCSBN. Furthermore I would like to see each state board member share the initiatives of NCSBN with their perspective area. I truly believe this would be a positive initiative for all to see the emphasis placed on patient safety.

Date of expiration of term: N/A
Eligible for reappointment: N/A

Director-at-Large

Katherine Thomas, MN, RN

Board Staff, Texas, Area III

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

National Level

National Council of State Boards of Nursing (NCSBN) Task Force to Study the Feasibility of a Core Competency Examination for Nurse Practitioners, 1993-1995

NCSBN Advanced Practice Registered Nurse Advisory Committee, 1995-2007

NCSBN Representative to the APRN Joint Dialogue Group, 2007- present

NCSBN APRN Compact Subcommittee, 2001 – 2003

NCSBN Nursing Practice and Education Committee, Chair, 1999-2001

Nurse Licensure Compact Administrators (NLCA) Member for Texas, 2000- present

NLCA Vice Chair 2002-2006

NLCA Executive Committee

APRN Member at Large, 2007- present

State Level

Executive Director, Texas Board of Nursing, November, 1995- present

Director of Practice and Enforcement, Texas Board of Nursing Examiners, 1994-1995

Nursing Consultant for Advanced Practice, Texas Board of Nurse Examiners, 1990-1994

Nursing Consultant for Education, Texas Board of Nurse Examiners, 1989-1990

Texas Health Professions Council, Chair, 2000- present; Vice-Chair

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

Patient safety is inherent in the mission of boards of nursing. Increasingly, nursing regulation is being challenged to be proactive in promoting patient safety. Patient safety literature has identified individual and systems factors that contribute to error. Several states are piloting models to study and remedy both individual and systems factors. TERCAP is an initiative that will provide boards of nursing with the evidence of the effect of both types of factors on patient safety. Sharing lessons learned from this project may result in changes to systems to better protect patients in the future. I believe boards of nursing have a wealth of data and information that can be mined for the improvement of patient safety. These initiatives are consistent with NCSBN's objectives to implement regulatory best practices and provide models of evidenced-based regulation.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

I would advance NCSBN's mission, vision and strategic initiatives through active study, discussion, listening, and generative thinking with fellow members of the Board and with the broader member board community. I like to think I have an open mind to all points of view. I believe that through consideration of all perspectives, we arrive at our best decisions.

New Director-at-Large

Date of expiration of term:
March 1, 2010

Eligible for reappointment:
No

Catherine Giessel, MS, ANP, FAANP

Board Member, Alaska, Area I

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Professional Boards and Commissions

Alaska Board of Nursing (2003- present) secretary 2004-2005, chair 2005-present; NCSBN Disciplinary Resources Committee 2006- present; Anchorage Health and Human Services Commission 2002- present; Governor's transition advisory team for the Department of Health and Social Services 2002 and 2006; Physical Activity Committee of the Mayor's Task Force on Obesity and Health, chair 2007- present; Governor's Healthcare Strategy Planning Council 2007; International Winter Cities, Health and Medicine Tract chair 2004; Commonwealth North Healthcare Study Group 2004-2005; Premera Blue Cross/Blue Shield Conversion Task Force 2003-2004.

Professional involvement

Sigma Theta Tau, Theta Omicron chapter 2004- present; Alaska Nurse Practitioner Association 1999- present (Legislative Affairs Liaison 2000-2006; Public Relations chair 2002-2005); American Academy of Nurse Practitioners 1998- present (Alaska State Representative 2003- present; Fellow 2006- present). Community involvement.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

In times of crisis, it is tempting to compromise standards. The growing shortage of primary care providers, the growing population of chronic disease, and the aging of our population as well as our healthcare workforce are all factors that create pressure on regulatory boards to relax standards. As nurses, we recognize that this is unacceptable and will ultimately have deleterious results. The NCSBN provides a pool of knowledge and experience from all the Member Boards that advances evidence-based, best practices in regulation. I believe it is out of this network that nursing will develop the workforce answers to meet the needs of our nation, without compromising public safety and trust.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

The mission, vision and strategic initiatives are all areas of such importance for NCSBN and the Member Boards! Board members advance the mission, vision and strategic initiatives of an organization through their persistent attention to those guiding statements. All Board work should, in some way, advance the direction set out by the Board of Directors and Member Boards. I believe that each Board member effectively advances the mission, vision and strategic initiatives by faithfully preparing for Board meetings and diligently completing their part of the work between meetings. As we each support the organization goals, and each other, the more success and achievement the organization will realize.

Date of expiration of term:
Sept. 27, 2011

Eligible for reappointment:
Yes

New Director-at-Large

Lynda Narwold, MA, RN

Board Member, IN, Area II

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Indiana Hospital Council;

Indiana State Board of Nursing;

Indiana League for Nursing Treasurer;

NLN site visitor;

Founder/Director of Camp Eeze-the-Wheeze: a camp for children with asthma;

Served on multiple local service agencies Boards of Directors.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

In Indiana a challenge to nursing regulation is being able to provide the assistance to educational institutions to develop strong nursing programs. The Board is expected to make multiple site visits for programs with poor performance or who are requesting opening a new program. These visits are made without charge to the institution. I would like to work with the committee on rules and regulations to develop a fee schedule for these site visits.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

There is a huge amount of stress on the health care system today due to the nursing and nursing faculty shortage. Combine this with an aging population and advances in technology, public safety is an increasing concern. Through collaboration with other Board members and members of NCSBN, I will work with rules committees to set regulations for nursing educational programs that encourage innovation without compromising the safety of the consumer. One specific initiative I would like to promote is the development of a statewide approved transitional program for new graduates. A program of this magnitude would need the input from multiple stakeholders including representatives from educational institutions, health care facilities, accrediting agencies, and state legislatures. I believe it is important for regulatory bodies to be involved in the development of quality programs to protect the public, but I don't want regulation to be so prescriptive that innovation is discouraged.

Leadership Succession Committee – Area I

Date of expiration of term: N/A
Eligible for reappointment: N/A

Barbara Swehla, MN, RN, Executive Director

Board Staff, Montana, Area I

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

I have served on the PERC Committee for 2 years in 2001 and 2002, and am currently serving on the CORE Committee. I am actively involved in statewide endeavors involving nursing regulation. My experience on NCSBN Committees/Task Forces has afforded me the tremendous opportunity to learn and to impact growth in the NCSBN member organization and our board. Serving on this committee requires commitment to networking with other boards and encouraging others to serve on the board or committees. I am blessed to have board and administrative support to be involved at the national level and these experiences have been such great opportunities that I am pleased to try to entice others to serve.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

There is definitely a push to standardize many regulatory processes on a national level. Even if we don't reach that objective, we can learn from one another and provide opportunities for boards to improve licensing and disciplinary processes as well as promote quality nursing education. Having some barriers to licensure is a reality and is necessary, yet we should be basing such decisions on evidence – and asking ourselves, does it make a difference? NCSBN and individual states are gathering a great deal of data and need to continue to do so. Then, we need to take the data and make sound regulatory decisions, even in the face of a nursing shortage.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

By participating in the process of enticing member board staff and board members to be involved at the national level. Broad participation in national activities enhances the ultimate objective of protecting the public through evidence-based regulatory decisions. Much of the evidence is produced by an incredible research department at NCSBN and individual participants (committee and board members) from Member Boards. We all benefit by these activities and broad representation enriches the process.

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Area II

Nancy Bohr, RN, MBA, MSN

Board Staff, South Dakota, Area II

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

South Dakota Healthcare Association;

CNA Test Review Committee member;

IRE participant;

Presenter for South Dakota Department of Health and nursing education program;

Past member of South Dakota Nurses Association;

Sigma Theta Tau International;

User for St. Katherine Drexel Parish.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

Delivery of safe quality care of unlicensed personnel through delegation of tasks is a challenge. The delegating nurse is legally accountable for the tasks and there may be a lack of statutes and rules to guide this process. Medication administration and the safe delivery, accountability, diversion, and management of medications are areas which need to be regulated. This challenge is present in our state and we are bringing stakeholders together to develop a strategic plan for regulation of medication assistants which will be mutually acceptable to all agencies involved.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

I will strive to work with Member Boards and staff in Area II to seek qualified individuals that are committed to advancing the mission and strategic initiatives of NCSBN.

Area III

Rick García, MS, RN, CCM

Board Staff, Florida, Area III

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Faculty, Member Board Licensing Staff Conference, Fraudulent Document Detection, Credential Agency practices in Florida shared and discussed with New Mexico.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

Fraudulent academic credentials and nurse imposters pose a concern in the protection of the public. I would like for NCSBN and Member Boards to work towards standardizing academic credential evaluation. I am also interested in the continuing competency/licensure maintenance discussion from our MyM area meeting.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

Our Division has built upon the NCSBN mission and came up with our values as a Division to include "I CREATE" = Integrity, Commitment, Respect, Excellence, Accountability, Teamwork, and Empowerment. These values I not only believe in but practice everyday at the Board office. I will bring these values and employ them in my charge when elected to forward NCSBN's mission of regulatory innovation.

Date of expiration of term:
January 13, 2013

Eligible for reappointment:
No

Area III

Richard Gibbs, LVN

Board Member, Texas, Area III

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Board member Texas Board of Vocational Nurse Examiners 2002-2003;

Board member Texas Board Nurse Examiners 2004-2007;

Board member Texas Board of Nurses 2008-present;

Served as Vice-President Texas Board of Nurse Examiners 2005-2006;

Currently serving second term as committee member for Resolutions Committee;

Currently serving as Editor-in-Chief of LPN 2008.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

I feel with the joint effort of NCSBN and the state boards of nursing we can continue to regulate, monitor, recruit and retain nurses for the present and future. With the present high median age of the nursing professional it is with utmost importance that we as partners continue to find ways to recruit, educate and retain our future nurses.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

If elected to serve I would continue to support and carry out the mission and vision of NCSBN and work collaboratively with NCSBN and other Member Boards. I bring my experience as a NCSBN committee member, state board member and twenty-six years of nursing experience to the table.

Designated Member (Board Member of Member Board [one-year term])

Date of expiration of term:
Dec. 31, 2010

Eligible for reappointment:
No

Alexis Welch, RN, EdD

Board Member, North Carolina, Area III

PROFESSIONAL/REGULATORY/COMMUNITY INVOLVEMENT INCLUDING SERVICE ON NCSBN COMMITTEE(S):

This is my first attempt at a committee for National Council. I am actively involved in several professional groups to include the following: Sigma Theta Tau Beta Nu Chapter, NC ADN Deans and Directors Conference, NC ADN Council, Advisory committee member to Eastern Area Health Education Center, Duke University Gerontology Program. Currently, I am Chair of the NC Board of Nursing.

WHAT DO YOU SEE AS A CHALLENGE TO NURSING REGULATION AND HOW WOULD YOU PROPOSE RESOLVING THE CHALLENGE?

Regulation challenges are multi focused. The one challenge that seems to be theme at National Council meetings is continued competency for the licensed nurse. My proposal to resolve is to glean input from the "grassroots" nurses who provide direct patient care as a full time nurse. Each state could pull a team geographically representative of all types of communities from acute, chronic, home care and representative of rural, urban, suburban, metropolitan and seek ways to determine how best to ensure continued competency.

DESCRIBE HOW YOU WILL ADVANCE THE MISSION, VISION AND STRATEGIC INITIATIVES OF NCSBN:

It is vital to safe effective nursing care and regulation that nurses know the issues facing our great country, as well as international challenges. Knowledge is powerful, and we must get information in the hands of nurses. I believe in sharing information in writing or in speaking to groups vested in patient care. It takes a village to care for those needing nursing service and it will take all of us to proactively speak up and out.

2008 Report of the Board of Directors

Highlights of Business Activities Oct. 1, 2007 through May 31, 2008

STRATEGIC PLANNING

The Board of Directors reviewed, discussed, and developed strategic objectives, performance measures and targets for FY08 based on the 2008-2010 strategic initiatives adopted by the 2007 Delegate Assembly. The completed strategic plan (initiatives, objectives, performance measures, and targets) was implemented Oct. 1, 2007, and was the basis for the 2008 fiscal year budget.

At the first meeting of the FY08 Board of Directors, new Board Members were oriented to the role and responsibilities of the Board including continuation of strategies to build and maintain organizational confidence and trust. The Board addressed the ongoing development of governance competencies by attending the annual BoardSource Leadership Forum. As a result, the Board reviewed and revised meeting processes and procedures including evaluation of Board Member performance. Communication of Board meeting activities continued to be conveyed through the Member Board Dial In process and the informative president communiqué immediately following each meeting.

COLLABORATION WITH EXTERNAL ORGANIZATIONS

Strategic Partnership Meeting Attendance by Board of Directors and/or NCSBN Staff

- National Black Nurses Association
- Alabama Board of Nursing
- Competency and Credentialing Institute (CCI)
- European Federation Nursing Regulators (FEPI)
- Council on Licensure, Enforcement and Regulation (CLEAR)
- NLN Education Summit
- International Society for Quality Healthcare
- ANSI World Standards Week
- Citizens Advocacy Center (CAC)
- National Organization of Associate Degree Nursing (NOADN)
- ICN Regulatory Forum, Credentialing Forum and Triad Meeting
- NCC-MERP
- Alliance for APRN Credentialing
- TriCouncil
- Study of Nursing Education DOE Meeting
- National Continuing Competence Conference
- American Association of Colleges of Nursing
- Institute for Healthcare Improvement (IHI)
- Montana Board of Nursing

Members

Faith Fields, MSN, RN
President, Arkansas, Area III

Laura Rhodes, MSN, RN
Vice President, West Virginia-RN, Area II

Ruth Ann Terry, MPH, RN
Treasurer, California-RN, Area I

Kathy Malloch, PhD, MBA, RN, FAAN
Area I Director, Arizona

Betsy J. Houchen, JD, MS, RN
Area II Director, Ohio

Julia L. George, MSN, RN, FRE
Area III Director, North Carolina

Gino Chisari, MSN, RN
Area IV Director, Massachusetts

Doreen Begley, MS, RN
Director-at-Large, Nevada

Allison Kozeliski
Director-at-Large (August 2007–October 2007), New Mexico

Lynne Cooper
Director-at-Large (October 2007–February 2008), Virginia

Staff

Kathy Apple, MS, RN, CAE
Chief Executive Officer

Board Meeting Dates

- Aug. 6, 2007 – Chicago, Illinois
- Sept. 5-7, 2007 – Chicago, Illinois
- Dec. 5-7, 2007 – Chicago, Illinois
- Feb. 6-8, 2008 – Chicago, Illinois
- May 7-9, 2008 – Chicago, Illinois
- July 9-11, 2008 – Chicago, Illinois
- Aug. 4, 2008 – Nashville, Tennessee

- Nebraska Board of Nursing
- New Mexico Board of Nursing
- Federation of Association of Regulatory Boards (FARB)
- Kentucky Board of Nursing
- Pennsylvania Board of Nursing
- New Hampshire Board of Nursing
- American Organization of Nurse Executives (AONE)
- National Student Nurses Association
- Federation of State Medical Boards
- AcademyHealth – Task Force on Ethical Recruitment of Foreign Nurses
- National Governor's Association (NGA)
- American Board of Nursing Specialties (ABNS)
- California Board of Vocational Nurse and Psychiatric Technicians
- World Health Professions Conference on Regulation

FINANCE

- The Board approved proposed revisions to the NCSBN Travel Policy 8.8, to provide for a healthier travel environment for NCSBN Board of Directors and staff to conduct business.
- The Board approved the budget for fiscal year Oct. 1, 2007 to Sept. 30, 2008. The budget was evaluated with thoughtful discussion, consideration and support for the mission, strategic plan, and vision of NCSBN.
- The Report of Independent Auditors for the fiscal year ending Sept. 30, 2007, was presented and reviewed. The Board met with the auditors without staff present. NCSBN received an unqualified opinion from an independent CPA firm attesting to the accuracy of the financial statements. After conducting an audit in accordance with generally accepted standards, in the opinion of the auditors, the statements fairly presented the financial position of the organization.
- The Board moved to accept the financial statements for the first and second quarter of FY08.
- The Board moved to approve the engagement of Legacy Professionals LLP to audit the financial statements for the year ending in September 2008, fulfilling the fiduciary responsibility of board of directors.

GOVERNANCE AND POLICY

- The Board accepted the resignation of Director-at-Large member, Allison Kozeliski (Executive Officer, New Mexico) and appointed Lynne Cooper (Consumer Board Member, Virginia) to fulfill the vacancy. The Board subsequently accepted the resignation of Lynne Cooper and elected to not fill the vacancy.
- The Board conducted an environmental scan during each meeting to identify relevant and emerging nursing and healthcare issues related to regulation.
- The Board reviewed and discussed Annual Meeting evaluations making suggestions for changes based on the evaluation feedback.
- The Board authorized legal counsel to begin legal proceedings against the Kang Dong Academy to protect the integrity of NCSBN's intellectual property.

- The Board reviewed and discussed the historical and current role of the board liaison to NCSBN committees for revision and current relevancy. The Board noted that the liaison is not required to attend every committee meeting and that it is the responsibility of the Board as a whole to evaluate the needs of a committee.
- The Board elected to join the membership of the National Quality Forum and the National Patient Safety Foundation to better understand and influence patient safety initiatives as they relate to nursing regulation.
- The Board reviewed and discussed the current and future role of NCSBN in the international regulatory arena. The Board supported presentations at the 2008 Midyear Meeting by seven international regulatory bodies to assist the organization as a whole to better understand nursing regulation around the world.
- The Board reviewed and discussed the Licensure Maintenance proposal for the assessment of continued competence and presented the proposal to the membership at the 2008 Midyear Meeting for discussion by the membership.
- The Board approved policy revisions to Policy 5.1. Major Meetings specifically to hold all Midyear Meetings in Chicago.
- The Board monitored the operational implementation of the 2007 Delegate Assembly revisions to the bylaws.
- The Board appointed chairs and committee members to all 2008 Committees consistent with policy and focusing on the expertise needed for each committee while balancing membership with areas and state board members and state board staff.
- The Board reviewed and approved program revisions to the Institute for Regulatory Excellence Fellowship program.
- The Board received and reviewed organizational reports from the chair of the Nurse Licensure Compact.
- The Board met via conference call with the Committee on Nominations to discuss the diversity needs of the Board and the role and responsibilities of the board members.
- The Board approved a $25,000 donation to the National Student Nurses Association for the production of a video program that will motivate and inspire students to continue their education.
- The Board directed focus groups to be held with executive officers representing both single state and multistate jurisdictions to gather information on the impact of the two licensure models on all states.
- The Board reviewed and discussed a compilation of regulatory trend data obtained through various interaction modalities with the membership.
- The Board continuously monitored the progress toward completion of all strategic objectives for FY08.
- The Board approved an updated revision to the Public Policy agenda.
- The Board reviewed and approved the 2007 annual report outline.
- The Board discussed and approved a new policy (2.9) on direct contributions to Member Boards providing assistance in the form of products and services to individual jurisdictions.
- The Board met with Dr. Patricia Benner to review and discuss the results of the Carnegie Study on Nursing Education and prepared a response based on a nursing regulation perspective.

- The Board meet with Dr. Mark Yessian, retired HRSA/Office of the Inspector General, to discuss possible interfaces between healthcare licensing boards and the patient safety movement.
- The Board approved a data request from HRSA to help facilitate the research process for the next national sample survey.
- The Board reviewed, discussed and made improvement suggestions from the Member Board Needs Assessment and the annual CQI report.
- The Board approved a donation of $3,000 to the Federation of Association of Regulatory Boards towards the cost of a facilitated strategic planning process.
- The Board reviewed and discussed the meeting evaluations of all summits, conferences, and workshops conducted for the membership by NCSBN.
- The Board reviewed and revised Policy 2.4 Resource Fund to expand the definition of eligible members who may access this resource.
- The Board reviewed and approved the All Hazards Emergency Operations Guideline for Boards of Nursing.

EXAMINATIONS

- The Board approved a passing standard of -0.37 logits for the NCLEX-PN® examination, effective April 1, 2008, through March 31, 2011, based on available information to assure examinees are competent and able to practice safely.
- The Board approved the revised Policy 11.12 NCLEX ID regarding acceptance of electronic passports and signature comparison procedures at test centers.
- The Board approved the acquisition of the intellectual property of the national Nurse Aide Assessment Program and the medication aide certification examination (MACE) programs.
- The Board reviewed and discussed a candidate NCLEX-RN® challenge.
- The Board reviewed and approved for distribution to the membership a paper on International Nurse Testing Decisions

PRACTICE, EDUCATION AND REGULATION

- The Board reviewed and discussed the proposed Global Standards for Initial Nursing and Midwifery Education.
- The Board reviewed and discussed progress towards a consensus paper on a new model of regulation of advanced practice nurses that would impact licensure, certification, education and accreditation.
- The Board reviewed and approved the proposed revision to the education model rules regarding faculty qualifications.
- The Board reviewed and approved for distribution to the membership, the Pain Management Resource Pack.
- The Board reviewed the progress towards a regulatory model on transition to practice and supported the recommendations for further development.

INFORMATION TECHNOLOGY

- The Board approved the Washington D.C. and Commonwealth of Northern Mariana Islands Board of Nursing licensure data entry proposal and associated funding to support electronic management of nurse data with Nursys®.

- The Board routinely reviewed an update on discipline and licensure participation in Nur*sys*.
- The Board approved the recommendation to populate Nur*sys* with nurse related data from the NCSBN NCLEX data source and the U.S. Postal Service to enhance the Nur*sys* database.
- The Board approved the recommendation to implement a unique identifier for the Nur*sys* database system.
- The Board reviewed and discussed the HIPDB reporting agent performance of NCSBN.

RESEARCH

- The Board reviewed and discussed the literature review related to chemically dependent nurses and related programs. As a result, the Board approved the creation of a new committee to review discipline and alternative programs and provide recommended regulatory practices for chemically dependent licensees.
- The Board reviewed and discussed the analysis of disciplinary data submitted by Member Boards to Nur*sys* from 1996-2006.
- The Board reviewed and discussed progress on the project to electronically collect national nursing workforce data.
- The Board reviewed the current work of the Commitment to Ongoing Regulatory Excellence program.

Attachment

A. Annual Progress Report, October 2007 – May 2008

Background

The Annual Progress Report is provided as a summary of the year's activities and accomplishments in the work toward achieving the organization's strategic initiatives.

Attachment A

Annual Progress Report, October 2007 – May 2008

A. NCSBN strategically advances patient safety for the health and welfare of the public.

STRATEGIC OBJECTIVE 1

Develop patient safety recommendations for nurse regulators.

To fulfill this objective, NCSBN staff has been reviewing patient safety research to identify possible links to nursing regulation. In addition, NCSBN has actively sought out opportunities to inform and educate public officials and decision makers regarding the regulatory and public safety implications of proposed legislation or other government actions related to patient safety. In this regard, NCSBN has worked closely with Americans for Nursing Shortage Relief; American Telemedicine Association; American Medical Association; National Governors Association; the National Council of State Legislators; Human Resources and Services Administration; AcademyHealth; Nursing Network; Council on Licensure, Enforcement and Regulation; and other organizations.

STRATEGIC OBJECTIVE 2

Promote patient safety initiatives.

A roundtable discussion was conducted on innovations in education. The Board of Directors approved for membership those organizations whose mission is to improve patient safety (National Quality Forum, National Patient Safety Foundation). In addition, NCSBN collaborated with federal agencies such as the U.S. Public Health Service on issues surrounding this objective.

STRATEGIC OBJECTIVE 3

Enhance communication between Member Boards and external stakeholders.

Ongoing communication took place throughout the year between Member Boards and external stakeholders such as CGFNS International, American Diabetes Association, American Academy of Ambulatory Care Nurses, and the American College of Nurse Practitioners. Several topics were addressed including international nurses and nurse licensure; policy issues involving advanced practice registered nurses; and nurse education legislation and related bills.

Opportunities to share disciplinary information were discussed with key national advanced practice certifying bodies. The transfer of certification status for all nurse anesthetists to Member Boards will be facilitated by a system that was a developed with the American Association of Nurse Anesthetists.

NCSBN representatives and Member Boards collaborated with advanced practice registered nurse (APRN) accreditors and certifiers to discuss ongoing issues regarding APRNs. The APRN Joint Dialogue Group conducted several meetings in which they tackled issues such as grandfathering and the overlap of acute primary care for nurse practitioners and certified nurse specialists. Additionally, the APRN Committee reviewed the new adult acute care nurse practitioners certification examination developed by the American Association of Critical Care Nurses.

STRATEGIC OBJECTIVE 4

Assist Member Boards with disaster preparedness.

Representatives from the Red Cross and the Emergency System of Advanced Registration of Volunteer Health Professionals were selected to serve on the Member Board Disaster Preparedness Committee. A model disaster preparedness plan was developed based on the current plans and needs of Member Boards. External access to the Nursys® database during a disaster is under exploration.

B. NCSBN contributes to Member Board excellence by providing resources, communication, education and technology.

STRATEGIC OBJECTIVE 1

Recognize Member Board excellence.

An award commemorating NCSBN's 30th Anniversary was developed. Annual award recipients and the 2008 cohort of the Institute for Regulatory Excellence Fellowship participants have been selected. Enhancements to the existing Institute for Regulatory Excellence Program were approved by the Board of Directors.

STRATEGIC OBJECTIVE 2

Continuously provide and evaluate education, information sharing and networking opportunities.

NCSBN constituents were invited to participate in a myriad of educational programs such as the Institute for Regulatory Excellence Conference; Executive Office/Member Board President Leadership Conference; Faculty Shortage Summit; Executive Officer Seminar, Information Technology Summit; Investigator and Attorney Workshop; TERCAP™ Forum; APRN Roundtable; NCLEX® Invitational; Assistive Personnel Workshop; and three NCLEX® Regional Workshops. In addition, several online resources were launched including the President's Governance Role on a Board of Nursing; Introduction to Board of Nursing Discipline Investigations; as well as revised versions of the NCSBN 101 and Delegate Orientation courses.

NCSBN information was disseminated via print media outlets such as *Leader to Leader, Council Connector, Policy Perspectives and Link*. The 2008 Directory of Nurse Aides and the NCLEX® Fact Sheet were posted for reference on the NCSBN Web site. The NCLEX® Examination Committee reviewed recommendations for making licensure decisions form countries that had experienced a test security breach.

Several networking opportunities existed for executive officers: Member Board presidents; Member Board education consultants and participants; Member Board practice consultants; policy call participants; Member Board discipline/investigators; and advanced practice registered nurse stakeholders. Information sharing was made easy through conference calls in areas such as practice, education and policy. Networking sessions also took place at the 2008 Midyear Meeting and Delegate Assembly. The results from the Continuous Quality Improvement survey and the Member Board Needs Assessment were analyzed and distributed to the Board of Directors, Member Boards and the Leadership Team Recommendations for service enhancements stemming from these results were developed.

STRATEGIC OBJECTIVE 3

Assure integrity of fiscal management and responsiveness.

The Finance Committee met with insurance brokers from USI and investments consultants from Becker Burke to re-examine NCSBN's investments and liability insurance. The an-

nual audit was conducted and later reviewed by the Board of Directors and auditors from Legacy Professionals. The budget for FY08 was developed and approved.

STRATEGIC OBJECTIVE 4

Bylaw revisions implemented.

A bylaw revision implementation plan was developed and presented to the Board of Directors. The Board is recommending to the Delegate Assembly that all associate members be assessed a membership fee.

C. NCSBN advances evidenced-based nursing regulation and regulatory solutions for public protection.

STRATEGIC OBJECTIVE 1

Assist Member Boards in implementing regulatory best practices.

Results from the CORE questionnaire were analyzed and presented. Surveys were sent to Member Boards and external stakeholders in an ongoing effort to measure performance. Enhancements to the existing TERCAP™ and the TERCAP™ Protocol were developed. Webinars were also conducted to promote this data collection instrument. NCSBN assisted Member Boards with the development of performance measures, research and evaluation studies, and the implementation of criminal background checks (CBCs). CBCs were topics of discussions at the New Mexico and Pennsylvania boards of nursing visits and were also addressed by an FBI audit supervisor at the Investigator and Attorney Workshop.

STRATEGIC OBJECTIVE 2

Provide models and resources for evidence-based regulation to Member Boards.

A report on the proposed, new advanced practice registered nurse (APRN) regulatory model was drafted by the NCSBN APRN Committee based on the work of the APRN Joint Dialogue Group and APRN Consensus Work Group. The proposed model was presented at the Midyear Meeting and will be presented at Delegate Assembly for adoption by the membership.

A review of existing disciplinary resources was conducted and recommendations were made to the Board of Directors. Revisions to the resources, as well as the inclusion of appendices to the existing Statement on the Regulatory Implications of Pain Management, have been completed.

A new regulatory model for transition for practice has been designed and presented to the Board of Directors. Board members also discussed the qualifications and roles of future faculty members. The feasibility of Journal of Regulatory Science was also explored with direction to develop and implement.

STRATEGIC OBJECTIVE 3

Conduct and support research that provides evidence regarding regulatory initiatives that supports public protection.

Approximately 101 TERCAP™ cases were analyzed. The Research Department is awaiting additional cases before further analysis is conducted. Literature, standards and guidelines specific to the scope of practice of LPN/VNs in the care of dialysis patients are being examined. The Center for Regulatory Excellence Program awarded grants for regulatory research. Member Board Profiles were distributed and posted on the NCSBN Web site with 100 percent participation from the membership. The Board of Directors reviewed a literature review on Chemically Impaired Nurses. An analysis of disciplinary actions from 1996-2006

was conducted. Projects due for completion by September include Phase I of the North Carolina Transition Study, Simulation Training Study, Negotiation Skills Training and Post-Entry Competency Study.

STRATEGIC OBJECTIVE 4

Support single state and multistate licensure initiatives.

NCSBN continues to provide licensure information to Member Boards and external stakeholders upon request regarding both licensure models. The federal Licensure Portability Grant was distributed to eligible Member Boards who are in the process of implementing criminal background checks and the Nurse Licensure Compact. Additionally, single state and multistate licensure boards were invited to take part in three separate focus groups to discuss the impact and interface of the two licensure models.

D. NCSBN provides comprehensive data management for use by Member Boards and external stakeholders.

STRATEGIC OBJECTIVE 1

Maintain a comprehensive national nurse licensure database.

Nur*sys*® 2.0 was launched in January 2008. The Nur*sys*® Committee continues to implement strategies to offset barriers in the acquirement of licensure data. The Board of Directors reviewed customer service metrics and system performance statistics, as well as a report on a national unique identifier for Nur*sys*.

A Fraud and Imposter Tracking System (FITS) was developed. Different development options have been explored for a new Comprehensive Licensure Data Management System (CLDMS). The different options and details surrounding this new software were reviewed by the Board.

The Nur*sys*® Committee worked with the Health Resources and Services Administration on the submission of legacy data, as well as the reporting of corrections, revisions, and voids. The committee met with representatives from the federal agency to discuss the status of the Health Integrity and Protection Data Bank clean up project and reporting enhancement. The Board was apprised with information surrounding this ongoing effort.

STRATEGIC OBJECTIVE 2

Serve as national source of nurse workforce data.

The development of a national workforce database and reporting mechanism has been completed. Data collection piloting efforts are under way. NCSBN has been in dialogue with state workforce centers regarding issues of mutual concern.

E. NCSBN is the premier organization to define and measure continued competence.

STRATEGIC OBJECTIVE 1

NCLEX® development, security, psychometrics, administration and quality assurance processes are consistent with Member Boards needs examinations.

Performance measures revealed that all processes and programs enacted to ensure proper delivery of the NCLEX exams were in compliance with contractual and operational requirements. A survey of the RN Practice Analysis was developed and distributed. The NCLEX® Examinations Committee continues to explore innovative items such as sound,

video and simulated tasks for future use in exams.

STRATEGIC OBJECTIVE 2

Develop and evidence-based methodology to measure continued competence of RNs and LPN/VNs.

A pilot proposal on licensure maintenance was reviewed by the Board of Directors and presented at the Midyear Meeting.

STRATEGIC OBJECTIVE 3

Maintain the quality of the NNAAP™ exam.

The Board approved acquiring the intellectual property rights for the NNAAP™ examination. The terms and conditions of the contract have been reviewed and accepted by the Board of Directors.

STRATEGIC OBJECTIVE 4

Administer medication assistant examination.

The board approved acquiring the intellectual property rights for the medication aide certification examination. The terms and conditions of the contract have been reviewed and accepted by the Board of Directors.

F. NCSBN advances the development of regulatory excellence worldwide.

STRATEGIC OBJECTIVE 1

Identify education models of other countries.

The results of a survey revealed that most boards of nursing use a list of recognized international nursing education programs provided by CGFNS International. NCSBN collaborated with organizations such as International Council of Nurses, National Organization of Associate Degree Nursing, and the American Association of Colleges of Nursing on nursing education competency comparisons between the U.S. and the European Union.

STRATEGIC OBJECTIVE 2

Facilitate the mobility of safe and competent international nurses.

NCSBN continues to work with AcademyHealth in developing ethical guidelines for recruiters of international nurses. Data collection began on Member Boards' needs for licensure of international nurses. An initial draft of Frequently Asked Questions on U.S. licensure for international nurses has been developed.

STRATEGIC OBJECTIVE 3

Develop and maintain collaborative working relationship with key national and international organizations.

NCSBN's visibility and mission was advanced through staff participation at numerous national and international meetings. Board members and/or staff represented NCSBN at conferences and forums for organizations such as TriCouncil; National Institute of Nursing Research; Federation of Association of Regulatory Boards; Council on Licensure, Enforcement and Regulation; National League for Nursing; American National Standards Institute; International Council of Nurses; National Organization for Associate Degree Nursing; American Cancer Society; and the Irish Society for Quality Initiatives in Healthcare.

NCSBN invited representatives from several international nurse regulatory bodies to attend Delegate Assembly.

In addition to actively participating in various organizations' meetings, NCSBN staff continued to offer the European Federation of Nursing Regulators (FEPI) guidance and support when needed. NCSBN provided speakers for FEPI's conference in Italy, as well as collected U.S. articles on the uncertainty in illness concept.

STRATEGIC OBJECTIVE 4

Develop and implement a Member Board communication plan regarding international nursing regulatory issues.

In an effort to keep Member Boards apprised on issues surrounding international nursing regulation, notices from the International Council of Nurses (ICN) Migration Center and World Health Professions Regulation conference, as well as report from ICN's Regulatory Forum were sent to boards of nursing. In addition, representatives from several international organizations were invited to speak on the matter during Education Day at the 2008 Midyear Meeting.

Section II

2008 NCSBN Annual Meeting

SECTION II: COMMITTEE REPORTS

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Report of Advanced Practice (APRN) Committee

Board of Directors' Recommendation

1. ***Adopt the proposed APRN Model Act and Rules.***

   Rationale:
   The purpose of the proposed APRN model act and rules is to promote the homogeneity of Advanced Practice Registered Nurse regulation across the country. The proposed model was written to reflect the consensus results of the national dialogue on changes to advanced practice education, accreditation, certification and licensure.

Background

The charge to the Advanced Practice Committee was to: 1) Develop a new APRN regulatory model and model act language consistent with the APRN Consensus Work Group and the NCSBN Draft APRN Vision Paper; 2) Develop strategies for implementing a new regulatory model for APRNs; 3) Facilitate the APRN Roundtable; and 4) Communicate and collaborate with APRN stakeholders regarding APRN issues.

The proposed APRN Model Act and Rules is the culmination of a national dialogue on the future of advanced practice beginning several years ago. The Advanced Practice Committee, formerly the APRN Advisory Panel, developed a draft vision for the future regulation of APRNs. The draft generated much national discussion. At the same time, NCSBN was participating with the APRN Consensus Work Group—a multi-organization discussion group on the future of advanced practice education, accreditation, certification and licensure. With the support of the NCSBN Board of Directors, a collaborative decision was made to develop one multi-stakeholder paper on the future of advanced practice regulation. This decision resulted in the creation of the APRN Joint Dialogue Group that is composed of members of the NCSBN Advanced Practice Committee and members of the APRN Consensus Work Group. NCSBN staff have routinely communicated the results of these discussions throughout the year.

The collaborative paper, titled, *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education*, was recently completed and is under going professional editing. It is the intent of the multi-stakeholder group to ask for organizational endorsement once completed. The proposed APRN Model Act and Rules is based on the concepts of this paper and was presented to the membership at the 2008 NCSBN Midyear Meeting (see Attachment A).

Should the APRN regulatory model language be passed by the Delegate Assembly, the Advanced Practice Committee identified strategies for the model's implementation including: an APRN summit or smaller focus groups; monthly updates to boards of nursing; development of a group consisting of representatives from Licensure, Accreditation, Certification and Education (LACE); and development of a Web page on the member-only side. This will keep Member Boards informed as to the progress including resources such as a history, FAQs, contact information, the model language and updates on issues such as LACE meetings and progress of state passage of the model language.

The Advanced Practice Committee also worked with certification programs to ensure the legal defensibility of APRN certification examinations and with all APRN stakeholders to promote communication regarding APRN regulatory issues. Member Boards were provided routine communication updates including an invitation to attend the annual APRN roundtable.

Members

Ann L O'Sullivan, PhD, CRNP, CPNP, FAAN
Chair, Pennsylvania, Area IV

Patty Brown, MS, BSN, RN
Kansas, Area II

Darlene Byrd, MNSc, APN, PA
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Cristiana Rosa, MSN, RN
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Cathy Williamson, MSN, RN, CNS
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Charlene Hanson, EdD, RN, CS, FNP, FAAN
Consultant

Doreen Begley, MSN, RN
Board Liaison

Staff

Nancy Chornick, PhD, RN, CAE
Director, Practice and Credentialing

Carin Zuger
Coordinator, Credentialing and Education

Meeting Dates

- Sept. 13, 2007 (Conference Call)
- Oct. 31, 2007 (Conference Call)
- Nov. 12-13, 2007
- Dec.11-12, 2007
- Jan. 22-22, 2008
- Feb. 13-14, 2008
- April 29, 2008 (Conference Call)
- May 13-14, 2008

Relationship to Strategic Plan

Strategic Initiative A
NCSBN strategically advances patient safety for the health and welfare of the public.

Strategic Objective 3
Enhance communication between Member Boards and external stakeholders.

Strategic Initiative B
NCSBN contributes to Member Board excellence by providing resources, communication, education and technology.

Strategic Objective 2
Continuously provide and evaluate education, information sharing and networking opportunities.

Strategic Initiative C
NCSBN advances evidenced-based nursing regulation and regulatory solutions for public protection.

Strategic Objective 2
Provide models and resources for evidenced-based regulation to Member Boards.

Highlights of FY08 Activities

- Held the APRN Roundtable in Chicago on May 14, 2008.
- Continued to meet with the APRN Joint Dialogue Group.
- Maintained an APRN List Serve to enhance communication among Member Boards regarding APRN regulatory issues.
- Met with the American Association of Critical Care Nurses to review and approve their new Acute Care Nurse Practitioner examination.
- Met with APRN certifying bodies to discuss issues of common concern.
- Developed model legislative language for the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education* report.
- Developed strategies to implement the new APRN regulatory model.
- Met with APRN accreditors, who consisted of the Council of Accreditation of Nurse Anesthesia Educational Programs; American College of Nurse-Midwives Division of Accreditation; Commission on Collegiate Nursing Education; and the National League for Nursing Accrediting Commission, to discuss issues such as pre-approval of new programs, blended/dual tracts, and distance educational programs.

Future Activities

- Continue the APRN Roundtable.
- Maintain and enhance communication among APRN stakeholders, Member Boards, and NCSBN.
- Enhance and operationalize the implementation strategies suggested for the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education* report.

Attachments

A. Proposed APRN Model Act and Rules

Attachment A

Proposed APRN Model Act and Rules

Article XIX APRN Scope of Nursing Practice	Chapter Nineteen
Section 1: Practice of APRN Advanced Practice Registered Nurse (APRN). Advanced practice registered nursing by nurse practitioners, nurse anesthetists, nurse midwives or clinical nurse specialists is based on knowledge and skills acquired in basic nursing education; licensure as a registered nurse; graduation from or completion of a graduate level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate APRN role and at least one population focus. Practice as an APRN means an expanded scope of nursing in a role and population focus approved by the board, with or without compensation or personal profit, and includes the registered nurse scope of practice. The scope of an APRN includes, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing and ordering. APRNs may serve as primary care providers of record. APRNs are expected to practice as licensed independent practitioners within standards established and/or recognized by the board. Each APRN is accountable to patients, the nursing profession and the board for complying with the requirements of this Act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate.	**19.1 Standards Related to the APRN** a. The APRN shall comply with the standards for registered nurses as specified in Chapter II above and to the standards of the national professional nursing associations approved by the board. Standards for a specific role and population focus of APRN supersede standards for registered nurses where conflict between the standards, if any, exists. b. APRNs shall practice within standards established by the board in rule and assure patient care is provided according to relevant patient care standards recognized by the board, including standards of national professional nursing associations. c. An APRN performing direct patient care shall maintain a method of quality assurance for evaluation of the APRN's practice. Proof of quality assurance reviews must be maintained for five years. The APRN will make the method and reviews available to the board upon request.

Article XIX APRN Scope of Nursing Practice	Chapter Nineteen
Section 2: Licensure of APRNs **A. Initial Licensure for APRN** An applicant for initial licensure or privilege to practice as an APRN shall: 1. Submit a completed written application and appropriate fees as established by the board. 2. Hold an unencumbered license as a registered nurse. 3. Have completed an accredited graduate level APRN program in one of the four roles and at least one population focus. 4. Be currently certified by a national certifying body recognized by the board in the APRN role and population foci appropriate to educational preparation. 5. Report any criminal conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction. 6. Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for disciplinary action as set forth in Article X, Section 2, of this Act, the board has found, after investigation, that sufficient restitution has been made. 7. Provide other evidence as required by rule.	**19.2 Licensure as an APRN** **19.2.1 Application for initial licensure as an APRN** An applicant for licensure as an APRN in this state shall submit to the board the required fee as specified in Chapter 15, verification of licensure or eligibility for licensure as a registered nurse in this jurisdiction and a completed application that provides the following information: **Competence Development** a. Graduation from a graduate program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA) as acceptable by the board. b. Verification of completion as evidenced by official documentation directly from a graduate program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA) as acceptable by the board. This documentation shall verify the date of graduation, credential conferred, clinical hours completed, role and population focus of the education program, qualifications for prescribing and ordering and evidence of meeting the standards of nursing education in this state. **Competence Assessment** a. In order to be licensed in this state, all APRN applicants must be currently licensed as a registered nurse. b. In order to be licensed in this state, all APRN applicants must take and pass the appropriate APRN national certification examination in the APRN role and population focus congruent with educational preparation. **Criteria for Evaluating APRN Certification Programs** The board shall determine whether a certification program can be used as a requirement for licensure of APRNs based upon the following standards: a. The certification program is national in the scope of its credentialing; b. Conditions for taking the certification examination are consistent with standards of the testing community; c. Educational requirements are consistent with the requirements of the advanced practice role and population foci; d. The standard's methodologies used are acceptable to the testing community such as incumbent job analysis studies and logical job analysis studies; e. Certification programs are accredited by a national accreditation body as acceptable by the board; f. The examination represents entry-level practice in the APRN role and population focus; g. The certification program will have an established process of communication with the board of nursing; h. The examination represents the knowledge, skills and abilities essential for the delivery of safe and effective advanced nursing care to patients; i. Examination items shall be reviewed for content validity and correct scoring using an established mechanism, both before use and at least every five years. When possible, items will be reviewed for cultural bias; j. Examinations are evaluated for psychometric performance. k. The passing standard is established using acceptable psychometric methods and is re-evaluated at least every five years; l. Examination security is maintained through established procedures; m. Certification is issued based upon meeting all certification requirements and passing the examination; n. A re-take policy is in place;

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	o. The certification program will notify the board when individuals are certified, recertified and when there is a change in certification status; p. Certification maintenance program, which includes review of qualifications and continued competence, is in place; q. Mechanisms are in place for communication to boards of nursing for timely verification of an individual's certification status, changes in certification status, and changes in the certification program, including qualifications, test plan and scope of practice; and r. An evaluation process is in place to provide quality assurance in the certification program. The board will notify certification programs when APRNs have encumbrances placed on their licenses or privilege to practice. **Competence Conduct** APRN competence conduct is the same as previously stated for RN and LPN competence conduct in 6.7.3.
	19.2.2 Application of an Internationally Educated APRN An internationally educated applicant for licensure in this state as an APRN shall: a. Graduate from a graduate level APRN program equivalent to an APRN educational program in the U.S. accepted by the board. b. Documentation will be obtained through an official transcript directly from the international nursing education program and verified through a qualified credentials evaluation process for the license being sought. c. Meet all other licensure criteria required of applicants educated in the U.S.
B. Endorsement of APRNs The board may issue a license by endorsement to an APRN licensed under the laws of another state if, in the opinion of the board, the applicant meets the qualifications for licensure in this jurisdiction. An applicant for APRN licensure by endorsement shall: 1. Submit a completed written application and appropriate fees as established by the board. 2. Hold an unencumbered license or privilege to practice as a registered nurse. 3. Have completed an accredited graduate level APRN program in one of the four roles and at least one population focus or meets the standards for grandfathering as described in section 19.7.1. 4. Be currently certified by a national certifying body recognized by the board in the APRN role and at least one population focus	**19.2.3 Application for Licensure by Endorsement Requirements as an APRN** An applicant for licensure by endorsement as an APRN in this state shall submit to the board the required fee as specified in Chapter 15, verification of eligibility for an unencumbered license or privilege to practice as a registered nurse in this jurisdiction, and a completed APRN application that provides the following information: **Competence Development** a. Graduation from or verification of completion from a graduate level APRN program, as evidenced by an official transcript or other official documentation received directly from a graduate program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA) as acceptable by the board. This documentation shall verify the date of graduation; credential conferred; clinical hours completed and role and population focus of the education; qualifications for prescribing and ordering; and evidence of meeting the standards of nursing education in this state; or b. Verification of completion as evidenced by official documentation directly from a graduate program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA) as acceptable by the board. This documentation shall verify the date of graduation; credential conferred; completion of 500 clinical hours; completion of three separate graduate level courses in advanced physiology and pathophysiology; advanced health assessment; and advanced pharmacotherapeutics; role and population focus of the education program; and evidence of meeting the standards of nursing education in this state. c. Demonstrates successful completion of approved APRN certificate program. **Competence Assessment** a. Current certification by a national certifying body in the APRN role and population focus appropriate to educational preparation. b. Primary source of verification of certification is required.

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appropriate to educational preparation. 5. Meet continued competency requirements as stated in Article VI, Section 9 and as set forth in board rules. 6. Report any conviction, nolo contendere plea, Alford plea or other plea arrangement in lieu of conviction. 7. Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for disciplinary action as set forth in Article X, Section 2, of this Act, the board has found, after investigation, that sufficient restitution has been made. 8. Provide other evidence as required by the board in its rules. ***An individual new to a state can apply for an RN and an APRN license at the same time.	c. If the applicant has not been in clinical practice for more than the past two years, the applicant shall provide evidence of satisfactory completion of 15 contact hours of pharmacotherapeutics within the two years prior to applying for approval to practice. No more than two hours may concern the study of herbal or complementary therapies. d. If the applicant has not been in clinical practice for more than the past five years, the applicant shall provide evidence of satisfactory completion of 45 contact hours of pharmacotherapeutics within the two years prior to applying for approval to practice. No more than two hours may concern the study of herbal or complementary therapies. The applicant must also successfully complete a refresher course approved by the board or an extensive orientation in the appropriate advanced practice role and population focus which includes a supervised clinical component by a qualified preceptor who meets the following requirements: ■ Holds an active unencumbered license or privilege to practice; ■ Is in current practice in the advanced role and population foci; and ■ Functions as a supervisor and teacher and evaluates the individual's performance in the clinical setting. The preceptor may be a practicing physician or other licensed graduate prepared health care provider with comparable practice focus. **Competence Conduct** – APRN competence conduct is the same as previously stated for RN and LPN competence conduct in 6.7.3.
C. Renewal of APRN License APRN licenses issued under this Act shall be renewed at least every two years according to a schedule established by the board. An applicant for APRN license renewal shall: 1. Submit a renewal application as directed by the board and remit the required fee as set forth in rule. 2. Maintain national certification in the appropriate APRN role and at least one population focus, authorized by licensure, through an ongoing certification maintenance program of a nationally recognized certifying body recognized by the board. 3. Meet other requirements set forth in rule.	**19.2.4 Application for Renewal of License as an APRN** An applicant for license renewal as an APRN shall submit to the board the required fee for license renewal, as specified in Chapter 15, and a completed license renewal application including: a. Detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background; b. Evidence of completion of a minimum of 24 contact hours obtained within the most recent licensure renewal cycle; twelve hours in pharmacotherapeutics and twelve hours in the clinical management of patients from an approved continuing education provider recognized by the board. No more than two pharmacology contact hours may concern the study of herbal or complementary therapies; and c. Evidence of current certification(s) by a national professional certification organization that meets the requirements of 19.2.1. **19.2.5 Quality Assurance/Documentation and Audit** The board may conduct a random audit of nurses to verify current APRN certification and/or continuing education. Upon request of the board, licensees shall submit documentation of compliance as described in Chapter 6.

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D. Reinstatement of APRN License The board may reinstate an APRN nursing license as set forth in board rules.	**19.2.6 Reinstatement of APRN License** The reinstatement of APRN licensure is the same as previously stated for RN and LPN in Chapter 6 plus the following: a. Refresher Course Required An individual who applies for licensure reinstatement who has been out of practice for more than five years shall provide evidence of passing an APRN nursing refresher course approved by the board or an extensive orientation in the appropriate advanced practice role and population focus which includes a supervised clinical component by a qualified preceptor who meets the following requirements: ■ Holds an active unencumbered license; ■ Is in current practice in the advanced role and population foci; and ■ Functions as a supervisor and teacher and evaluates the individual's performance in the clinical setting. The preceptor may be a practicing physician or other licensed graduate prepared health care provider with comparable practice focus. b. Reinstatement Following Disciplinary Action For those licensees applying for licensure reinstatement following disciplinary action, compliance with all board licensure requirements as well as any specified requirements set forth in the board's discipline order is required.
E. Duties of Licensees The duties of licensees are the same as previously stated for RN and LPN in article. VI; section 12. In addition: At reasonable intervals, the APRN shall be afforded the opportunity to demonstrate competence to resume the practice of nursing with reasonable skill and safety to patients.	

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Section 3: Titles and Abbreviations for APRNs. Only those persons who hold a license or privilege to practice advanced practice nursing in this state shall have the right to use the title "APRN" and the roles of nurse anesthetist, nurse midwife, clinical nurse specialist and nurse practitioner; and the abbreviations "APRN" and CRNA, CNM, CNS and CNP respectively. The abbreviation for the advanced practice nurse designation of certified registered nurse anesthetist a certified nurse midwife, a clinical nurse specialist, and for a certified nurse practitioner will be "ARPN" plus the role title, i.e., CRNA, CNW, CNS and CNP. It shall be unlawful for any person to use the title advanced practice registered nurse or "APRN" plus their respective role titles, or their authorized abbreviations, or any other title that would lead a person to believe the individual is an APRN unless permitted by this Act.	**19.3 Titles and Abbreviations for APRNs** Individuals are licensed or privilege to practice as APRNs in the roles of Nurse Anesthetist (CRNA), Nurse Midwife (CNM), Clinical Nurse Specialist (CNS) and nurse practitioner (CNP) and in the population foci of psych/mental health, gender specific, adult/gerontology, pediatrics, neonatal, or across the life span. Each APRN shall use the designation "APRN" plus role title as a minimum for purposes of identification and documentation. When providing nursing care, the APRN shall provide clear identification that indicates his/her APRN designation. The APRN with an earned doctorate may use the term 'doctor' or abbreviation 'Dr.'
Section 4: APRN Nursing Education Programs a. *Approval Standards*. The board shall, by administrative rules, set standards for the establishment and outcomes of nursing education programs, including clinical learning experiences, and approve such programs that meet the requirements of the Act and board rules.	**19.4 APRN Education** **19.4.1 Purpose of Nursing Education Standards** The purpose of APRN nursing education standards is the same as previously stated for RN and LPN in Section 9.1.

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	19.4.2 Required Criteria for APRN Nursing Education Programs The board shall determine whether an APRN nursing education program meets the qualifications for the establishment of a school based upon the following standards: **Faculty** 1. APRN program administrator qualifications shall include: a. A current, active, unencumbered APRN license or privilege to practice in the state where the program is approved and/or accredited; b. A doctoral degree in a health-related field; c. Educational preparation or experience in teaching and learning principles for adult education, including curriculum development and administration, and at least two years of clinical experience; and d. A current knowledge of APRN practice. 2. Qualifications for nursing faculty who teach in the clinical learning experiences leading to licensure as an APRN: a. A current, active, unencumbered APRN license or privilege to practice in the state where the program is approved and/or accredited; b. A minimum of a master's degree in nursing or health related field; c. Two years of APRN clinical experience; and d. Current knowledge and competence of APRN nursing practice in role and population foci. *** Doctorate education is desirable for faculty of the APRN graduate nursing education track. *** There is an evolving field of nursing where the nurse is educated with a practice doctorate, also termed a nurse doctorate. This education emphasizes the science of nursing practice, rather than nursing theory and research. Boards should be aware of this movement and understand how it differs from traditional doctoral education and consider this degree for faculty qualifications for all three types of program when appropriate. 3. Adjunct clinical faculty employed solely to supervise clinical nursing experiences of students shall meet all the faculty qualifications for the program level they are teaching. 4. Interdisciplinary faculty who teach non-clinical nursing courses shall have advanced preparation appropriate to these areas of content. 5. Clinical preceptors shall have demonstrated competencies related to the area of assigned clinical teaching responsibilities and will serve as a role model and educator to the student. Clinical preceptors may be used to enhance faculty-directed clinical learning experiences but not to replace them. Clinical preceptors will be approved by faculty and meet the following requirements: ■ Hold an active unencumbered APRN license or privilege to practice; ■ Is in current practice in the advanced role and population focus; and ■ Functions as a supervisor and teacher and evaluates the student' performance in the clinical setting. The preceptor may be a practicing physician or other licensed graduate prepared health care provider with comparable practice focus. However, they cannot consist of a majority of the preceptors.

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	Curriculum The curriculum of the APRN nursing education program must prepare the graduate to practice on one of the four identified APRN roles (i.e., CRNA, CNM, CNS and CNP) and at least one of the six population foci (i.e., psych/mental health, gender specific (e.g., women's health), adult/gerontology, pediatrics, neonatal, and across the life span). The curriculum shall include: 1. Three (3) separate graduate level courses (the APRN Core) in: a. Advanced physiology and pathophysiology, including general principles that apply across the lifespan; b. Advanced health assessment which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and c. Advanced pharmacology which includes phcodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents. [Additional content, specific to the role and population focus, in these three APRN core areas should be integrated throughout the other role and population didactic and clinical courses.] 2. Diagnosis and management of diseases across practice settings including diseases representative of all systems and caused by major morbidities; 3. Preparation which provides a basic understanding of the principles for decision making in the identified role; 4. Preparation in the core competencies for the identified APRN role; and 5. Role preparation in one of the six population foci of practice. Preparation in a specialty area of practice is optional but if included must build on the APRN role/population-focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

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	Additional Required Components of Graduate Education Programs preparing APRNs A. Licensure Requirement for APRN Students. Each student enrolled in an APRN program shall be currently licensed as a registered nurse in this or another state prior to involvement in clinical practice as a student APRN, unless exempted from this licensure requirement under §13.1. *** This requirement for RN licensure reflects that APRN roles and population foci build upon educational preparation and experience as a registered nurse. B. Education programs offered by an accredited college or university that offers a graduate degree with a concentration in the advanced nursing practice role and at least one population focus or post-masters certificate programs offered by an accredited college or university shall include the following components: 1. Clinical supervision must be congruent with current national professional organizations and nursing accrediting body standards applicable to the APRN role and population focus 2. The curriculum is congruent with national standards for graduate level and advanced practice nursing education and is consistent with nationally recognized APRN roles and population foci, and includes but is not limited to: a. Graduate nursing program core courses. b. An advanced practice-nursing core, including legal, ethical and professional responsibilities of the APRN. *** Examples of APRN core courses include advanced pathophysiology, advanced pharmacotherapeutics, advanced assessment and diagnostic reasoning, and management of health care status. 3. Coursework focusing on the APRN role and population focus. The curriculum meets the following criteria: a. Consistent with competencies of the specific areas of practice; b. APRN programs preparing for two population foci or combined nurse practitioner/clinical nurse specialist shall include content and clinical experience in both functional roles and population foci; c. Each instructional track/major has a minimum of 500-hours supervised clinical. The supervised experience is directly related to the role and population foci including pharmacotherapeutic management of patients; and d. There shall be provisions for the recognition or prior learning and advanced placement in the curriculum for individuals who hold a master's in nursing and are seeking preparation in a different role and population foci. Post-masters nursing students shall complete the requirements of the master's APRN program through a formal graduate level certificate in the desired role and population foci. Post-master students must master the same APRN outcome competencies as the master level students. *** The advanced practice nursing student prepared in any of the current direct care provider roles must receive sufficient clinical experience to provide depth and breadth in a given population foci. This rule reflects the 500-hours supervised clinical standard of the National Organization of Nurse Practitioners Faculties; the National Task Force on Quality Nurse Practitioner Education; and the National Association of Clinical Nurse Specialist and endorsed by the American Association of Colleges of Nursing. Boards should be aware that other APRN groups are requiring set numbers of cases (nurse anesthetists) or mastery of clinical skills (nurse midwives) to meet the supervised clinical requirement. 4. A lead faculty member who is educated and nationally certified in the same role and population foci and licensed as an APRN shall coordinate the educational component for the role and population foci in the APRN program.

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b. *Process for Determining Compliance with Standards.* The board shall, by administrative rules, identify the process for determining APRN nursing education program compliance with standards.	**19.4.3 Models for Determining Compliance with Standards** The models for determining compliance with APRN nursing education standards is the same as previously stated for RN and LPN in chapter 9.2.
c. *Establishment of a New Nursing Education Program.* The board shall set requirements for the establishment of a new APRN nursing education program. New programs will be preapproved by an accrediting body.	**19.4.4 Establishment of a New APRN Nursing Education Program** Before establishing a new nursing education program, the APRN program shall complete the process outlined below: 1. Application to the professional accrediting body. The proposed program shall provide the following information to the board: a. Results of a needs assessment, including identification of potential students and employment opportunities for program graduates. b. Identification of sufficient financial and other resources. c. Governing institution approval and support. d. Community support. e. Type of educational program proposed. f. Clinical opportunities and availability of resources. g. Availability of qualified faculty. h. A pool of available students. i. A proposed time line for initiating and expanding the program.
Section 5: Prescribing and Ordering Authority The board grants prescribing and ordering authority through the APRN license. All licensed APRNs are authorized to diagnose, prescribe and institute therapy or referrals of patients to health care agencies, health care providers, and community resources. They are authorized to prescribe, procure, administer, dispense over the counter, legend, and controlled substances. They plan and initiate a therapeutic regimen that includes ordering and prescribing medical devices and equipment, nutrition, diagnostic and supportive services including, but not limited to, home health care, hospice, physical and occupational therapy.	**19.5 Prescribing and Ordering Authority** **19.5.1 Requirements for Prescribing and Ordering Authority** A. Regulating Authority – An APRN licensed by the board may prescribe, procure, administer and dispense over the counter, legend and controlled substances pursuant to applicable state and federal laws. Licensed APRNs plan and initiate a therapeutic regimen that includes ordering and prescribing medical devices and equipment, nutrition, diagnostic and supportive services including, but not limited to, home health care, hospice, physical and occupational therapy. Boards may limit the ability of APRNs to prescribe and order. B. Prescribing Practices – Written, verbal or electronic prescriptions and orders will comply with all applicable state and federal laws. 1. All prescriptions will include but not be limited to the following information: a. Name, title, address and phone number of the APRN who is prescribing; b. Name of patient; c. Date of prescription; d. The full name of the drug, dosage, route, amount to be dispensed and directions for its use; e. Number of refills; f. Signature of prescriber on written prescription; and g. DEA number of the prescriber on all scheduled drugs. 1. The APRN will comply with Federal Drug Enforcement Administration requirements related to controlled substance. 2. The APRN will immediately file any and all of the nurse's DEA registrations and numbers with the board. 3. The board will maintain current records of all APRNs with DEA registration and numbers.

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	19.5.2 Distribution of Samples 1. APRNs will receive, sign for, record and distribute samples to patients. 2. Distribution of drug samples shall be in accordance with state law and the DEA laws, regulations and guidelines.
Section 6 Discipline APRN Discipline and proceedings shall be the same as stated for the RN and LPN in Article XI.	**19.6 Discipline** **19.6.1** APRN discipline and proceedings is the same as previously stated for the RN and LPN in chapter 11. **19.6.2** The Board may limit, restrict, deny, suspend or revoke APRN licensure and/or prescriptive and/or dispensing authority. **19.6.3** Grounds for discipline related to prescriptive and/or dispensing authority will include but is not limited to: 1. Prescribing, dispensing, administering or distributing drugs in an unsafe manner or without adequate instructions to patients according to acceptable and prevailing standards; 2. Selling purchasing, trading, or offering to sell, purchase or trade drug samples; 3. Prescribing, dispensing, administering or distributing drugs for other than therapeutic or prophylactic purposes; and 4. Prescribing or distributing drugs to individuals who are not patients of the APRN or who are not within that nurse's role and population focus. *** These rules are related to the statutes, Article XI, section 1 (authority) and Article XI, Section 2 grounds for discipline.
Section 7: APRN Implementation a. Any person holding a license to practice nursing as an APRN in this state that is valid on Dec. 30, 2015; shall be deemed to be licensed as an APRN under the provisions of this Act; and shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.	**19.7.1 APRN Implementation** After Dec. 31, 2015, all new graduates applying for APRN licensure must meet the stipulated licensure requirements. An APRN applying for licensure by endorsement in another state, the APRN would be eligible for licensure if s/he demonstrates that the following criteria have been met: ■ current, active practice in the advanced role and population focus area; ■ current active national certification, or recertification as applicable, in the advanced role and population focus area; ■ compliance with the APRN educational requirements of the state in which the APRN is applying for licensure that were in effect at the time the APRN completed his/her APRN education program; and ■ compliance with all other criteria set forth by the state in which the APRN is applying for licensure (e.g., continuing education).

Definitions – to be placed in the appropriate section of the Model Nurse Practice Act

a. ***APRN*** – an "APRN" means:
The definition of an Advanced Practice Registered Nurse (APRN) is a nurse:
   1. who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;
   2. who has passed a national certification examination that measures APRN role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
   3. who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients; as well as a component of indirect care; however the defining factor for all APRNs is that a significant component of the education and practice focuses on direct care of individuals;
   4. whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
   5. who has been educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
   6. who has clinical experience of sufficient depth and breadth to reflect the intended license; and
   7. who has obtained a license as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

b. ***Advanced Assessment*** – assessment by an APRN based on additional knowledge and skill developed, a graduate level nursing education program in the APRN category, and the nurse's experience working in the APRN role and population focus.

c. ***Alford Plea*** – plea agreements where the defendant may plead guilty yet not admit all the facts that comprise the crime. North Carolina vs. Alford, 40 US 25, 91 S Ct 160,27 L Ed2d 162 (1970).

d. ***Patient*** – the patient, as a recipient of care, may be an individual, family, or group.

e. ***Competence*** – the application of knowledge and the interpersonal decision-making and psychomotor skills expected for the practice role within the context of public health, safety and welfare.

f. ***Competence conduct*** – the health and behavior expectations that may be evaluated through reports from the individual practitioner, employer reports.

g. ***Health care provider*** – "Health care provider" means: an individual authorized (e.g., licensed or certified) to prescribe and/or administer various aspects of health care.

h. ***Internationally educated APRN*** – a nurse educated outside the U.S. who applies for state licensure.

i. ***Lapsed license*** – the termination of an individual's privilege to practice nursing due to the individual's failure to renew the nursing license within a specified period of time.

j. ***Legal Scope of Practice*** – the parameters under which the APRN practices based on education and competence assessment.

k. ***Nolo contendere plea*** – a "no contest" plea in a criminal case that has a similar effect as pleading guilty.

l. ***Prescribing*** – determining which legend of drugs and controlled substances shall be used by or administered to a patient exercised in compliance with applicable state and federal laws.

m. ***Primary Care Provider*** – the provider who acts as the first point of consultation for all patients with an undiagnosed health concern as well as providing continuing care of varied medical conditions not limited by cause, organ systems or diagnosis.

n. ***Population focus*** – the section of the population which the APRN has targeted to practice within. The categories of population foci are: family/individual, adult-gerontology, gender related, neonatal, pediatrics and psychiatric mental health.

a. ***Adjunct Faculty*** – temporary nursing faculty, in addition to regulator program faculty used to enrich student experiences.

b. ***Advanced nurse refresher course*** – formal program with both didactic and clinical components, designed to prepare an APRN who has been out of practice to re-enter into the profession.

c. ***Clinical Judgment*** – the application of the nurses knowledge and experience in making decisions about patient care.

d. ***Clinical learning experiences*** – the planned, faculty-guided learning experiences that involve direct contact with patients.

e. ***Competence Assessment*** – evaluation of the practitioner's knowledge, skills and abilities. Assessment mechanisms may include examination, peer review, professional portfolio and professional certification.

f. ***Competence Conduct*** – the health and behavior expectations that may be evaluated through reports from the individual practitioner employer reports and discipline checks. Part of competence conduct is assurance that licensees possess the functional abilities to perform the essential functions of the APRN role and population focus.

g. ***Competence Development*** – the method by which a practitioner gains, maintains, or refines practice knowledge, skills and abilities. This development can occur through formal education program, continuing education or clinical practice and is expected to continue throughout the APRN's career.

h. ***Faculty directed clinical practice*** – the role of nursing program faculty in overseeing student clinical learning including those programs utilizing preceptors.

i. ***Grandfathering*** – provision in a new law or regulation exempting those already in or a part of the existing system that is being regulated. An exception to a restriction that allows all those already doing something to continue doing it even if they would be stopped by the new restriction.

j. ***Health-related*** – any domains that affect the well-being of a population.

k. ***Interdisciplinary faculty*** – faculty from other professions who in addition to regular program faculty, add diversity and enrich student experiences.

l. ***Nursing program faculty*** – individuals employed full or part time by academic institution responsible for developing, implementing evaluating and updating curricula.

m. ***Preceptor*** – an individual at or above the level of licensure that an assigned student is seeking, who may serve as a teacher, mentor, role model and/or supervisor in a clinical setting.

n. ***Prescribed devices*** – an instrument or an apparatus intended for use in diagnosis or treatment and in the prevention of disease or restoration of health.

o. ***Professional boundaries*** – the space between the nurse's power and the patient's vulnerability – The power of the nurse comes from the professional position and access to private knowledge about the patient. Establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the patient's needs.

p. ***Professional Certification*** – a credential issued by a national certifying body meeting specified requirements acceptable to the board that is used as a requirement for APRN licensure.

Report of the Bylaws Committee

Board of Directors' Recommendation

1. ***That the Board of Directors forward the current Standard Rules of the Delegate Assembly presented under the Bylaws Committee Report to the 2008 Delegate Assembly.***

Background

The Board of Directors or Delegate Assembly charges the Bylaws Committee with reviewing and making recommendations on proposed bylaw amendments. The Bylaws Committee was charged this year to review the current Standing Rules.

Highlights of FY08 Activities

- The committee reviewed and discussed the current Standing Rules of the Delegate Assembly. No changes were proposed.
- The committee reviewed, discussed, and met their performance measures and targets from the Balanced Scorecard.
- The committee evaluated their meeting performance.

Future Activities

None scheduled at this time.

Attachments

A. 2008 Standing Rules

Members

Charlene Kelly, PhD, RN
Nebraska, Area II, Chair

Martha Barr, MSN, RN
Tennessee, Area III

Kathryn L. Busby, JD
Arizona, Area I

Janet Shields, MSN, CRNP, APRN, BC
Pennsylvania, Area IV

Laura Rhodes, MSN, RN
Board Liaison

Staff

Kathy Apple, MS, RN, CAE
Chief Executive Officer

Kristin Garcia, Manager
Executive Office Administration

Kate Jones
Coordinator, Executive Office & Meetings

Meeting Dates

- March 11, 2008 (Conference Call)

Attachment A

Standing Rules

1. Credentialing Procedures and Reports
   A. The President shall appoint the Credentials Committee, which is responsible for registering and accrediting delegates and alternate delegates.
   B. Upon registration, each delegate and alternate shall receive a badge and the appropriate number of voting cards authorized for that delegate. Delegates authorized to cast one vote shall receive one voting card. Delegates authorized to cast two votes shall receive two voting cards. Any transfer of voting cards must be made through the Credentials Committee.
   C. A registered alternate may substitute for a delegate provided the delegate turns in the delegate badge and voting card(s) to the Credentials Committee, at which time the alternate is issued a delegate badge. The initial delegate may resume delegate status by the same process.
   D. The Credentials Committee shall give a report at the first business meeting. The report will contain the number of delegates and alternates registered as present with proper credentials, and the number of delegate votes present. At the beginning of each subsequent business meeting, the committee shall present an updated report listing all properly credentialed delegates and alternate delegates present, and the number of delegate votes present.
2. Meeting Conduct
   A. Delegates must wear badges and sit in the section reserved for them.
   B. All attendees shall be in their seats at least five minutes before the scheduled meeting time.
   C. There shall be no smoking in the meeting room.
   D. All cellular telephones and pagers shall be turned off, or turned to silent vibrating mode. An attendee must leave the meeting room to answer a telephone.
   E. A delegate's conversations with non-delegates during a business meeting must take place outside the designated delegate area.
   F. All attendees have a right to be treated respectfully.
   G. There shall be no videotaping, audio recording or photographing of the sessions without the written permission of NCSBN.
3. Agenda
   A. Business
      1. The Business Agenda is prepared by the president in consultation with the executive director and approved by the Board of Directors.
   B. Consent
      1. The Consent Agenda contains agenda items that do not recommend actions.
      2. The Board of Directors may place items on the Consent Agenda that may be considered received without discussion or vote.
      3. An item will be removed from the Consent Agenda for discussion or vote at the request of any delegate.

4. All items remaining on the Consent Agenda will be considered received without discussion or vote.

4. Motions or Resolutions

A. Only delegates, members of the Board of Directors, and the Examination Committee may present motions or resolutions to the Delegate Assembly. Resolutions or motions made by the Examination Committee are limited to those to approve test plans pursuant to Article X, Section 1(a) of the bylaws of the National Council.

B. All motions, resolutions and amendments shall be in writing and on triplicate motion paper signed by the maker and a second. All motions, resolutions, and amendments must be submitted to the Delegate Assembly chair and the parliamentarian. All resolutions and non-procedural main motions must also be submitted to the chair of the Resolutions Committee before being presented to the Delegate Assembly.

C. The Resolutions Committee, according to its Operating Policies and Procedures, shall review motions and resolutions submitted before Wednesday, Aug. 8, 2007, at 4:30 pm. Resolution or motion-makers are encouraged to submit motions and resolutions to the Resolutions Committee for review before this deadline.

D. The Resolutions Committee will convene its meeting on Wednesday, Aug. 8, 2007, at 4:30 pm and schedule a mutually agreeable time during the meeting to meet with each resolution or motion-maker. The Resolutions Committee shall meet with the resolution or motion-maker to prepare resolutions or motions for presentation to the Delegate Assembly and to evaluate the resolution or motion in accordance with the criteria in its operating policies and procedures. The Committee shall submit a summary report to the Delegate Assembly of the Committee's review, analysis, and evaluation of each resolution and motion referred to the Committee. The Committee report shall precede the resolution or motion by the maker to the Delegate Assembly.

E. If a member of the Delegate Assembly wishes to introduce a non-procedural main motion or resolution after the deadline of 4:30 pm on Wednesday, Aug. 8, 2007, the request shall be submitted under New Business; provided that the maker first submits the resolution or motion to the chair of the Resolutions Committee. All motions or resolutions submitted after the deadline must be presented with a written analysis that addresses the motion or resolution's consistency with established review criteria, including, but not limited to, the NCSBN mission, purpose and/or functions, strategic initiatives and outcomes; preliminary assessment of fiscal impact; and potential legal implications. The member submitting such a motion or resolution shall provide written copies of the motion or resolution to all delegates. A majority vote of the delegates shall be required to grant the request to introduce this item of business. [The Resolutions Committee shall advise the Delegate Assembly where the required analyses have not been performed and/or recommend deferral of a vote on the motion pending further analysis.]

5. Debate at Business Meetings

A. Order of Debate: Delegates shall have the first right to speak. Non-delegate members and employees of Member Boards including members of the Board of Directors may speak only after all delegates have spoken.

B. Any person who wishes to speak shall go to a microphone. When recognized by the chair, the speaker shall state his or her name and Member Board or organization.

C. No person may speak in debate more than twice on the same question on the same day, or longer than four minutes per speech, without permission of the Delegate Assembly, granted by a majority vote without debate.

D. A red card raised at a microphone interrupts business for the purpose of a point of order, a question of privilege, orders of the day, a parliamentary inquiry or an appeal. Any of these motions takes priority over regular debate.

E. A timekeeper will signal when the speaker has one minute remaining, and when the allotted time has expired.

F. The Delegate Assembly may by a majority vote go into executive session. The enacting motion shall specify those permitted to attend.

6. Nominations and Elections

A. A delegate making a nomination from the floor shall have two minutes to list the qualifications of the nominee. Written consent of the nominee and a written statement of qualifications must be submitted to the Committee on Nominations at the time of the nomination from the floor.

B. Electioneering for candidates is prohibited except during the candidate forum.

C. The voting strength for the election shall be determined by those registered by 5:00 pm on Wednesday, Aug. 8, 2007.

D. Election for officers, directors, and members of the Committee on Nominations shall be held Thursday, Aug. 9, 2007, from 7:45 to 8:45 am.

E. If no candidate receives the required vote for an office and repeated balloting is required, the president shall immediately announce run-off candidates and the time for the run-off balloting.

- If no candidate for officer or area director receives a majority on the first ballot, the run-off shall be limited to the two candidates receiving the highest number of votes.
- If no candidate for director-at-large receives a majority on the first ballot, the run-off shall be limited to the four candidates receiving the highest number of votes. If no candidate receives a majority on the second ballot, another run-off shall be limited to the three candidates receiving the highest number of votes.
- If, on the initial ballot, one candidate for director-at-large receives a majority, a run-off shall be limited to the two candidates receiving the next highest number of votes.

7. Forums

A. Scheduled: The purpose of scheduled forums is to provide information helpful for decisions and to encourage dialogue among all delegates on the issues presented at the forum. All delegates are encouraged to attend forums to prepare for voting during the Delegate Assembly. Forum facilitators will give preference to voting delegates who wish to raise questions and/or discuss an issue. Guests may be recognized by the Chair to speak after all delegates, non-delegate members and employees of Member Boards have spoken.

B. Open: Open forum time will be scheduled to promote dialogue and discussion on issues by all attendees. Attendee participation determines the topics discussed during an Open Forum. The president will facilitate the Open Forum.

C. To ensure fair participation in forums, the forum facilitators may, at their discretion, impose rules of debate.

Report of Faculty Qualifications Committee

Board of Directors' Recommendation

1. Adopt the proposed revisions to the Education Model Rules

Rationale:

The Faculty Qualifications Committee reviewed the literature and received feedback from Member Boards and educators and concluded that the NCSBN Model Education Rules should be revised to include stronger language for requiring graduate level clinical practice and education. Further, given the complexity in nursing practice and nursing education today, the education level for Practical Nurse educators should be increased from a baccalaureate degree with a major in nursing to a master's degree with a major in nursing.

Fiscal Impact:

None

Background

2007-2008 CHARGES

- **Advise staff on content of Faculty Shortage Conference**

  The Faculty Qualifications Committee members planned and held the "Faculty Shortage: Implications for Regulation" conference on March 26, 2008, in Chicago. The conference objectives were:

  - Examine the regulatory issues that arise when there is public pressure to waive faculty qualifications during the faculty shortage.
  - Discuss creative solutions to the faculty shortage that encourage collaboration with practice, regulation, and education.
  - Analyze the impact of innovative teaching strategies on patient safety.

  There was an overwhelming response to the conference, as registration had to be closed weeks before it was held. There were 200 educators, regulators, and practice administrators present, with attendees from 40 states and 2 countries. The conference was also Web-cast to 20 Member Boards, and the Web cast will be made available to the public on NCSBN's Web site. The participants had an enthusiastically positive response to the conference and asked for NCSBN to continue collaborating with our education and practice partners through this type of venue.

- **Review and present recommendations for future nursing faculty qualifications and roles.**

  The mission of the boards of nursing is to protect the public, and, as such, part of their responsibility is making sure that nursing programs have sufficient numbers of qualified faculty for meeting their educational outcomes. Most boards of nursing approve the nursing education programs in their states, developing the standards for "qualified faculty." During the last five years, legislators, and other stakeholders, in light of the faculty shortage, have begun questioning whether faculty qualifications set by boards of nursing are too high. Recognizing the need for evidence to support nursing education rules and regulations, the 2007–2008 NCSBN Board of Directors created the Faculty Qualifications Committee and charged them to study the role and qualifications of nursing faculty. For a more detailed report of NCSBN's work related to faculty qualifications (see Attachment A).

Members

Brenda S. Jackson, PhD, MSN, RN
Texas, Area III, Chair

Duane Napier, MSN, RN, BC
West Virginia-PN, Area II

Barbara Newman, MS, RN
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Linda Shanta, PhD, RN
North Dakota, Area II

Laura Rhodes, MSN, RN
West Virginia-RN, Area II,
Board Liaison

Staff

Nancy Spector, PhD, RN
Director of Education

Meeting Dates

- September 17-18, 2008
- February 14-15, 2008
- March 27-28, 2008
- April 4, 2008 (Conference call)

Relationship to Strategic Plan

Strategic Initiative B
NCSBN contributes to Member Board excellence by providing resources, communication and technology.

Strategic Objective 2
Continuously provide and evaluate education, information sharing and networking opportunities.

Strategic Initiative C
NCSBN advances evidence-based nursing regulation and regulatory solutions for public protection.

Strategic Objective 2
Provide models and resources for evidence-based regulation to Member Boards.

Highlights of FY08 Activities

- Hosted collaborative conference call on Sept. 18, 2008, with representatives from the American Association of Colleges of Nursing (AACN), the Commission on Collegiate Nursing Education (CCNE), the National Association for Practical Nurse Education and Service (NAPNES), the National League for Nursing (NLN), and the National League for Nursing Accrediting Commission (NLN-AC).
- Reviewed the following evidence:
  - Nursing education literature.
  - NCSBN's Member Board Profiles.
  - Minutes from Education Consultant Network calls.
  - Relevant surveys from the Education Consultant Network.
  - PR&E's 2007 Faculty Shortage Survey.
  - PR&E's 2007 Comparison of Faculty Qualifications in National Documents.
- Made recommendations for faculty qualifications; future roles of faculty; orientation of part-time, adjunct, and novice faculty; and for collaboration with educators to foster innovation in nursing education.
- Hosted "Faculty Shortage: Implications for Regulation" conference.

Future Activities

Charge was met.

Attachments

A. Nursing Faculty Qualifications and Roles.

B. Proposed Revisions to the Education Model

Attachment A

Nursing Faculty Qualifications and Roles

April 7, 2008:

To supplement the work done by the Faculty Qualifications Committee, the background of the work of the Faculty Qualifications Committee, the premises for their recommendations and a synopsis of the literature are presented below.

BACKGROUND

In response to questions being raised by legislators and stakeholders regarding faculty qualifications, in 2005-2006 NCSBN's Board of Directors charged the Practice, Regulation and Education (PR&E) Committee to develop evidence-based nursing education indicators. PR&E Committee members participated with NCSBN's Research Department to conduct the "National Study of Elements in Nursing Education" (NCSBN, 2006b) and with NCSBN's Education Department to conduct a systematic review of nursing education outcomes (NCSBN, 2006c), for the purpose of developing evidence-based nursing education guidelines for the boards of nursing. Ultimately, the PR&E Committee presented "Evidence-Based Nursing Education for Regulation," or EBNER (NCSBN, 2006a), to the boards of nursing. The EBNER document explicitly describes, for the boards of nursing, the published evidence that underpins nursing education outcomes.

As often occurs when research is conducted, further questions were identified. EBNER, which was an analysis of NCSBN's research and other published research, supported the need for "qualified faculty" to guide and supervise student nurses. However, the question of "what is meant by 'qualified faculty'?" then arose.

At the same time, some nursing programs were struggling to maintain their faculty standards, as set by their boards of nursing, because of the current faculty shortage. Programs were having problems attracting qualified faculty, and lawmakers, in some states, were calling for a lowering of faculty standards so that more nursing students could be graduated. Yet, is lowering standards the answer? The Institute of Medicine (Greiner and Knebel, 2003, pp. 1-2) has called for an "overhaul" of health care education, stating that health professionals aren't adequately prepared, as it is, to address the ever-changing demands of health care. Similarly, the National Nursing Education Study of the Carnegie Foundation for the Advancement of Teaching has found that nursing education classroom teaching suffers from a lack of adequate teaching in the areas of natural sciences, social sciences, and humanities. (Benner, Sutphen, Leonard and Day, 2007) In this healthcare crisis, where medical errors annually kill more people than AIDS or breast cancer does (Kohn, Corrigan and Donaldson, 1999), neither the boards of nursing, whose mission is public protection, nor educators, thought the answer was to lower standards.

Therefore, the 2007-2008 NCSBN Board of Directors charged the Faculty Qualifications Committee with:

- Advising staff on content of Faculty Shortage Conference
- Reviewing and presenting recommendations for future faculty qualifications and roles.

The committee members made their recommendations for future faculty qualifications and roles after reviewing the following:

- Input from a collaborative conference call with representatives from the American Association of Colleges of Nursing (AACN), the Commission on Collegiate Nursing Education (CCNE), the National Association for Practical Nurse Education and Service (NAPNES), the National League for Nursing (NLN), and the National League for Nursing Accrediting Commission (NLN-AC).

- There were 35 evidence-based articles and/or consensus statements by experts in nursing education.
- Input from the speakers and participants of the "Faculty Shortage: Implications for Regulation" conference hosted by the committee members.
- Reports developed by 2006-2007 Practice, Regulation and Education (PR&E) Committee members, including the "Faculty Shortage Survey" and the "Comparison of Faculty Qualifications in National Documents" reports.
- Minutes from Education Consultant Network calls.
- Relevant surveys from the Education Consultant Network.

RECOMMENDATIONS

A. Nursing faculty in RN programs (full-time and part-time) shall have either a master's degree or a doctoral degree in nursing. Their education should include graduate preparation in the science of nursing, including clinical practice, and graduate preparation in teaching and learning, including curriculum development and implementation. Other supportive faculty with graduate degrees in related fields may participate on a nursing faculty team to enrich and augment nursing education.

B. Nursing faculty in PN programs (full-time and part-time) shall have either a master's degree or doctoral degree in nursing. Their education should include graduate preparation in the science of nursing, including clinical practice, and graduate preparation in teaching and learning, including curriculum development and implementation. Other faculty, BSN prepared, may participate on a nursing faculty team to enrich and augment nursing education.

C. Clinical preceptors shall be educated at or above the level for which the student is preparing.

D. When boards of nursing evaluate the preparation of nursing faculty members, it is essential to consider the three roles of faculty: collaborator, director of learning, and role modeling.

E. When boards of nursing evaluate the preparation of nursing faculty members, they should assess processes of faculty orientation. All part-time faculty members, adjunct faculty members, preceptors, novice faculty members, and others, should be oriented to the nursing program's curriculum and engaged in formal mentorships and faculty development.

F. Boards of nursing are encouraged to collaborate with educators to foster innovation in nursing education.

PREMISES

The Faculty Qualifications Committee members developed the following premises as a foundation for their recommendations:

A. The mission of the boards of nursing is the protection of public health, safety and welfare.

B. Nursing education programs are faculty driven, reflective of the parent institution's mission, and based on national standards.

C. Program outcomes are consistent with competencies required for safe and effective nursing practice.

D. Nursing faculty members facilitate the development of clinical judgment necessary for safe and effective practice.

E. Faculty members are licensed to practice nursing, as required by the jurisdiction in which they are teaching.

F. Nursing education programs recognize that collaboration with other disciplines is essential in the education of today's nurses.

G. Recognizing the complexity of nursing education, even though the scopes of practice differ for practical nurses and registered nurses, the roles of the faculty members are similar.

H. The science of learning drives teaching-learning methodologies in nursing education.

FUTURE FACULTY QUALIFICATIONS

In order to effectively meet the roles of faculty, how should faculty be prepared? This question was asked in the National Study of Elements of Nursing Education study (NCSBN, 2006b) and at a meeting of key stakeholders where those research results were discussed. There is some evidence in the literature related to faculty qualifications, and the Faculty Qualifications Committee members identified and reviewed those reports and data. Having reviewed the relevant literature and reports and with an eye to the future, the Faculty Qualifications Committee members make the following recommendation for faculty qualifications.

Master's in Nursing Degree Recommendation

The requirement for a master's degree in nursing has been a part of the NCSBN Education Model Rules for the RN nursing program and for the PN nursing program. The rules state, "It is preferable that the nursing faculty members have a master's degree with a major in nursing or a nursing doctorate degree." (NCSBN, 2004) The Faculty Qualifications Committee was asked to review these qualifications, considering the looming faculty shortage and that sometimes Boards are being asked to lower their faculty standards in order to graduate more nurses. After reviewing the literature and consensus statements of experts in nursing education, the Faculty Qualifications Committee members decided that the master's degree with a major in nursing should be maintained for RN programs and required for PN programs.

The Faculty Qualifications Committee members recommended strengthening the requirement of the PN nursing faculty because of the complexity in nursing practice and nursing education today. PN faculty take on many of the same roles as RN faculty and therefore should have the same qualifications as RN faculty. Further, the roles of PNs and RNs in clinical practice are changing, and, in this complex health care environment, this will only continue. Therefore, it is essential for PNs to understand the differentiation, and multiplicity, of the various roles in nursing and health care; graduate prepared faculty members will be able to facilitate this understanding. Graduate prepared faculty will also be able to teach, and role model, the intricacies of delegation, supervision, and assignment that are so important for PNs.

Further, practical nurses are often employed in long-term agencies, caring for vulnerable populations, who often have multiple conditions with higher-level care needs than ever before. It is predicted that in 25 years one in every four, instead of the current one in every six, Americans will be 60 years of age or older. Therefore, this recommendation is guided by looking toward the future of nursing and health care and envisioning the continued complexity in nursing care, as well as the changing roles of nurses.

Orsolini-Hain and Malone (2007) described the impending gap in clinical nursing expertise, related to an increased ratio of new graduates to experienced nurses, increased retirements of experienced nurses, the faculty shortage, and insufficient research to determine best practices in nursing education. Concomitantly, patient acuity is increasing, health care systems are becoming more complex, technology advances are growing exponentially, and the economic pressures are increasing. Furthermore, as was stated earlier, medical errors and

patient safety are major concerns for health care workers (Kohn et al., 1999). Orsolini-Hain and Malone (2007) call this the "perfect storm" in nursing, unless we address it immediately. These authors predict that this expertise gap could actually extend the nursing shortage. Therefore, it is not the time to lower the education standards of the nurse educator.

A statewide study of nursing faculty and a national study of evidence-based nursing education support the master's in nursing degree. Riner and Billings (1999) conducted a study to identify perceived needs of faculty members in one midwestern state. Their final sample consisted of a robust 352 nursing faculty who teach in LPN through PhD programs. They found that faculty with bachelor's degrees, or those with master's degrees in other fields, had significantly higher needs than those with master's in nursing degrees or doctorates. This is one of only a few studies that addressed LPN faculty. However, there is consensus data that support LPN faculty having a master's in nursing degree. The NCSBN Education Consultant Network members, during a conference call, strongly agreed that a graduate-prepared faculty was an essential element of a successful nursing program. Further, some Boards have found that when faculty members are prepared with a master's degree, those programs have significantly higher NCLEX pass rates. The National League for Nursing Accredited Commission (NLNAC) has found that there are significantly better outcomes (one outcome measure includes NCLEX pass rates) when programs are accredited, versus when they are not, most likely related to the higher standards associated with accreditation. (Tanner, 2008)

NCSBN's EBNER report (NCSBN, 2006a), which included data from a systematic review of nursing education outcomes (NCSBN, 2006c), and NCSBN national research findings, identified evidence-based faculty-student relationships and teaching methodologies that would imply the need for master's in nursing degrees for faculty members. The faculty-student relationships identified would require high-level interaction between students and faculty, beyond what a bachelor's educated faculty member could provide. Likewise, faculty members would need graduate coursework in education strategies to implement the research-based teaching methodologies that were identified.

Carnegie's study of nursing education (Benner et al., 2007), Riner and Billings (1999), Bartels (2007), and AACN's position statement for the preferred vision of the professoriate in baccalaureate and graduate nursing programs (2008b) all go a step further and support doctoral education of RN nursing faculty members. Riner and Billings (1999), for example, found that nursing faculty members without doctoral preparation had significantly greater developmental needs in almost all items on their scale. However, the Faculty Qualifications Committee members recognized that with the multiple levels of education for prelicensure nursing programs, and with the current faculty shortage, it is not the time for this recommendation. As it is, states are struggling to maintain the master's in nursing standard. For example, an NCSBN survey of Member Boards conducted in 2007 by the PR&E Committee found that 25 of the 36 Boards responding to the survey were allowing waivers for their RN faculty requirements for those nursing programs that provided evidence that they couldn't fill their positions with qualified faculty members. Of those states with waivers, 18 allow waivers on fewer than 10 percent of faculty in their state or territory, 4 allow waivers on 10 to 19 percent of faculty, and 3 allow waivers on 20 to 29 percent of faculty. For PN faculty, 16 Boards allowed waivers on fewer than 10 percent of the faculty in that state or territory, while one Board allowed waivers on 21 to 30 percent.

Our Member Board Profiles (NCSBN, 2008) reports on current faculty requirements in the boards of nursing:

- *Baccalaureate programs*: one requires a doctorate, two doctorate preferred; twenty-eight require an MSN, seven MSN preferred, four MS, one master's other, and fourteen other; two require a BSN, and one BS.
- *ADN programs*: one requires a doctorate; twenty-seven require an MSN, eight MSN preferred, four MS, and thirteen other; six require a BSN, one BS.

- *Diploma programs*: eleven require an MSN, seven MSN preferred, three MS, four other; three require a BSN, one BSN preferred; thirteen not applicable (no diploma programs in that jurisdiction).
- *PN programs*: nine require MSN, two MSN preferred; twenty-three require BSN, five BSN preferred, two BS, and fourteen other.

Graduate Preparation in Clinical Practice

In order for faculty members to act as role models for their students, and others, faculty members should have advanced clinical preparation in their areas of expertise. One finding from the Carnegie study of nursing education (Benner et al., 2007) was that some classroom teachers hadn't been in practice for years, and in the worst cases, students complained that faculty were not current in their understanding of clinical practice. While faculty members surely cannot be expert in everything and are encouraged to collaborate with other clinical experts, they still should have advanced background in clinical nursing science.

With advanced education at the master's level in clinical practice, the educator has the background necessary to teach about the multiple roles of health care workers and how to delegate and supervise in clinical practice. NCSBN research has shown that new nurses report that they lack skills in delegating and supervising (NCSBN, 2006b) health care personnel. Further, faculty prepared at the graduate level in clinical practice possess skills in high-level questioning that are valuable for teaching within the context of clinical practice. Phillips and Duke (2001) identified these high-level questioning skills to be application, analysis, synthesis, and evaluation, and they found that these were important elements for stimulating learning in the clinical setting. Likewise, NCSBN research (NCSBN, 2006b) has found significant differences in student outcomes when faculty members have in-depth interactions with students.

Position statements from the National League for Nursing (NLN, 2002) and the American Association of Colleges of Nursing (AACN, 2008b) support graduate clinical preparation. While the NLN (2002) statement stresses the need for more attention to the teaching/pedagogical component of the educator role, they also acknowledge that educators still need to be competent clinicians and that the scientific basis for practice is important. AACN (2008b, p. 1) more specifically states, "Clinically focused graduate preparation is the minimal expectation for clinical instruction and the coordination of mentoring of preceptors." At the Faculty Shortage conference, March 26, 2008, in Chicago, in a Fishbowl Discussion, representatives from AACN and NLN agreed that faculty should be educated at the graduate level in clinical practice.

Graduate Preparation in Education

While a graduate-level foundation in the science of nursing is essential for any nurse educator, so is graduate coursework in the science of teaching/learning. Rationale for this was provided under the faculty member taking the role of director of student learning. It is obvious that if the faculty member is responsible for directing student learning, he or she must understand the science of education, which would include an understanding of learning styles, including adult learning and diverse learners; education theory; evaluation and assessment of learners, curriculum and program outcomes; curriculum design; and diverse teaching strategies. The two national education associations, AACN and NLN, have both taken positions that nursing faculty need graduate background in education coursework (AACN, 2008b; NLN, 2002). A national study in nursing education (Benner et al., 2007) also has highlighted the need for nursing faculty to have graduate level education preparation, as have leaders in nursing education. (Bartels, 2007; Tanner, 2007; Zungolo, 2004)

Riner and Billings (1999) provide some research data that support inclusion of education coursework in graduate nursing education. In their study of 352 nursing faculty members, they found that faculty with no formal teacher education had significantly higher needs for

the following items: understanding how what is taught fits into the curriculum, establishing an effective teaching/learning environment, planning clinical experiences, and using simulations that provide experience in critical thinking and problem solving.

Balancing the Faculty Team

The Faculty Qualifications Committee emphasizes that support faculty with graduate degrees in related fields are encouraged to participate on an RN nursing faculty team and will enrich and augment nursing education. Similarly, for PN nursing programs the Faculty Qualifications Committee members recommend BSN prepared support faculty. As above, under the Collaborator Role, it is important to create a balanced faculty that will provide depth to student learning experiences. Benner et al., (2007), in their study of nursing education, found that nursing curricula are weak in the areas of psycho-social coursework, humanities, and education experiences that enable students to work with diverse populations. Further, Wolf, Dunbar-Jacobs, and Greenhouse (2006) make a case for practice/education collaborative models and support the findings of Benner et al., (2007) regarding the importance of contextual learning in nursing education. Wolf et al., (2006, p. 577) write, "Most of these transformational competencies are best learned through a combination of classroom and real-time practice setting experiences." This can best happen when there is a strong faculty team led by nursing faculty, with support by faculty in related fields.

FUTURE FACULTY ROLES

The Faculty Qualifications Committee recognizes that faculty have multiple functions in their educator roles, including, but not limited to: administrative, advisor for matriculation and career, clinical coach, continuing quality improvement of education, distance learning coordination, educator in the classroom, global representative, laboratory instructor, maintaining clinical relevancy, mentor to novice faculty members, mentor to preceptors, online course development, professional leadership, research/scholar, and simulation instructor. In order to understand the future roles of the nurse faculty members more conceptually, the Faculty Qualifications Committee members have developed the following categories, based on a literature review, discussion, and feedback from the Faculty Shortage Conference.

Similar to Halstead's (2007) assertion about faculty competencies, that it's not the expectation that all educators possess all competencies, the same is true for the role of faculty. Not every faculty member is expected to take every role. At the same time, these categories are not always discrete. That is, a faculty member could act as a role model in directing student learning by collaborating with a clinical expert to teach.

It is expected that there will be a rich balance of faculty members to take on these three roles. It is also understood that the composition of the faculty team is very much dependent upon the mission and philosophy of the nursing program. For example, in many ADN and diploma programs, the focus on scholarship is more likely to be on the scholarship of teaching than on conducting research studies.

The following three categories incorporate all the various roles that nursing faculty members currently are responsible for and will be responsible for in the future.

A. Collaborator

The following are some examples of this role:

- Communication;
- Manager of learning experiences;
- Interdisciplinary/professional;
- Inclusive;
- Shared decision making;

- Alliances;
- Joint efforts;
- Build partnerships; and
- Teamwork.

The Carnegie study of nursing education (Benner et al., 2007), and others (AACN, 2008a; Halstead, 2007), assert that we must educate nurses differently in these rapidly changing times in science, technology and clinical practice. In order to meet these new demands in nursing education, faculty must collaborate with educators from the natural sciences, social sciences and humanities (AACN, 2008b; Benner et al., 2007; Felton, 2000; Halstead, 2007), as well as those in practice. (Wolf et al., 2006) The nursing faculty members will bring these experts together and coordinate the student learning. This collaborative mindset will enhance student learning and prepare students for the future. Other health care fields are in line with this thinking. In a position paper defining core faculty for the physical therapy discipline, Brueilly, Williamson and Morris (2007) refer to their faculty as taking a collaborative role. They also find it essential to integrate faculty from related fields or from the foundational sciences; they refer to this balance as the "ideal faculty team" (p.14). However, they also assert that these interdisciplinary faculty members should be "vigorously mentored" (p. 10) by the physical therapy faculty.

Additionally, collaboration in clinical practice and across disciplines (Garman, Leach and Spector, 2006; Greiner and Knebel, 2003; McKay and Crippen, 2008) is essential in today's health care environment. Collaborative relationships have been linked to better patient outcomes, decreased costs of healthcare, and greater responsiveness of health care providers. (McKay and Crippen, 2008) Therefore, nurse educators must model this behavior in their roles as faculty.

B. Director of Student Learning

The following are some examples of this role:

- Clinical faculty;
- Simulation faculty;
- Classroom faculty;
- Curriculum development;
- Student evaluation;
- Program evaluation; and
- Laboratory faculty.

The director of student learning role encompasses facilitation of learning, curriculum and program development, program evaluation, and assessment and evaluation of students. Halstead (2007) writes an excellent review of the available evidence in these areas, and she identified some of the gaps in the literature, with most of them being in clinical education.

This role requires that faculty members have graduate preparation in education courses (AACN, 2008b; Bartels, 2007; Benner et al., 2007; NLN, 2002). Tanner (2007, p. 52), in an editorial, similarly states that "It is critical that we continue our efforts to develop nursing pedagogies that are firmly rooted in the research on learning to find a way to best prepare nurses for the 21st century." Bartels (2007, p. 157), in writing about the scholarship of teaching, acknowledges that nursing, as well as other disciplines, has been "painfully remiss in including in graduate curricula the content and applied experiences necessary to support the critical academic role of teaching." Preparation for the role of director of student learning is crucial for providing faculty with the essential background in teaching-learning

pedagogies, curriculum designs, and the complex issues associated with the assessment of student learning, the curriculum and the nursing program.

C. Role model

The following are some examples of this role:

- Professional/Ethical comportment;
- Leadership;
- Scholarship/Research;
- Practice/Clinical relevance (that is, the faculty members are teaching in their areas of clinical expertise);
- Patient focused;
- Relationship-based model;
- Preceptor mentorship; and
- Novice faculty mentorship.

Nursing faculty members act as role models for their students, whether for first semester prelicensure students, seasoned graduate students, preceptors, or novice faculty members. Role modeling is especially important during clinical experiences where students learn how to relate to patients, assess the situation, and make decisions. Wiseman (1994) described several role modeling behaviors that are important for clinical faculty members, including asking questions, reporting data to staff, and interacting with physicians.

It is important for seasoned faculty members to role model teaching behaviors for novice faculty members and preceptors. Siler and Kleiner (2001), in a phenomenological study of 12 nurse lecturers, found that novice nurse faculty members reported they were rarely prepared for the faculty role; were unfamiliar with the language, culture and practices for the role; and reported the workload was much higher than they had expected. In Halstead's (2007) literature review of novice faculty members, it is clear that novice faculty members have many needs that require role modeling of the faculty role by seasoned faculty members. Similarly, role modeling is important for part-time faculty members and preceptors. Riner and Billings (1999) reported that part-time faculty members have significant development needs, particularly in the areas of teaching methods, evaluation, and curriculum. These researchers stressed the importance of having experienced faculty mentor them. There is a similar need for experienced faculty members to role model teaching for preceptors. In a study of 86 preceptors, researchers found that preceptors reported they were unprepared to precept new graduates and that they needed more support from seasoned faculty members (Yonge, Hagler, Cox and Drefs, 2008).

Closely related to role modeling is the importance of integrating feedback and reflection into this role so that students and others can learn from the experience. NCSBN, in a systematic review, found feedback and reflection to be an evidence-based component of nursing education that every faculty member should incorporate into their teaching and mentoring (NCSBN, 2006a; NCSBN, 2006c). Bjørk and Kirkvold (1999), in Norway, conducted an elegantly designed study of new graduates that found how essential feedback and reflection is for new graduates. With only a short orientation period and no opportunity for feedback and reflection on how to improve, new nurses made the same mistakes (such as dangerously removing tubes and contaminating wounds) after eight to fourteen months in practice.

FACULTY ORIENTATION

As the Faculty Qualifications Committee reviewed the literature on nursing education, they found a need for preceptors, part-time, adjunct, novice, and other faculty members, to be

integrated into the nursing curriculum. This issue was also reviewed in the Role Modeling section of this document, and some relevant research findings were reported in that section.

Halstead (2007) cites several studies that report the significant needs of novice educators, who often become overwhelmed with the faculty role. Likewise, in Benner et al., (2007) national study of nursing education, they found that staff nurses who partnered with students frequently had no teaching experience and had difficulties integrating their clinical teaching with the classroom teaching. The Carnegie researchers, Benner et al., (2007) recommended ongoing faculty development for all part-time clinical instructors. Interestingly, similar problems are seen globally, as Dempsey (2007), from Ireland, qualitatively studied six clinical nurses who were being transitioned into faculty roles, and they often felt a low self-confidence, overwhelmed with the role, and under-prepared.

These findings can be extrapolated to all faculty members who take part in nursing education. A comprehensive orientation and ongoing development is important, along with engagement in the curriculum.

The Faculty Qualifications Committee considered the possibility of recommending a required full-time/part-time percentage of faculty members. They reviewed an August 2007, NCSBN survey of the Education Consultants which found that only four of the 36 Boards that responded had specific percentages limiting part-time faculty. Further, the Faculty Qualifications Committee held a collaborative conference call at their September 2007 PR&E meeting, with representatives from AACN, CCNE, NAPNES, NLN, NLNAC. While the participants on the call recognized that part-time faculty members are increasing in nursing programs, they also felt that requiring a percentage of full-time faculty to part-time faculty would be too prescriptive during this faculty shortage.

COLLABORATION TO FOSTER INNOVATION IN NURSING EDUCATION

The IOM 2003 report (Greiner and Knebel, 2003) on health professions education challenged the nursing community to develop a new vision for health professions education. Given the complexity of health care today, it is important for nurse educators and regulators to collaborate so that we can design and implement innovative and better ways of educating our future nurses. Innovation in nursing education was discussed at the "Faculty Shortage: Implications for Regulation," and it was clear that collaboration between educators and regulators is the key to successful innovation in nursing education.

One exciting collaborative project discussed at the faculty shortage conference was the work of the Texas Board of Nursing (Wilson and Thomas, 2008). With nursing education stakeholders, this Board of Nursing created a plan for fostering innovative nursing education models, which are designed to promote increased graduations from Texas professional nursing education programs. The purpose of the Board's focus on innovation is to reach the state's goal of graduating 9,700 professional nursing students by the year 2010 while maintaining quality education and staying above the 80 percent NCLEX pass rate (Innovation in Nursing Education, 2008).

Another collaborative project between regulation and education presented at the March 26, 2008, conference was the North Dakota Nurse Faculty Intern (NFI) pilot program. The purpose of this pilot project is to investigate the role development of nurse educators. A further purpose is to expand the general knowledge about the mechanism by which nursing graduate students gain competencies related to teaching and learning through practical experience, while working closely with seasoned mentors. With this pilot project the nurse faculty member is assigned to a mentor (MSN prepared) and an academic advisor (PhD prepared).

The use of simulation in nursing education was addressed at the Faculty Shortage Conference, and there was a presentation on using robots to extend the career of the aging nurse faculty.

Perceived and real regulatory and education barriers to innovation were discussed, and strategies on how to remove these barriers were provided

The Faculty Qualifications Committee members recommend that educators and regulators collaborate more closely to design and implement innovative nursing education strategies and programs that will allow us to graduate a sufficient number of competent and safe nurses.

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Attachment B

Proposed Revisions to the Education Model Rules

1. Qualifications for nursing faculty who teach in a program leading to licensure as a registered nurse.

Change from:

A. Have a minimum of a master's degree with a major in nursing or a nursing doctorate degree.

B. Have < > years of clinical experience.

C. Have preparation in teaching and learning principles for adult education, including curriculum development and implementation.

D. Have current knowledge of RN nursing practice.

**** It is preferable that the nursing faculty hold an earned doctorate related to nursing education and/or the specific content area that the individual teaches.*

To (changes in bold):

Qualifications for nursing faculty who teach in a program leading to licensure as a registered nurse:

A. Have a minimum of a master's degree with a major in nursing or a **doctorate in nursing** degree.

B. Have < > years of clinical experience.

C. **Have graduate preparation in the science of nursing, including clinical practice, and graduate preparation in teaching and learning, including curriculum development and implementation**.

D. Have current knowledge of RN nursing practice.

**** It is preferable that the nursing faculty hold an earned doctorate related to nursing education and/or the specific content area that the individual teaches.*

Rationale:

The rationale for changing from the "nursing doctorate" to the "doctorate in nursing" is an editorial change, suggested for the sake of clarity. The "nursing doctorate" degree has been a specific degree that nursing graduate programs have awarded, whereas the doctorate in nursing is a general phrase referring to faculty members who have a doctoral degree in nursing (either PhD or DNP).

Because of the complexity in today's health care and nursing education, it is important to include stronger language for requiring graduate coursework both in clinical practice and in teaching/learning.

2. Qualifications for nursing faculty who teach in a program leading to licensure as a practical/vocational nurse.

Change from:

E. Have a minimum of a baccalaureate degree with a major in nursing.

F. Have < > years of clinical experience.

G. Have preparation in teaching and learning principles for adult education, including curriculum development and implementation.

H. Have current knowledge of LPN/VN nursing practice.

*** *It is preferable that the nursing faculty members have a Master's degree with major in Nursing or a Nursing Doctorate degree.*

To (changes in bold):

Qualifications for nursing faculty who teach in a program leading to licensure as a practical/vocational nurse:

E. Have a minimum of a **master's** degree with a major in nursing.

F. Have < > years of clinical experience.

G. Have **graduate preparation in the science of nursing, including clinical practice, and graduate preparation in teaching and learning, including curriculum development and implementation**.

H. Have current knowledge of LPN/VN nursing practice.

Rationale:

Given the complexity in nursing practice and nursing education today, PN faculty take on many of the same roles as RN faculty. While PNs and RNs have different scopes of practice, faculty of each have to know how to develop a curriculum, evaluate students, develop reliable and valid exams, etc. Therefore, they should have the same qualifications as RN faculty. Further, the roles of PNs and RNs in clinical practice are changing, and, in this health care environment, this will only continue. Therefore, it is essential for PNs to understand the differentiation, and multiplicity, of the various roles in nursing and health care; graduate prepared faculty members will be able to facilitate this understanding. Graduate prepared faculty will also be able to teach, and role model, the intricacies of delegation, supervision, and assignment that are so important for PNs.

Practical nurses are often employed in long-term agencies, caring for vulnerable populations, who often have multiple conditions with higher-level care needs than ever before. It is predicted that in 25 years one in every four, instead of the current one in every six, Americans will be 60 years of age or older. Therefore, this recommendation is guided by looking toward the future of nursing and health care and envisioning the continued complexity in nursing care, as well as the changing roles of nurses.

3. Qualifications for clinical preceptors:

Change from:

Clinical preceptors shall have demonstrated competencies related to the area of assigned clinical teaching responsibilities and will serve as a role model and educator to the student. Clinical preceptors may be used to enhance faculty-directed clinical learning experiences. Clinical preceptors should be licensed at or above the level for which the student is preparing.

To (changes in bold):

Clinical preceptors shall have demonstrated competencies related to the area of assigned clinical teaching responsibilities and will serve as a role model and educator to the student. Clinical preceptors may be used to enhance faculty-directed clinical learning experiences. Clinical preceptors should be **educated** at or above the level for which the student is preparing.

Rationale:

Baccalaureate students are taught to practice public health nursing, which is commonly not taught in ADN or diploma programs. Since preceptors are role models for students, this change is appropriate.

Report of the Awards Committee

Background

The Board of Directors established the Awards Panel in FY01 to review and evaluate the NCSBN Awards Program. The panel was charged with selection of award recipients and developing an awards program that ensured consistency, fairness, and celebrated the contributions and accomplishment of the membership. The panel, now called a committee, has continued to refine the awards program.

Highlights of FY08 Activities

- Selected the 2008 Award Recipients.
- Reported to the Board of Directors, the 2008 recipients selected by the awards committee.
- Reported to the Board of Directors the committee's recommendation to give a special award.
- Reviewed the boards Of nursing centennial dates and no boards were identified for 2008.
- Initiated a new process to notify award recipients that involves the recipient's board staff and board members.
- Explored ways to present the recipients bios and acknowledge their guests that attend the awards program.
- Enhanced the award recipient slide presentations by requesting recipients include both professional and personal photographs.
- Established the NCSBN 30th Anniversary Special Award and criteria to commemorate the NCSBN 30th Anniversary.
- Reviewed and evaluated the award category template forms and the scoring/rating forms. No changes were made.
- Determined a greater focus should be placed on the recipient of the R. Louise McManus award at the award ceremony. Additional time for the recipient's speech and a prominent display on the annual meeting poster was also alotted.
- Discussed an evening Awards Celebration as part of NCSBN's 30th anniversary gala.

2008 AWARD RECIPIENTS:

NCSBN 30th Anniversary Special Award

Joey Ridenour, Executive Director, Arizona State Board of Nursing

Mildred S. Schmidt, former Executive Secretary, New York State Board of Nursing

Sharon Weisenbeck Malin, former Executive Director, Kentucky Board of Nursing

R. Louise McManus Award

Shirley Brekken, Executive Director, Minnesota Board of Nursing

Meritorious Service Award

Sandra Evans, Executive Director, Idaho Board of Nursing

Regulatory Achievement Award

Kentucky Board of Nursing

Members

Marty Alston
West Virginia-RN, Area II

Joan K. Bainer, MN, RN, CAN, BC
South Carolina, Area III

Rachel Gomez, LVN
Texas, Area III

Valerie Smith, MS, RN
Arizona, Area I

Susan L. Woods, PhD, RN
Washington, Area I

Staff
Alicia Byrd
Director, Member Relations

Meeting Dates

- Oct. 24, 2007 (Conference Call)
- April 4, 2008

Relationship to Strategic Plan

Strategic Initiative B
NCSBN contributes to Member Board excellence by providing resources, communication, education and technology.

Strategic Objective 1
Recognize Member Board excellence.

Exceptional Contribution Award

Lisa Emrich, Board Staff, Ohio Board of Nursing

Barbara Newman, Board Staff, Maryland Board of Nursing

Calvina Thomas, Board Staff, Arkansas State Board of Nursing

Executive Officer Recognition Awards

10 YEARS

- Myra Broadway, Executive Director, Maine State Board of Nursing
- Connie Kalanek, Executive Director, North Dakota Board Nursing
- Paula Meyer, Executive Director, Washington State Nursing Care Quality Assurance Commission

15 YEARS

- Ruth Terry, Executive Officer, California Board of Registered Nursing
- Laura Poe, Executive Administrator, Utah State Board of Nursing

20 YEARS

- Lorinda Inman, Executive Director, Iowa Board of Nursing
- Barbara Morvant, Executive Director, Louisiana State Board of Nursing
- Charlene Kelly, Executive Director, Nebraska Board of Nursing

Special Award

- Thomas Abram, NCSBN Legal Counsel

Future Activities

- Select the 2009 awards recipients.
- Assess the Awards Presentation Program and make recommendations to the Board of Directors.

Report of the Commitment to Ongoing Regulatory Excellence (CORE) Committee

Background

The Commitment to Ongoing Regulatory Excellence project (CORE) was approved by the FY02 Board of Directors to provide an ongoing performance measurement system for nursing regulators. CORE utilizes data collected periodically from boards of nursing and stakeholders and identifies best practices in the provision of regulatory services. By promoting excellence in the provision of regulatory services Boards can improve their management and delivery of safe, effective nursing care to the public.

To measure performance boards of nursing are surveyed periodically regarding five functions of boards: (1) discipline; (2) practice; (3) education program approval; (4) licensure; and (5) governance. Five groups of stakeholders that are directly affected by Board actions were surveyed in 2002 and 2006. The most recent surveys were sent out in April 2008. The five groups that were surveyed include: (1) employers; (2) nursing programs; (3) nurses; (4) nurses who were the subjects of complaints; and (5) persons who made a complaint. Random samples of these stakeholders are surveyed to gain their perspectives about interactions with their board of nursing and about the effectiveness of nursing regulation in general.

In FY08 the CORE Committee took a number of steps to increase participation thereby making the results more representative of all Member Boards. Highlights of these activities are listed below.

Highlights of FY08 Activities

- Based on feedback from Member Boards the CORE Committee took several steps to eliminate barriers to participation and make the surveys easier to fill out. The committee eliminated the survey of associations after concluding the responses were not constructive. This eliminated the burden on jurisdictions to provide a list of associations to be surveyed.
- The other five surveys were reviewed and shortened considerably. Only questions deemed essential to measure performance were included. In addition, the format of the questionnaires was changed from a scanned form to a paper and pencil format making the surveys more visually appealing and easier to fill out.
- In the past there was a very low response rate from persons making a complaint and persons who were the subject of a complaint. In order to increase response rates, the CORE Committee conducted a pilot study whereby surveys were sent to respondents along with the BON's usual form of notification at the time that their case was closed.
- Another burden on boards has been the request to provide lists of stakeholders. Many states do not have lists of employers or it is difficult to provide a list of nurses. In order to reduce the burden on boards of having to provide a list of education programs, the CORE Committee decided to use the list of education programs from NCLEX®. For jurisdictions participating in Nur*sys*® they were asked permission to have NCSBN draw a sample of nurses from Nur*sys* rather than have the boards provide lists of nurses themselves. This strategy is the primary reason why there has been a 68 percent increase in the number of lists of nurses obtained from boards in 2006 (n=28) to 2008 (n=47).
- Getting boards of nursing to participate in CORE has always been a challenge. A board might participate in one aspect of CORE by filling out the board survey but not provide lists of nurses. This meant the aggregate results were less representative than they might have been and a board would be missing feedback from some or all of its stakeholders. A new strategy was, therefore, implemented that provides boards

Members

Margaret Walker, EdD, RN, FRE
New Hampshire, Area IV, Chair

Mary Blubaugh, MSN, RN
Kansas, Area II

Shirley Brekken, MS, RN
Minnesota, Area II

Katie Daugherty, MN, RN
California-RN, Area I

Marilyn L. Hudson, RN, CNS
Oregon, Area I

Joey Ridenour, MN, RN
Arizona, Area I

Karen Scipio-Skinner, MSN, RN
District of Columbia, Area IV

Barbara Swehla, MN, RN
Montana, Area I

Betsy Houchen, JD, RN
Ohio, Area II, Board Liaison

Staff

Kevin Kenward, PhD
Director, Research

Lindsey Gross
Administrative Assistant, Research

Richard Smiley
Statistician, Research

Meeting Dates

- Nov. 28-29, 2007
- Jan. 30-31, 2008
- March 27-28, 2008
- July 24-25, 2008

Relationship to Strategic Plan

Strategic Initiative #2
Promote evidence-based regulation that provides for public protection. (Regulatory Excellence)

Strategic Objective 1
Revise CORE data collection instruments

Strategic Objective 2
When requested, assist Member Boards to develop performance measures and conduct research and evaluation studies.

feedback from all their stakeholders. For any jurisdiction that could not provide a list of nurses or employers, NCSBN obtained the list from other sources, with the board's permission, and surveyed them. For example, New York cannot provide addresses of nurses. In order to survey nurses in New York, NCSBN (with the NY Board's permission) obtained a list of nurses from a company that compiles such lists and mailed a survey to those nurses. The nurses' responses are then included in the state-level report.

Future Activities

- Disseminate individual state reports and aggregate results.
- Assist boards in interpreting performance measures and implementing best practices.
- Review all CORE surveys and modify and refine questions that will be used for collection of data in 2010.

Attachments

A. Board of Nursing Survey

B. Board of Nursing Survey of Nurses

C. Board of Nursing Survey of Employers

D. Board of Nursing Survey of Nursing Education Programs

E. Board of Nursing Survey of Persons Who Made a Complaint

F. Board of Nursing Survey of Nurses Who Have Been the Subject of a Complaint

Attachment A

Board of Nursing Survey

Board of Nursing Survey

This questionnaire is part of the Commitment to Ongoing Regulatory Excellence **(CORE)** project: a performance measurement system for nursing regulators. These data will help improve organizational performance practices, capabilities, and evidenced-based results in the provision of regulatory services.

Please answer the following questions for each type of nurse.

	RN/LPN	APRN	Total
1. On average, in FY2007, how many days (please estimate if data not readily available) does it take for a case to be resolved from the date the complaint was received to the date of final resolution?	☐	☐	☐
2. What was the total number of cases open for investigation on the last day of FY2006?	☐	☐	☐
3. What was the total number of new cases assigned to investigators during FY2007?	☐	☐	☐
4. What was the total number of investigations open on the last day of FY2007?	☐	☐	☐
5. How many individual nurses had investigations opened against them during fiscal year (FY) 2007?	☐	☐	☐
6. How many individuals were initially placed on active probation/restriction/monitoring for even one day during FY2007 (excluding alternative programs)?	☐	☐	☐
7. How many nurses violated board orders in FY2007? (excluding alternative programs)	☐	☐	☐
8. Please indicate the number of board actions for each type of nurse during FY2007 and whether the settlement process was formal or informal.	☐	☐	☐
a. Formal Settlement (board hearing/board action)	☐	☐	☐
b. Informal Settlement (Attorney General lawyer/Board Members/Investigator/Staff negotiate settlement on behalf of the board)	☐	☐	☐
9. For each type of nurse, how many verifications of licensure did your board perform in FY2007 for other boards of nursing?	☐	☐	☐
If verifications are performed by Nursys®, skip to question 11.	☐	☐	☐
10. On average, how many days does it take to verify a license for each type of nurse registered in your state for another board of nursing?	☐	☐	☐

Over ▶

11. Please indicate the number of education programs (include each program and campus that is assigned an NCLEX program code) in your state and how many at the end of FY2007 had received initial approval, full approval, conditional approval, denied initial approval or had lost approval.

Number of Education Programs	Number of Programs with Initial Approval	Number of Programs With Full Approval	Number of Programs With Conditional Approval	Number of Programs Denied Initial Approval	Number of Programs that Lost Approval
☐	☐	☐	☐	☐	☐

12. Estimated number of practice related phone/fax/face-to-face/e-mail questions received during FY2007: ☐

13. What are the estimated number of practice decisions handled by the Board in FY2007 according to the following categories:

Activity	# Decisions Made
Advice/clarification*	☐
Formal Board decision*	☐
Total	☐

14. What are the estimated response times to answer calls by the Board in FY2007 according to the following categories:

Activity	Response Time
Advice/clarification*	☐
Formal Board decision*	☐
Total	☐

***Note**: *For the purpose of this survey advice/clarification is defined as providing information based on law, rule, previous Board decisions and opinions, or professional nursing knowledge. Formal Board decisions are defined as practice decisions that require Board action, such as advisory opinions, declaratory rulings, and Board opinions.*

15. How autonomous are staff in providing advice about or clarifying practice information? *Choose 1 best answer*

- ❑ No autonomy in answering practice questions. All questions are referred to Board.
- ❑ Staff may only respond to questions that had prior Board action or decision.
- ❑ Staff refer to the Board only when the resources available do not provide a clear response.
- ❑ Complete autonomy by staff. Questions are never referred to Board.

16. Please enter the number of full-time equivalent (FTE) staff who were involved in the discipline process during FY2007 (excluding investigators): *Please enter all that apply.*

**To convert part-time employees to FTEs, divide the number of paid hours by 2,080 (52 weeks multiplied by 40 hours per week).*

	Total FTE	Nurse	Non-Nurse
Board of Nursing employees	☐	☐	☐
Contracted Personnel	☐	☐	☐
Non-board employees from other state agencies	☐	☐	☐
Other _____ *(Please specify)*	☐	☐	☐

17. Of the number of FTEs in question 16, how many FTEs are assigned to monitor nurses on active probation/restriction/ monitoring (excluding alternative programs)? ☐

18. Excluding capital expenditures, please indicate the Board's total FY2007 expenditures. Please use the worksheet provided to calculate your costs. Fill out what you are able to.

	Actual dollars	Percent of total expenditures
Total FY2007 Expenditures		
Discipline/Complaint Handling		
Licensure		
Education Program/Monitoring Approval		
Practice		
Other _____		

19. Please provide the name and telephone number of a person we can contact about the information provided.

Contact Name

First Name _____ Last Name _____

( ) _____
Telephone Number

National Council of State Boards of Nursing

Commitment to Ongoing Regulatory Excellence

Data Requested from Boards
FY2007 Budget Clarification Worksheet

This worksheet is provided so that costs will be uniformly reported. In the past, not all boards included indirect costs or salaries in their calculations. Because we want to be able to calculate variables such as "cost per complaint handled" and compare the costs of the work of the board by staffing patterns, we are requesting you use this worksheet to calculate your costs.

Please indicate expenses for the following budget items. If you do not have exact figures, please estimate. Adding the total expenses for all items should match your total FY2007 expenditures. **When a member of the Board staff contributes to more then one category, please allocate a proportion of their salary among the appropriate items.**

Note: *Please do not include one-time capital expenditures or expenses related to the regulation of Certified Nursing Assistants (CNAs) or other Assistive Personnel in any of the following categories.)*

1. **The Board's total fiscal year 2007 expenditures** (excluding capital expenditures) _____

2. **Discipline/Complaint Handling**
   - **a.** Total salaries (including fringe) of board staff involved in discipline/ complaint handling _____
   - **b.** Attorney (non board staff) fees _____
   - **c.** Investigator (non board staff) fees _____
   - **d.** Hearing Costs (including board expenses related to hearings) _____
   - **e.** Board expenses (excluding hearing costs) _____
   - **f.** Expenses related to monitoring compliance with probation _____
   - **g.** Expenses related to alternative programs _____
   - **h.** Misc. expenses (witness fees, etc) _____

3. **Licensure (including renewal)**
   - **a.** Total salaries (including fringe) of board staff involved in licensure _____
   - **b.** Verification expenses _____
   - **c.** Expenses related to endorsement (excluding board staff salaries) _____
   - **d.** Expenses related to examination (excluding board staff salaries) _____
   - **e.** Expenses related to renewal (excluding board staff salaries) _____
   - **f.** Other costs related to licensure _____

4. **Education Program Approval**
   - a. Total salaries (including fringe) of board staff involved in education program approval _____
   - b. Travel expenses related to education program approval _____
   - c. Expenses related to distribution of information and materials _____
   - d. Other costs related to approval of nursing programs _____

Over ▶

5. Practice

a. Total salaries (including fringe) of board staff involved in practice activities _____

b. Other costs related to practice _____

6. Operational Costs

a. Postage and mailing expenses _____

b. Office supplies _____

c. Rent _____

d. Mantenance on equipment _____

e. Data management expenses _____

7. Administrative Costs

a. Total salaries of Executive Officer and support staff (including support departments) not covered by previous categories _____

b. Board expenses (including payments such as per diem or for compensation to board members) not covered by previous categories. _____

c. Other administrative and indirect costs not covered by previous categories _____

For any expenses not covered by this questionnaire, please list them here:

Expense item	**Amount**

Enter total amount for # 7 _____

Total FY2007 expenditures
(Should match question #1) _____

Thank you for your assistance in completion of this survey instrument.
Your responses directly relate to the outcomes of this significant research study.

DUE DATE: June 2, 2008 or as soon afterwards as possible. If you have any questions, call 312.525.3634
Please return your completed questionnaire in the postage paid envelope to:
NCSBN 111 E. Wacker Dr., Chicago, IL 60601

Attachment B

Board of Nursing Survey of Nurses

NCSBN
Leading in Nursing Regulation

Board of Nursing Survey of Nurses

Your Board of Nursing wants to improve its services and we need your help! This survey is being conducted for the Board of Nursing by the National Council of State Boards of Nursing (NCSBN). Your answers to the questions below will help provide data to guide future development of evidenced-based regulation.

1. What type(s) of nursing license/certification do you hold?
Check all that apply.

- ❑ Licensed practical/vocational nurse (LPN/VN)
- ❑ Registered Nurse (RN)
- ❑ Advanced Practice (APRN) with prescriptive authority: (includes CNM, CRNA, NP, CNS, etc.)
- ❑ Advanced Practice (APRN) without prescriptive authority: (includes CNM, CRNA, NP, CNS, etc.)
- ❑ Other (identify) _____

2. Are you currently employed as a nurse?

- ❑ Yes **Go to Question 3**
- ❑ No
  a. If you checked No, how long has it been since you were employed in nursing?

  _____ Years and _____ Months ***Go to Question 4***

  b. Are you currently a nursing student?
  - ❑ Yes
  - ❑ No

3. Which one of the following *best* describes the type of organization that is your current primary place of employment?
Check only one.

- ❑ Hospital
- ❑ Academia/Nursing EducationProgram
- ❑ Long-term care facility
- ❑ Community-based care or ambulatory care facility/organization (including public health department, visiting nurses association, home health, physician's office, clinic, nursing education program, school health service, correctional facility, etc.)
- ❑ Managed Care Organization
- ❑ Temporary service/employment agency
- ❑ Other setting: (identify) _____

4. How long have you been licensed to practice as a nurse (total time at all levels of licensure)?

_____ Years and _____ Months

5. Where did you receive your basic nursing education for your LPN/VN or RN license? (If you have both, please report for the RN education only.)

- ❑ This State
- ❑ Another State, (which state)
- ❑ Outside the United States, (which country)_____

6. How well did your basic education prepare you to provide safe and effective nursing care?

- ❑ Very well prepared
- ❑ Well prepared
- ❑ Poorly prepared
- ❑ Very poorly prepared

7. Have you ever attended a board meeting in state of primary licensure?

- ❑ Yes
- ❑ No

8. To what extent do you believe that you understand the differences between the roles of the Board of Nursing and professional associations?

- ❑ Understand
- ❑ Somewhat understand
- ❑ Somewhat misunderstand
- ❑ Misunderstand
- ❑ Differences are not clear

Over ▶

9. How well do you understand the scope/legal limits of a nurse's practice, as defined by the Nurse Practice Act and related state statutes and rules?

- ❑ Understand
- ❑ Somewhat understand
- ❑ Somewhat misunderstand
- ❑ Misunderstand

10. During the past 12 months, did you ask the Board of Nursing in this state about practice issues?

- ❑ No ***Go to Question 14***
- ❑ Yes
  - a) If yes, overall, how helpful or unhelpful was the response you received from the Board of Nursing in this state?
    - ❑ Very helpful
    - ❑ Somewhat helpful
    - ❑ Somewhat unhelpful
    - ❑ Very unhelpful

11. Overall, did the Board respond to practice questions in a timely manner?

- ❑ Yes
- ❑ No
- ❑ Don't know how long it took

12. How knowledgeable was board staff regarding scope of practice?

- ❑ Very knowledgeable
- ❑ Knowledgeable
- ❑ Somewhat knowledgeable
- ❑ Not knowledgeable at all
- ❑ Don't know

13. How responsive is the Board of Nursing to changes in practice?

- ❑ Very responsive
- ❑ Responsive
- ❑ Somewhat responsive
- ❑ Not responsive at all
- ❑ Don't know

14. During the last 12 months, did you have any other communication with this state Board of Nursing? (e.g., attended a formal presentation by the Board of Nursing, asked a non-practice issue question, etc.)

- ❑ No
- ❑ Yes
  - a) If yes, how "Satisfied" or "Dissatisfied" were you with the other communication you had with this state Board of Nursing?
    - ❑ Very satisfied
    - ❑ Satisfied
    - ❑ Dissatisfied
    - ❑ Very Dissatisfied

15. By which of the following methods did you last obtain or renew your license in this state? *Please check one*

- ❑ Mail
- ❑ Walk-in
- ❑ Printed application from Board's Web site, completed it, and mailed/faxed it to Board
- ❑ Used on-line services
- ❑ Other, please specify _____

16. How satisfied or dissatisfied are you with the licensure process?

- ❑ Very satisfied
- ❑ Satisfied
- ❑ Dissatisfied *Explain:* _____
- ❑ Very Dissatisfied *Explain:* _____

17. How satisfied or dissatisfied are you with the renewal process?

- ❑ Very satisfied
- ❑ Satisfied
- ❑ Dissatisfied *Explain:* _____
- ❑ Very Dissatisfied *Explain:* _____

18. If you had a statute, rule, and other legal requirements question, which one of the following resources would you be most likely to contact <u>first</u> for assistance? *Please check one.*

- ❑ Nursing practice law and rules
- ❑ Board of Nursing
- ❑ Board of Health
- ❑ Professional Association
- ❑ Facility Attorney
- ❑ Risk Management Department
- ❑ School of Nursing
- ❑ Other (please identify) _____

19. Which of the following do you use to find out about scope of practice/practice decisions? *Please check all that apply.*

- ❑ Nursing practice law and rules
- ❑ Board newsletter
- ❑ Other association newsletter
- ❑ Board Web site
- ❑ Other association Web site
- ❑ Personal communication with Board staff or member
- ❑ Public meetings/educational workshops
- ❑ Public hearings
- ❑ Public notice
- ❑ Other (please identify) _____

_____

20. lease rate the degree or extent of regulation in this state in each of the following areas.
Please circle the appropriate response.

	Too Much regulation	Adequate regulation	Too little regulation	Not Sure
a. Practice standards/ scope of practice	1	2	3	4
b. Complaint resolution/ discipline process	1	2	3	4
c. Education program approval/accreditation	1	2	3	4
d. Requirements for licensure	1	2	3	4
e. Other (specify):	1	2	3	4

_____

21. Please rate the Board of Nursing's newsletter.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Didn't read
- ❑ Board does not have a newsletter

22. Please rate the Board of Nursing's Web site.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Didn't use
- ❑ Board does not have a Web site

23. Please rate the Board of Nursing's automated telephone system.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Didn't use
- ❑ Board does not have an automated telephone system

24. During the past 24 months, have you been involved in any aspect of the Board of Nursing's <u>disciplinary process</u> (e.g., filed a complaint, provided a report to the Board, was the focus of a complaint, was a witness during a hearing, or was interviewed about a complaint)?

- ❑ No
- ❑ Yes

25. Overall, how effective or ineffective was the Board's <u>disciplinary (complaint/investigation/resolution)</u> process in protecting the public?

- ❑ Very effective
- ❑ Effective
- ❑ Ineffective
- ❑ Very ineffective

26. How well do you understand the laws in your state about reporting misconduct by a nurse?

- ❑ Understand
- ❑ Somewhat understand
- ❑ Somewhat misunderstand
- ❑ Misunderstand

27. Do you know how to report a suspected violation of the nursing laws or rules?

- ❑ Yes
- ❑ No

28. Overall, how effective is the state's Board of Nursing in protecting the health and safety of the public

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor

Over ▶

What other suggestions do you have for improving the Board of Nursing's activities?

Thank you for your assistance in completion of this survey instrument.
Your responses directly relate to the outcomes of this significant research study.

DUE DATE: June 2, 2008 or as soon afterwards as possible. If you have any questions, call 312.525.3634
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NCSBN 111 E. Wacker Dr., Chicago, IL 60601

Attachment C

Board of Nursing Survey of Employers

Board of Nursing Survey of Employers

The Board of Nursing wants to improve its services and we need your help! This survey is being conducted for the Board of Nursing by the National Council of State Boards of Nursing (NCSBN). Your answers to the questions below will help provide data to guide future development of evidenced-based regulation.

1. Which of the following describes your position?

- ❑ Director of Nursing/Chief Nursing Officer/Nursing Department Head
- ❑ Other supervising nurse
- ❑ Employer/supervisor, not a nurse
- ❑ Other (describe)

_____

_____

a) How long have you been in this position?

_____ Years and _____ Months

2. Which of the following best describes your place of employment? *Please check one*

- ❑ Hospital
- ❑ Long-term care facility
- ❑ Community-based or ambulatory care facility/organization (including public health department, visiting nurses association, home health, physician's office, clinic, school health service, nursing education program, correctional facility,
- ❑ Temporary service/employment agency
- ❑ Other (please identify)

_____

_____

3. Approximately how many full-time equivalent (FTE) nurses are employed by your facility/agency? (Count nurses by their most advanced license.)

____ Nursing Assistive Personnel (aides, nursing assistants, etc.)
____ Licensed Practical/Vocational Nurses
____ Registered Nurses
____ Advanced Practice Registered Nurses (all categories)

4. Which method do you use to verify licenses ("verification" means confirmation of licensure status): (Check all that apply)

- ❑ Call-in
- ❑ Phone - Automated system
- ❑ Fax
- ❑ E-mail
- ❑ Letter
- ❑ Nursys
- ❑ Web-based verification system (other than Nursys)

5. Approximately how many new graduates (licensed 12 months or less) were hired by your facility/agency during the past 12 months?

- ❑ LPN/VNs
- ❑ RNs
- ❑ APRNs

Over ▶

6. In your opinion, how well or poorly prepared are new graduates (licensed less than 12 months)? *Please circle the appropriate number*

	Very Well prepared	Well prepared	Poorly prepared	Very Poorly prepared
a. Administer medication by common routes	1	2	3	4
b. Work with machinery used for patient care (i.e., IV infuser, NG suction, etc.)	1	2	3	4
c. Work effectively within a health care team	1	2	3	4
d. Perform psychomotor skills (i.e., start IVs, insert NGs, do dressing changes, etc.)	1	2	3	4
e. Communicate relevant informantion	1	2	3	4
e. Perform thorough assessments	1	2	3	4
f. Document a legally defensible account of care provided	1	2	3	4
g. Recognize abnormal assessment findings	1	2	3	4
h. Teach patients	1	2	3	4
i. Assess the effectiveness of treatments	1	2	3	4
j. Recognize abnormal diagnostic/lab findings	1	2	3	4
k. Do math necessary for medication administration	1	2	3	4
l. Respond to emergency situations	1	2	3	4
m. Create a plan of care for patients	1	2	3	4
n. Supervise care provided by others	1	2	3	4
o. To what extent do you feel that experienced nurses (licensed for more than 12 months) with whom you had direct contact over the past 12 months were adequately prepared to provide safe and effective nursing care?	1	2	3	4

The following questions address your recent experiences with the Board of Nursing.

7. How responsive or unresponsive is the Board of Nursing to changes in practice?

- ❑ Responsive
- ❑ Somewhat Responsive
- ❑ Somewhat Unresponsive
- ❑ Unresponsive

8. How satisfied or dissatisfied were you with information or assistance provided by the Board of Nursing over the past 12 months during presentations you attended or in response to an inquiry you made (other than questions about practice issues)?

a. In response to an inquiry your office made (whether in writing or orally)

- ❑ Very satisfied
- ❑ Satisfied
- ❑ Dissatisfied
- ❑ Very dissatisfied
- ❑ No contact with the Board

b. Presentations by Board representatives

- ❑ Very satisfied
- ❑ Satisfied
- ❑ Dissatisfied
- ❑ Very dissatisfied
- ❑ No opportunity to evaluate

9. Please rate the Board of Nursing's automated telephone system.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Didn't use
- ❑ The Board does not have an automated telephone system

10. Please rate the Board of Nursing's newsletter.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Didn't read/receive
- ❑ The Board does not have a newsletter

11. Please rate the Board of Nursing's Web site.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Didn't use
- ❑ The Board does not have a Web site

12 Do you know how to report a suspected violation of the nursing statute or rule?

❑ Yes ❑ No

13. Which of the following do you use to find out about scope of practice/practice decisions? *Please check all that apply*

- ❑ Nursing practice law and rules
- ❑ Board newsletter
- ❑ Association newsletter
- ❑ Association Web site
- ❑ Board Web site
- ❑ Personal communication with Board staff or member
- ❑ Public meetings/educational workshops
- ❑ Public hearings
- ❑ Public notice
- ❑ Other (please identify) _____

14. How well do you understand the scope/legal limits of a nurse's practice as defined by the Nurse Practice Act and related state statutes and rules?

- ❑ Understand
- ❑ Somewhat understand
- ❑ Somewhat do not understand
- ❑ Do not understand

15. If you had a practice question, which one of the following would you be most likely to contact first for assistance? *Check only one*

- ❑ Board of Nursing
- ❑ Board of Health
- ❑ Professional Nursing Association
- ❑ Facility Attorney
- ❑ Risk Management Department
- ❑ School of Nursing
- ❑ Nursing practice law and rules
- ❑ Other _____

16. How well do you understand your obligation to report conduct that you think may violate the nursing statutes and rules of the Board of Nursing?

- ❑ Understand
- ❑ Somewhat understand
- ❑ Somewhat do not understand
- ❑ Do not understand
- ❑ Was unaware this obligation exists

17. Does your state board have non-disciplinary remediation activities for nurses who have practice issues? (Exclude programs that address alcohol, drug or mental health problems).

- ❑ Yes
- ❑ No
- ❑ Don't know

18. What best reflects the Board's current role regarding regulatory policy?

- ❑ Almost all of the focus is on regulatory policy development
- ❑ More focus on regulatory policy development than regulatory policy enforcement
- ❑ An equal focus on regulatory policy development and regulatory policy enforcement
- ❑ More focus on policy enforcement than regulatory policy development
- ❑ Almost all of the focus is on regulatory policy enforcement

19. What best reflects the Board's ideal role regarding regulatory policy?

- ❑ Almost all of the focus is on regulatory policy development
- ❑ More focus on regulatory policy development than regulatory policy enforcement
- ❑ An equal focus on regulatory policy development and regulatory policy enforcement
- ❑ More focus on policy enforcement than regulatory policy development
- ❑ Almost all of the focus is on regulatory policy enforcement

20. What are your views about Board of Nursing's existing statutes and administrative rules/regulations on each of the following? *Please circle your response*

	Too Much regulation	Adequate regulation	Too little regulation	Not sure
a. Practice standards/ scope of practice	1	2	3	8
b. Complaint resolution/ discipline process	1	2	3	8
c. Education program approval/accreditation	1	2	3	8
d. Requirements for licensure/certification	1	2	3	8
e. Other (specify): _____ _____	1	2	3	8

21. Are Board of Nursing statues/rules accessible?

❑ Yes ❑ No

22. Are Board of Nursing statues/rules clear?

❑ Yes ❑ No

23. In your opinion, what is the Board of Nursing's level of involvement in the following issues? *Please circle your response*

	Too Much involvement	Adequate involvement	Too little involvement	Not sure
a. Nursing supply and demand issues	1	2	3	8
b. Evolving scopes of practice	1	2	3	8
c. Legislative issues	1	2	3	8
d. Workplace issues	1	2	3	8

Over ▶

24. During the past 12 months did you make any inquiries of the Board staff in this state asking about practice issues?

❑ Yes ❑ No ***(If no, skip to 29)***

25. How helpful or unhelpful was the response you received from the Board staff in this state when inquiring about practice issues during the past 12 months?

❑ Very helpful
❑ Somewhat helpful
❑ Somewhat unhelpful
❑ Very unhelpful

26. What do you think is a reasonable time for the Board staff to respond to a practice question?

_____

27. Overall, did the Board staff respond to practice questions in a timely manner?

❑ Yes ❑ No

28. How knowledgeable or unknowledgeable was board staff regarding scope of practice?

❑ Very knowledgeable
❑ Somewhat knowledgeable
❑ Unknowledgeable
❑ Very unknowledgeable

29. Have you been involved in any aspect of this state Board's complaint handling/discipline process over the past 24 months (e.g., filed a complaint or provided a report to the Board, as a witness, an interviewee, were the focus of a complaint, etc)?

❑ No ***Go to question 35*** ❑ Yes

If Yes,
a. Please indicate about how many times over the past 24 months _____
b. Please indicate how you were involved. *Check all that apply*

❑ I was involved in the filing of a complaint (or provider report) with the Board of Nursing
❑ I had a complaint filed against me at the Board of Nursing
❑ I was interviewed by representatives (staff, investigator) from the Board of Nursing and/or Attorney General's office
❑ I served as a witness during a hearing
❑ Other (please identify) _____

30. What do you think is a reasonable time to resolve (take action, dismiss) any complaint?

_____

31. Overall, did the Board process resolve the complaint(s) in a timely manner?

❑ Yes ❑ No ❑ Don't know how long it took

32. Overall, how well or poorly was the Board of Nursing's disciplinary process communicated to you?

❑ Very well
❑ Well
❑ Poorly
❑ Very poorly

33. How well or poorly did the Board staff provide you with assistance you needed during the disciplinary process?

❑ Very well
❑ Well
❑ Poorly
❑ Very poorly

34. Overall, how effective or ineffective is the Board's disciplinary process in protecting the public?

❑ Very effective
❑ Effective
❑ Ineffective
❑ Very ineffective

35. Overall, how well or poorly does the Board of Nursing fulfill its role in protect the health and safety of the public

❑ Very well
❑ Well
❑ Poorly
❑ Very poorly

36. What other suggestions do you have for improving the Board of Nursing's activities for the protection of the public?

_____
_____
_____
_____
_____

Thank you for your assistance in completion of this survey instrument.
Your responses directly relate to the outcomes of this significant research study.

DUE DATE: June 2, 2008 or as soon afterwards as possible. If you have any questions, call 312.525.3634
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Attachment D

Board of Nursing Survey of Nursing Education Programs

Board of Nursing Survey of Nursing Education Programs

The Board of Nursing wants to improve its services and we need your help! This survey is being conducted for the Board of Nursing by the National Council of State Boards of Nursing (NCSBN). Your answers to the questions below will help provide data to guide future development of evidenced-based regulation.

1. Please rate your Board of Nursing's effectiveness in each of the following areas. *Circle the correct response.*

Area	Effective	Somewhat effective	Ineffective	Not effective at all
a. Public protection/accountability	1	2	3	4
b. Promotion of quality in education	1	2	3	4
c. Responsiveness to health care changes	1	2	3	4
d. Responsiveness to innovation in education	1	2	3	4

2. Does the Board of Nursing review your Nursing Program? ❑ No ***Go to question 6*** ❑ Yes

3. Please rate your Board of Nursing's review process in the following program areas. *Circle the correct response.*

Program Area	Effective	Somewhat effective	Ineffective	Not effective at all	Not applicable
a. Organization & Administration	1	2	3	4	8
b. Curricula	1	2	3	4	8
c. Clinical facilities/sites	1	2	3	4	8
d. Classroom/Lab/Resources	1	2	3	4	8
e. Student/Faculty policies	1	2	3	4	8
f. Program evaluation plan	1	2	3	4	8

4. Please rate each of the following areas related to the approval process. *Circle the correct response.*

Area	Adequate	Somewhat Adequate	Somewhat Inadequate	Inadequate	Not applicable
a. Interval between Board visits	1	2	3	4	8
b. Notification of Board visits	1	2	3	4	8
c. Communication with Board staff	1	2	3	4	8
d. Time spent on site during visit	1	2	3	4	8
e. Feedback/evaluation provided by Board	1	2	3	4	8
f. Timeliness of providing feedback	1	2	3	4	8
g. Comprehensiveness of feedback provided	1	2	3	4	8
h. Fairness/objectivity of Board findings	1	2	3	4	8
i. Time given to correct deficiencies	1	2	3	4	8
j. Fairness in monitoring compliance	1	2	3	4	8
k. Overall benefit of approval process	1	2	3	4	8
l. Due process for disagreements regarding findings and plan of corrections	1	2	3	4	8

Over ▶

5. How essential is Board of Nursing involvement in approving distance education programs?

- ❑ Not essential
- ❑ Somewhat essential
- ❑ Essential
- ❑ Very essential
- ❑ Not applicable

6. Are board staff helpful in addressing emerging issues? (For example, the proliferation of distance learning, development of new models to provide preceptorship/ mentorship experiences for students and graduates, etc.)

- ❑ Very helpful
- ❑ Somewhat helpful
- ❑ Somewhat unhelpful
- ❑ Very unhelpful

7. Are board staff timely in addressing emerging issues? (For example, the proliferation of distance learning, development of new models to provide preceptorship/ mentorship experiences for students and graduates, etc.)

- ❑ Very timely
- ❑ Somewhat timely
- ❑ Somewhat untimely
- ❑ Very untimely

8. Please rate the Board of Nursing's automated telephone system.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Did not use
- ❑ The Board does not have an automated telephone system

9. Please rate the Board of Nursing's newsletter.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Did not use
- ❑ The Board does not have a newsletter

10. Please rate the Board of Nursing's Web site.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Did not use
- ❑ The Board does not have a Web site

11. During the past 2 years, did you or any faculty members make any inquiries of the Board of Nursing in this state regarding educational issues?

- ❑ No
- ❑ Yes
  - a) If you responded "yes", then how helpful was the response you received?
    - ❑ Very helpful
    - ❑ Somewhat helpful
    - ❑ Somewhat unhelpful
    - ❑ Very unhelpful

12. Overall, were the Board of Nursing's activities and resources helpful in familiarizing program directors with pertinent rules, regulations and policies?

- ❑ Very helpful
- ❑ Somewhat helpful
- ❑ Somewhat unhelpful
- ❑ Very unhelpful

13. During the past 2 years, has your nursing program received sanctions, faced closure, or been the subject of additional monitoring?

- ❑ No (go to question 18)
- ❑ Yes
  - a. If yes, please explain

_____

_____

_____

14. Overall, how fair or unfair to all parties was the process used by the Board to investigate and resolve problems?

- ❑ Very fair
- ❑ Fair
- ❑ Unfair
- ❑ Very unfair

15. Overall, were the outcomes of the Board of Nursing's involvement appropriate?

- ❑ Yes
- ❑ No
- ❑ Not certain
- ❑ Have no information on this

16. Overall, did the Board of Nursing act in a timely manner?

- ❑ Yes
- ❑ No
- ❑ Not certain
- ❑ Have no information on this

17. Overall, how well did the Board of Nursing keep you informed?

- ❑ The Board kept us very well informed.
- ❑ The Board kept us well informed.
- ❑ The Board kept us minimally informed.
- ❑ The Board did not keep us informed at all

18. How helpful has the Board of Nursing staff been with any assistance you have needed?

- ❑ Staff have been consistently helpful.
- ❑ Has been occasionally helpful.
- ❑ Has rarely been helpful.
- ❑ Has not been helpful at all.

19. What are your views about existing statutes and administrative rules/regulations on each of the following?
Please circle the appropriate response

	Too Much regulation	Adequate regulation	Too little regulation	Not sure
a. Practice standards/ scope of practice	1	2	3	8
b. Complaint resolution/ discipline process	1	2	3	8
c. Education program approval/accreditation	1	2	3	8
d. Requirements for licensure/certification	1	2	3	8
e. Other (specify): _____ _____	1	2	3	8

What other suggestions do you have for improving the Board of Nursing's activities?

Thank you for your assistance in completion of this survey instrument.
Your responses directly relate to the outcomes of this significant research study.

DUE DATE: June 2, 2008 or as soon afterwards as possible. If you have any questions, call 312.525.3634
Please return your completed questionnaire in the postage paid envelope to:
NCSBN 111 E. Wacker Dr., Chicago, IL 60601

Attachment E

Board of Nursing Survey of Persons Who Made a Complaint

Board of Nursing Survey of Persons Who Made a Complaint

Your Board of Nursing wants to improve its services and we need your help! This survey is being conducted for the Board of Nursing by the National Council of State Boards of Nursing (NCSBN). Your answers to the questions below will be kept confidential and will help provide data to guide future development of evidenced-based regulation.

The following questions ask about your experience with the Board of Nursing's disciplinary process (which includes the complaint, investigation, and resolution process) in this state.

1. What was your relationship to the nurse(s) involved?

- ❑ Health care consumer
- ❑ Family member of health care consumer
- ❑ Employer/supervisor of the nurse(s) complained against
- ❑ Co-worker (another nurse)
- ❑ Other (please describe)

2. How did you find out how to make a complaint to your Board of Nursing? *Check all that apply*

- ❑ Called the Board of Nursing
- ❑ Checked the Web site
- ❑ Asked colleagues
- ❑ Other _____

3. How courteous or discourteous were Board of Nursing representatives during the disciplinary process?

- ❑ Very courteous
- ❑ Somewhat courteous
- ❑ Somewhat discourteous
- ❑ Very discourteous

4. Overall, how fair or unfair was the disciplinary process to all parties?

- ❑ Very fair
- ❑ Fair
- ❑ Unfair
- ❑ Very unfair

5. To what extent did you receive the assistance you needed from Board staff during the disciplinary process?

- ❑ I received all of the assistance I needed
- ❑ I received most of the assistance I needed
- ❑ I received little of the assistance I needed
- ❑ I received none of the assistance I needed.
- ❑ I did not need any assistance.

6. Please rate the overall effectiveness of the Board's disciplinary process in protecting the public.

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor

7. How fair or unfair was the complaint process used by the Board? *Please circle the correct response*

	Very Fair	Fair	Unfair	Very Unfair
a. Provided the opportunity to present charges/allegations	1	2	3	4
b. Provided reasonable notice of meetings and hearings	1	2	3	4
c. Provided information regarding the appeals process	1	2	3	4
d. Provided an opportunity to petition/re-petition	1	2	3	4

Over ▶

8. How complete or incomplete was the investigative process?

- ❑ Very complete
- ❑ Somewhat complete
- ❑ Somewhat incomplete
- ❑ Very incomplete

9. Do you believe the decision(s) of the Board was appropriate?

- ❑ Yes
- ❑ No
- ❑ Don't know the decision/outcome

10. How satisfied or dissatisfied were you with the extent to which the Board kept you informed about the status of the complaint* process

*The process followed from receipt of any expression of dissatisfaction or concern through investigation and resolution.

- ❑ Very satisfied
- ❑ Satisfied
- ❑ Dissatisfied
- ❑ Very dissatisfied

11. Overall, did the Board resolve the complaint(s) in a timely manner?

- ❑ Yes
- ❑ No
- ❑ Don't know how long it took

12. What do you think is a reasonable time to resolve (take action, dismiss) any complaint?

_____

13. How satisfied or dissatisfied were you with the extent to which the Board kept you informed about the status of the resolution* process?

*The process of reaching a firm decision about a problem or dispute.

- ❑ Very satisfied
- ❑ Satisfied
- ❑ Dissatisfied
- ❑ Very Dissatisfied

14. How fair or unfair to all the parties was the resolution process used by the Board? *Please circle the correct response*

	Very Fair	Fair	Unfair	Very Unfair
a. Provided the opportunity to present charges/allegations	1	2	3	4
b. Provided reasonable notice of meetings and hearings	1	2	3	4
c. Provided information regarding the appeals process	1	2	3	4
d. Provided an opportunity to petition/re-petition	1	2	3	4

General Comments

_____

_____

_____

_____

_____

Thank you for your assistance in completion of this survey instrument.
Your responses directly relate to the outcomes of this significant research study.

DUE DATE: June 2, 2008 or as soon afterwards as possible. If you have any questions, call 312.525.3634
Please return your completed questionnaire in the postage paid envelope to:
NCSBN 111 E. Wacker Dr., Chicago, IL 60601

Attachment F

Board of Nursing Survey of Persons Who Have Been the Subject of a Complaint

NCSBN
Leading in Nursing Regulation

Board of Nursing Survey of Nurses Who Have Been the Subject of a Complaint

The Board of Nursing wants to improve its services and we need your help! This survey is being conducted for the Board of Nursing by the National Council of State Boards of Nursing (NCSBN). Your answers to the questions below will help guide future development of the Board of Nursing.

The following questions ask about your experience with the Board of Nursing's disciplinary process (which includes the complaint, investigation, and resolution process) in this state during the past 24 months.

1. What was the board decision/action of the complaint?

❑ Dismissal
❑ Non-disciplinary (including alternative programs)

Type of action

❑ Suspension
❑ Probation
❑ Revocation
❑ Reprimand

2. How respectful or disrespectful were Board of Nursing representatives during the disciplinary process?

❑ Very respectful
❑ Somewhat respectful
❑ Somewhat disrespectful
❑ Very disrespectful

3. What do you think is a reasonable time to resolve (take action, dismiss) a complaint?

_____
_____
_____
_____
_____

4. Overall, did the Board process resolve the complaint(s) in a timely manner?

❑ Yes
❑ No

5. How fair or unfair was the complaint process used by the Board? *Please circle the correct response*

	Very Fair	Fair	Unfair	Very Unfair
a. Provided an opportunity to respond to charges/allegations	1	2	3	4
b. Provided reasonable notice of meetings and hearings	1	2	3	4
c. Provided information on my right to legal representation	1	2	3	4
d. Provided information regarding the appeals process	1	2	3	4
e. Provided an opportunity to petition/re-petition	1	2	3	4

6. Overall, how well or poorly was the Board of Nursing's disciplinary process communicated to you?

❑ Very well
❑ Well
❑ Poorly
❑ Very poorly

Over ▶

7. Overall, how well or poorly did the Board follow its disciplinary process?

- ❑ Very well
- ❑ Well
- ❑ Poorly
- ❑ Very poorly

8. How well or poorly did the Board staff provide you with assistance you needed during the disciplinary process?

- ❑ Very well
- ❑ Well
- ❑ Poorly
- ❑ Very poorly

9. Overall, how effective or ineffective was the Board's disciplinary process in protecting the public?

- ❑ Very effective
- ❑ Effective
- ❑ Ineffective
- ❑ Very ineffective

10. Which one of the following best describes your highest level of licensure/certification? *Please check one*

- ❑ Licensed practical/vocational nurse (LPN/VN)
- ❑ Registered Nurse (RN)
- ❑ Advanced Practice (APRN) with prescriptive authority: (includes CNM, CRNA, NP, CNS, etc.)
- ❑ Advanced Practice (APRN) without prescriptive authority: (includes CNM, CRNA, NP, CNS, etc.)
- ❑ Other (please identify)

11. How long have you been licensed/certified to practice as a nurse (include time as LPN and RN, where applicable)?

_____Years and _____Months

12. What suggestions do you have for improving the complaint handling/discipline process of the Board of Nursing in this state?

_____

_____

_____

_____

_____

_____

_____

Thank you for your assistance in completion of this survey instrument.
Your responses directly relate to the outcomes of this significant research study.

DUE DATE: July 15, 2008 or as soon afterwards as possible. If you have any questions, call 312.525.3634
Please return your completed questionnaire in the postage paid envelope to:
NCSBN 111 E. Wacker Dr., Chicago, IL 60601

Report of Disciplinary Resources Committee

Background

The FY08 charge to the Disciplinary Resources Committee included the following:

1. Advise staff regarding the content of the 2008 Investigator and Attorney Workshop.
2. Develop additional supporting documents regarding regulatory implications to the *Statement on the Regulatory Implications of Pain Management*.
3. Identify and review existing disciplinary resources for currency, relevance, revision, and/or archiving.

2008 Investigator and Attorney Workshop:

This year's workshop was held May 18–21, 2008, at the Hilton Savannah DeSoto in Savannah, Georgia. The NCSBN Investigator and Attorney Workshop has become a yearly event that provides training and education for individuals involved in the investigation and prosecution of nursing licensure discipline cases. The program's first day focused on the challenges and changes taking place within the health care industry. Barbara Safriet, JD, was the keynote speaker for the day, addressing expectations for individuals who investigate and prosecute board of nursing cases. The second day keynote speakers were David Marx, JD, Outcome Engineering, and Julia George, MS, RN, North Carolina Board of Nursing and NCSBN board liaison to the Disciplinary Resources Committee, who spoke on the concept of "Just Culture." The final day of the program was geared towards exploring current hot topics, including cosmetic treatments, alternative programs, and best practices for interstate discipline cases.

Regulatory Implications of Pain Management Resources:

Pain management presents a variety of issues for nurse licensing boards. In 2007, this committee developed a general statement identifying with four unique pain management situations encountered by boards of nursing:

1. A nurse fails to meet the expected standards of nursing pain management, resulting in the risk of harm and suffering for patients.
2. An advanced practice registered nurse (APRN) fails to appropriately prescribe medications for pain management.
3. A nurse's personal pain or treatment for pain affects his/her ability to practice safely.
4. A chemically dependent nurse requires pharmacologic pain management.

The purpose of the general statement was to provide a concise identification and summary of the issues and was adopted by the 2007 NCSBN Delegate Assembly.

In FY08, the committee developed a packet of pain management resources that provide guidance and support for Board decision making regarding each of the four identified regulatory issues. These resources explore each regulatory topic in greater depth providing boards with additional information and tools for managing cases involving pain management. The purpose of additional pain resources is to present best practices that promote regulatory excellence and public protection (see Attachment A).

Review of Existing Disciplinary Resources

The committee completed this element of the 2007 charge by reviewing existing disciplinary resources. Committee members and staff used a form developed for the project that includes the origin, history and use of each document. Members and staff were assigned specific resources to review. The process included at least two members reviewing each individual resource. The findings of individual reviews were discussed by the committee as a whole to determine whether the resource was still current, needed revision or should be archived. The

Members

Sandra Evans, MAEd, RN
Idaho, Area I, Chair

Emily Brown, JD
Ohio, Area II

Catherine A. Giessel, MS, RN, ANP, FAANP
Alaska, Area I

Elliot Hochberg, BS
California-RN, Area I

Fred Olmstead, JD
Nevada, Area I

Margaret (Peg) A. Sheaffer, JD, RN, BBA
Pennsylvania, Area IV

Jane Tallant, MSN, RN
Mississippi, Area III

Julia George, MS, RN
North Carolina, Board Liaison

Staff

Vickie Sheets, JD, RN, CAE
Director, Practice and Regulation

Meeting Dates

- Sept. 10-11, 2007
- Dec. 10-11, 2007
- Jan. 22. 2008 (Webinar)
- Jan. 31, 2008 (Webinar)
- Feb. 11-12, 2008
- April 3, 2008 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative B:
NCSBN contributes to Member Strategic excellence by providing resources, communication, education, and technology.

Strategic Objective 2:
Continuously provide and evaluate education, information sharing, and networking opportunities.

Strategic Initiative C:
NCSBN advances evidenced-based nursing regulation and regulatory solutions for public protection by providing resources, communication, education, and technology.

Strategic Objective 2:
Provide models and resources for evidenced-based regulation to Member Boards.

members also discussed the priority of resources needing revision (see Attachment C for a summary of the results of this resource review).

Highlights of FY08 Activities

- Consulted with Tammy Spangler, executive producer, E-Learning Productions, regarding disciplinary topics for educational models.
- Consulted with Nur Rajwany, director, Information Technology, regarding tracking imposters.
- Participated on the Discipline Networking calls.
- Recommended to the NCSBN Board of Directors that the chemical dependency materials be updated in the coming year.
- Conducted debriefing and review of evaluations after the 2008 I&A Workshop.

Future Activities

- Develop a Discipline Outreach Toolkit to inform public of board discipline process.
- Revise and update sexual misconduct resources.
- Identify existing approaches used as alternatives to discipline for practice related cases, including information regarding programs and identifying advantages and disadvantages.

Attachments

A. *Regulatory Implications of Pain Management Resource Pack*

B. Summary of Discipline Resources Review Findings

Attachment A

Regulatory Implications of Pain Management Resource Pack

SECTION ONE:
Executive Summary

Pain management raises important regulatory issues to be addressed by boards of nursing. The treatment of pain is a complex issue, requiring increased awareness and specialized education by nurses.

In recent years there have been pharmacological and technical advances that provide new approaches to pain management. Nurses may be concerned about possible side effects of analgesics or fear patients becoming tolerant, physically dependent, or addicted to analgesics. Nurses may fear the scrutiny of regulation, especially related to controlled substances. When a nurse experiences pain, that nurse's ability to practice safely may be questioned due to the nurse's condition and/or pain treatment. For these reasons, the National Council of State Boards of Nursing (NCSBN) developed a national statement identifying the regulatory implications for nursing that was adopted by the 2007 NCSBN Delegate Assembly, which is included in this resource pack.

Based on the 2007 statement, the NCSBN Disciplinary Resources Committee developed additional resources to support boards of nursing dealing with the regulatory implications of pain management. These materials provide information, model policies, and strategies for making licensure decisions when pain management becomes a board of nursing regulatory issue.

The pain resources provide background information about the phenomenon of pain. Each of the four regulatory issues identified in the statement is addressed in a section of the resource pack: the nurse in pain, the chemically dependent nurse in pain, the role of the registered nurse (RN), and licensed practical/vocational nurses (LPN/VN) in pain management as well as the advanced practice registered nurse (APRN) prescribing for patients in pain.

When nurses experience pain, most are able to recognize when the effects of pain and/or pain treatment are having a negative impact on his/her ability to practice safely and take appropriate action. But when a nurse does not have insight into the situation or feels compelled to continue working, the board of nursing may need to intervene. Nurses sometimes present to the board with dual diagnoses of chemical dependency and pain. In addition, nurses being monitored for chemical dependency and recovery compliance may have health issues that require the medically directed use of analgesics. Professional evaluations are an important tool for boards addressing situations where the nurse is unable to practice safely as the result of pain or the treatment for pain. These resources include recommendations of what to look for in an evaluator and how to use evaluations effectively.

Other regulatory issues relate to the nurse's ability to meet the needs of patients experiencing pain. Standards of pain management nursing are included. There is a discussion of the regulatory implications of the RN and LPN/VN role in pain management. One section is devoted to the unique role of the APRN in pain management. Although many health professionals fear the scrutiny of regulatory boards, nurses who meet the nursing standards for pain management and practice within the appropriate nursing role are likely to avoid violations of nursing practice acts. The appendices provide additional resources and tools.

NCSBN fully supports the role of the nurse in the thorough assessment and effective management of pain. Boards of nursing mandates of public protection include a responsibility to protect the public from the mismanagement of pain. Boards also must address the impact

that being in pain and receiving pain treatment have on the ability of nurses to practice safely. *Pain Management Resources for boards of nursing* will support boards of nursing in meeting the regulatory challenges presented by pain management.

SECTION TWO:

Introduction and Purpose

The following materials were developed as a resource for boards of nursing to provide information, model policies, guidelines, and strategies for making licensure decisions and taking disciplinary actions when pain management becomes a board of nursing regulatory issue. This work will support boards of nursing in meeting the regulatory challenges presented by pain management. Nurses, nursing students, and other healthcare professionals, as well as policymakers and other public entities, may also find these resources useful.

The Statement on the Regulatory Implications of Pain Management was adopted by the NCSBN Delegate Assembly at its annual meeting in August 2007. The statement identifies the regulatory issues to be addressed by boards of nursing as well as articulating the role of the board of nursing in pain management. It provided the framework for the development of additional board resources on pain management.

SECTION THREE:

National Council of State Boards of Nursing Statement on the Regulatory Implications of Pain Management

Pain management raises important regulatory issues to be addressed by boards of nursing. The treatment of pain is a complex issue, requiring increased awareness and specialized education by nurses. In recent years there have been pharmacological and technical advances that provide new approaches to pain management. Nurses may be concerned about possible side effects of analgesics or fear patients becoming tolerant to analgesics or addicted to the medications. Nurses may fear the scrutiny of regulation, especially related to controlled substances. In addition, when a nurse experiences pain, that nurse's ability to practice safely may be questioned due to the nurse's condition and/or pain treatment. For these reasons there is a need for a national statement identifying the regulatory implications for nursing.

Role of the Board of Nursing

Boards of nursing deal with four unique pain management situations:

1. A nurse fails to meet the expected standards of nursing pain management, resulting in the risk of harm and suffering for patients.
2. An APRN fails to appropriately prescribe medications for pain management.
3. A nurse's personal pain or treatment for pain affects his/her ability to practice safely.
4. A chemically dependent nurse requires pharmacologic pain management.

Boards of nursing can be proactive in their charge to protect the public by:

- Acknowledging the unique regulatory challenges presented by pain management.
- Holding a nurse accountable for:
  - Acquiring the education necessary to effectively manage patients experiencing pain.
  - Adhering to accepted nursing pain management standards.

  - Practicing within the appropriate role for the level of licensure.
  - Evaluating one's own ability to safely and competently practice.
- Imposing appropriate action when a nurse fails to comply with the statutory and regulatory requirements and places patients at risk.
- Collaborating with stakeholders (e.g., regulatory entities, educators, professional organizations, employers, and consumers) in implementing regulatory processes that support effective pain management.

NCSBN fully supports the nursing role in the thorough assessment and effective management of pain. Boards' of nursing mandate of public protection includes a responsibility to protect the public from the mismanagement of pain. Boards also must address the impact that being in pain and receiving pain treatment have on the ability of nurses to practice safely.

Future Steps

Additional resources are planned to provide model policies and guidelines for each of the regulatory issues addressed above. This work will support boards of nursing in meeting the regulatory challenges presented by pain management.

Adopted August 2007

SECTION FOUR:

Background – a Discussion of Pain

> *Pain …holds sway over individual lives much as a sovereign power governs a state… not only when it appears in full regalia, displaying its power like a king at a banquet, but also when it remains behind the scenes, more or less invisible, its presence diffused through a thousand daily acts…*
>
> Jeremy Bentham, 1789[1] (Morris, 1998)

Pain is an alarm system for the body, warning that something is wrong or injured. Pain triggers thoughts, emotions, memories, and an array of biochemical events to protect the body from further harm. Pain is a protective response and is communicated through both language and nonverbal behavior. (American Pain Foundation, 2007)

The Joint Commission considers pain to be the fifth vital sign.[2] (JACHO, 2000) In 1979, the International Association for the Study of Pain introduced a commonly used definition of pain: "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage or both." (Usunoof, 2006) While the capacity to discern noxious stimuli is largely consistent among people, the meaning of pain and the subjective sense of suffering that accompanies the perception of pain is private and unique, set within one's larger life context. (Malik, 2000) Unrelieved pain is a serious public health problem in the U.S. (Pain and Policy, 2007)

Pain can be acute or chronic. Acute pain begins suddenly, is time limited, and can be mild or severe. Acute pain usually disappears when the underlying cause has been effectively treated or healed. It is typically responsive to analgesics and non-pharmacologic interventions. Unrelieved acute pain may lead to chronic pain problems.

Chronic pain is a persistent state that lasts longer than the expected healing time. It results from injury or disease or can occur for no apparent reason, last for weeks, months or years,

1 Jeremy Bentham was a nineteenth century English philosopher, economist, and theoretical jurist. He was the earliest and chief expounder of Utilitarianism.

2 The suggestion to associate pain assessment with vital signs and documentation originated with the American Pain Society and has been implemented by many hospitals where pain assessment is included on the vital sign record. (Mcaffery, 1999, p 3)

and can be mild to severe. Some chronic pain is organic, the result of an ongoing disease state or physical condition. But with some chronic pain, the pain signal continues, even when the cause and physical danger have passed. Dr. Sean Markey, chief, Pain Management Division, Stanford University, says "Pain causes a fundamental rewiring of the nervous system. Each time we feel pain there are changes that occur that tend to amplify our experience of pain." (Wallis, 2005, p.51-52) He describes pain as a "symphony" – a complex dynamic involving not only pain sensors but emotions, memory, and hormones. (Kalb, 2003) Chronic pain can be disabling and is often associated with long-term, incurable medical conditions.

The experience of pain is subjective, "that which cannot be denied, and that which cannot be confirmed." (Scarry, 1985, p.4) The same person experiencing pain may achieve a high level of functioning at one time and be dysfunctional at another.

Pain can adversely affect quality of life – physically, emotionally, socially, spiritually, and economically. Inadequately managed pain can produce anxiety, fear, depression, or cognitive dysfunction. Pain can affect one's ability to concentrate and think; physical mobility; and ability to perform daily tasks and sleep as well as overall mood.

Clinical experience has demonstrated that adequate pain management leads to enhanced functioning and quality of life, while uncontrolled chronic pain contributes to "disability and despair." (Pain, 2007) There are many effective drug and non-drug approaches to pain management that vary according to the patient's needs and situation. There have been medical advances in pain treatment, but there remains a gap between what is known and what is done in many settings. Another complicating factor in the treatment of pain is the potential for abuse, particularly of opioid medications where the interface among policy, practice, and patient care is complex. However, if the goal is to enhance healthcare with effective pain treatment, policies that encourage pain management and recognize the use of controlled substances are an expected part of healthcare practice and are preferable to policies that provide no positive guidance. (Pain, 2007)

Patients have the right to appropriate assessment and treatment of pain. (JCAHO, 2000, p. 7) The goal of pain management is to reduce the patient's pain to the lowest level possible while supporting the patient's level of functioning to the greatest extent possible. Since pain is individualized, pain treatment and management also must be individualized. An array of tools are available for use in pain management, including comfort measures, pharmacotherapy, psychosocial support, psychotherapy, surgery, technology and complementary therapies. (Loitman, 2000) Effective pain management is a high priority in the care of all patients, including nurses who are patients.

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SECTION FIVE:

Professional Evaluations

Boards of nursing often seek professional assistance to guide them with complex decisions. A professional evaluation may be one of the first necessary steps in determining a nurse's ability to practice safely. When weighing the nurse's desire to practice nursing, the public's need for access to care and the board's responsibility to protect the public, the evaluation's findings may be crucial to the board's determination.

Some boards are authorized by law, upon demonstration of probable cause, to require physical or mental health evaluations as part of the investigatory process. (NCSBN, 2004) If a board is not authorized to require such an evaluation, the board may request that the nurse comply with a recommendation for an evaluation. Another approach is for the board to make tentative findings conditioned upon the nurse having a thorough evaluation by a board-approved evaluator.

Professional evaluation includes both physical and psychological examination results. Board staff and attorneys may be involved in the selection of professionals who meet identified selection criteria and can provide assessments for use by the board. An assessment can provide valuable information to assist the board in determining an appropriate course of action. A qualified healthcare professional, with experience in the evaluation of pain and pain management, should be selected to assess the nurse's cognitive and physical abilities. A professional evaluation regarding the impact of pain on a nurse's ability to practice is complex. Ideally, a collaborative approach provides input from different professional perspectives. It is important to select qualified, expert evaluators, experienced in the evaluation of subjects whose medical knowledge may influence the evaluation findings (i.e., subjects who can use their knowledge and experience to skew the evaluation). Any board decision should be based on reliable evidence pertaining to the nurse's ability to practice and the risk of harm to the patient.

This paper offers one approach to selecting qualified expert evaluators. Every state has unique laws and regulations regarding what information can be shared and with whom. As with other sections of this paper, the recommendations must be evaluated to determine what is congruent with a jurisdiction's laws and rules. The following criteria are general recommendations, some of which may not be appropriate for every state.

Evaluator Selection:

Suggested characteristics for evaluator selection include:

- A practitioner, i.e., a physician, psychiatrist, psychologist, APRN, or other health professional, licensed in good standing who has experience evaluating professionals with pain issues.
- A practitioner who is not involved with the ongoing treatment of the subject nurse.
- A practitioner who is able to interpret psychological and neuropsychological test results.

- A practitioner who has an understanding of cognitive and psychomotor abilities and their relationship to nursing practice.
- A practitioner who can make recommendations regarding nursing practice, considering the risk factors in a particular nursing role and setting (e.g., someone is safe performing repetitive functions with predictable outcomes but not complex functions with variable outcomes). (NCSBN, 2001)

Neuropsychological Testing

Neuropsychological tests can provide quantifiable data about the following aspects of cognition:

- Reasoning and problem solving ability;
- Ability to understand and express language;
- Working memory and attention;
- Short- and long-term memory;
- Processing speed;
- Visual-spatial orientation;
- Visual-motor coordination; and
- Planning, synthesizing and organizing abilities. (Malik, 2006)

Guidelines for Evaluators

Health professionals who conduct third party evaluations must be aware of the limits of privacy and confidentiality. The evaluator should make sure that the nurse is informed as to the purpose of the evaluation and who will be receiving the report. Before the evaluation begins, the evaluator must articulate the goals of the assessment in a way to make clear to the nurse the reality of the situation. It is possible that the nurse's situation may be further complicated by the findings of the evaluation.

A third-party evaluator needs to review allegations, access expanded sources of information, and consider interviews with family members and employers. The evaluator may find it helpful to consult with nurses regarding specifics of the practice setting and nursing care.

Evaluation Reports

States may vary as to who controls the report. In some states it is the nurse's decision who receives the report; in others, the report belongs to the board directing the evaluation. The nurse needs to understand that refusal to provide the report to the board may have adverse licensure consequences. Failure to complete an evaluation would also be considered in determining the case resolution. Information may surface after the referral that could affect the evaluation. The evaluator can be apprised so that he/she can determine if this information would impact the evaluation.

Board Use of Professional Evaluations

Addictionologist Stephen Merlin, MD, Substance Abuse Consultants, Columbia, South Carolina, advises that assessments be conducted at the time of day that most closely mirrors the nurse's work situation. The nurse must be on his/her normal medication regimen to accurately evaluate functionality in their clinical practice. Dr. Merlin advises that it is not the type of medication, or the amount of medication that should be of concern to boards; rather, the concern is whether the nurse is able to think clearly and function safely.

Another key consideration is whether or not there have been any reported practice issues during the time the nurse has been taking the medication. Any incident of concern certainly increases the possibility that the nurse is having difficulty with competent practice as a result of the pain itself or the medication/treatment for pain.

Conclusion

Professional evaluations include both physical and psychological examination results. An evaluation regarding the impact of pain on a nurse's ability to practice is complex. Ideally, a collaborative approach provides input from different professional perspectives. An evaluation conducted by an expert provider provides additional information and analysis to inform board of nursing decisions regarding nurses dealing with pain.

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S. Merlin, (personal communication, March 10, 2004)

SECTION SIX:

The Ability to Practice Nursing Safely

Regulating the practice of nurses involves only one issue: can the nurse practice safely? Coping with personal pain and/or the treatment for pain can affect a nurse's performance. Boards of nursing often deal with nurses who are unable to practice safely because of the nurse's pain and/or the treatments they are receiving for pain. Other nurses are unable to practice safely because of the dual challenges of chemical dependency combined with the need for pain management.

> *Whether a nurse should continue active nursing practice when that practice becomes compromised depends upon the nurse's ability to function safely and effectively. The assessment of functional ability is an individualized process that does not lend itself to application of a set format based on select elements. On the contrary, assessment of functional ability requires active consideration of all relevant factors such as diagnosis, prescribed treatment and situational events, as well as an evaluation of the impact of those factors on the individual being assessed.* (Idaho BON, 2005)

A nurse may need a professional evaluation to determine whether he/she should continue nursing practice safely at times when that practice may be compromised. If the nurse lacks the insight to realize when there are serious safety issues, the board of nursing is the ultimate decision maker.

In addressing situations where the nurse demonstrates the inability to practice safely as a result of pain or the treatment for pain, boards should consider action that is fair and appropriate to protection of the public. Punitive action may not be the best course of action in many of these situations. If allowed by law, boards may consider alternatives to discipline, including monitoring or specific practice restrictions, among other options.

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SECTION SEVEN:

Regulatory Implications: The Nurse in Pain

Not all nurses who experience pain or are taking medications for the treatment of pain have a compromised ability to practice safely. In most situations, nurses are able to self-limit by recognizing when the effects of pain and/or pain treatment negatively impact their ability to practice nursing safely and competently. It is the professional responsibility of all nurses to recognize and limit one's practice when one's competence is or may be affected by pain or pain treatment.

However, sometimes recognition and self-limitation does not take place. There may be many reasons why the nurse does not self-limit. A nurse may have a lack of insight into his/her situation or feel compelled to continue working because of familial responsibilities, financial need, or employer demands. These are situations when the board of nursing may become involved. If the nurse is either unable or unwilling to self-limit and thus creates a risk of harm to patients, to self or both, the board may be compelled to intervene.

The board of nursing must evaluate the impact a nurse's pain has on his/her behavior and ability to practice safely. The board must balance its responsibility to protect the public while recognizing the privilege of the nurse to practice a chosen profession. Board actions may include:

- Educating the nurse;
- Admonishing the nurse;
- Requiring evaluation and/or treatment;[3]
- Monitoring the nurse's practice;
- Limiting or restricting the nurse's practice; and
- Separating the nurse from practice (e.g., suspension or revocation).

What Boards Need to Know

Boards need to recognize when the experience of pain affects a nurse's ability to practice safely. At what point does a nurse's pain[4] impair his or her ability to practice safely? In addition to feedback from the nurse's employer, primary care provider and/or pain management specialist or treatment program, some boards use independent evaluators to assess the nurse's functional ability.

> *Although constant evaluation of one's ability to safely and competently practice is the responsibility of each individual nurse, the board of nursing becomes the ultimate decision-maker. In some instances, it may be necessary for the Board to require objective physical and/or functional assessment, using reliable psychometric instruments and methods administered by qualified licensed professionals…* (Idaho BON, 2005)

The board staff coordinates the collection of the evaluation report and other evidence regarding the nurse's ability to practice (see Section Five for specific information regarding professional evaluations).

The Role of the Board of Nursing

The professional evaluation is a tool that the board may use to make informed decisions. Boards may:

3 When an evaluation is mandated, states vary as to who pays for the evaluation. In some states, usually those with the authority to mandate evaluations, the board pays for a mandated evaluation. In other states, the subject nurse is expected to pay for the evaluation.

4 Throughout this discussion of impact of pain on a nurse's ability to practice, the term pain refers to both the effects of pain and the effects of pain treatment.

- Use the evaluator's recommendations to support board decisions regarding a nurse's ability to practice safely.
- Use the evaluator's recommendations to develop requirements for monitoring compliance with the board's order.
- Identify and resolve discrepancies between the Board's findings and the outcomes of the evaluation
- Provide additional information to the evaluator if needed.
- Base disciplinary actions on the behavior and the resulting harm or risk of harm.

Conclusion

Complaints involving pain management are complex and challenging cases for boards of nursing. The opinion of a qualified professional evaluator is assistive in identifying any safety to practice implications for the nurse in pain. The nurse must have insight into how pain and pain treatment is affecting his/her ability to practice safely. When this insight is lacking, final authority rests with the board.

Board actions may range from revocation or suspension of the nurse's license, to restrictions or conditions on practice, to reprimanding or warning the nurse of the potential risk to patients and/or herself/himself. The nurse is accountable for her/his conduct and practice but must understand that the board is the final decision-maker. The board's decisions will affect the nurse's license to practice and the nurse's employment options.

Work Cited:

Idaho Board of Nursing, (2005). *Idaho Position on Safety to Practice*. Boise, ID: Author.

SECTION EIGHT:

Regulatory Implications: The Chemically Dependent[5] Nurse in Pain

Regulating the practice of a chemically dependent nurse who is in pain, on one hand, involves only one issue: can the nurse practice safely? Typically, a chemically dependent nurse is already in a board directed alternative program or under a disciplinary probation contract. If the terms and conditions of alternative program or disciplinary action provide for a monitoring process, thereby insuring safe practice, then a chemically dependent nurse can practice while in pain.

On the other hand, a chemically dependent nurse who is in pain presents a not-so-unique circumstance for a board of nursing (can a board intrude in a relationship between a nurse in

5 The phrase chemical dependency is used in this paper because it is commonly used and understood by the public. The literature usually refers to addiction rather than chemical dependency. The terminology used by DSM-IV is substance abuse and substance dependency. Substance abuse is a maladaptive pattern of substance use leading to clinically significant impairment or distress, manifested by (one or more) of the following:
- Recurrent use resulting in failure to fulfill major obligations.
- Recurrent use in situations where it is physically hazardous.
- Recurrent substance-related legal problems.
- Continued use despite problems caused by effects of substance.

Substance dependency is maladaptive pattern of substance use leading to significant impairment or distress as manifested by (three or more) of the following:
- Tolerance, shown by a need for markedly increased amounts of the substance to achieve desired effect or a markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, where the same substance is taken to relieve or avoid withdrawal, or when symptoms characteristic for the substance occur when the substance is not available.
- Substance taken in larger amounts or over longer period than intended.
- Persistent desire or unsuccessful efforts to cut down.
- Time spent in activities to obtain, use, recover from substance.
- Important activities given up.
- Continued use despite knowledge of having problems likely caused by substance. (DSM-IV, 2000).

pain and her treatment provider?) and the treatment provider (can pain medication safely be prescribed to a person dependent on that medication?).

McCaffery and Pasero state that "pain and addiction are not unrelated phenomena. Multiple sources of potential overlap between these conditions exist in both psychological and physiological domains. Evidence exists that the presence of pain and addiction affect the expression of each other." (1999) Nurses being monitored for chemical dependency and recovery compliance may have health issues that require medically directed use of analgesics. Nurses may present to the board with dual diagnoses of chemical dependency and pain. Pain relief is a primary goal for any person in pain, regardless of whether that individual has a history of addiction. A patient's history of addiction should be openly discussed as part of pain assessment and developing a plan for pain management. (ASPMN, 2002)

What the Board Needs to Know

Promoting pain relief while, at the same time, guarding against abuse of pain medications becomes a critical balancing act.

> *Preventing drug abuse is an important societal goal, but there is consensus by law enforcement agencies, health care practitioners, and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve.*[6] (Joint Statement of the DEA et al., 2001)

Chemically dependent nurses in pain who are prescribed drugs with addictive potential are at substantial risk of relapse and compromise of their recovery. Nurses often identify pain issues as the start of a cascading problem. Boards hear from many addicted nurses that pain issues led to the overuse of medication. Prescription misuse evolved into drug seeking behaviors that ultimately resulted in using multiple providers, fraudulent prescriptions and/or drug diversion. Poorly managed pain conditions can lead to self-medication, drug seeking behavior, and pseudo-addiction.[7]

Guidelines for the Treatment Provider

1. The plan for management and eventual discontinuance of the prescribed medications is ideally developed by the nurse's pain management provider in consultation with the nurse's chemical dependency treatment provider. Providers without experience treating chemically dependent nurses who in are pain can consult with a healthcare practitioner knowledgeable about addiction (e.g., an addictionologist) to develop a pain management plan for a chemically dependent nurse. (Ziegler, 2007)
2. The use of opioids, even in controlled settings and under carefully supervised conditions, does make the nurse more vulnerable to relapse. However, so does unrelieved pain. (ASPMN, 2002) Appropriate use of analgesia during and immediately after any procedure requiring pain treatment should be used to assure adequate pain relief. (Mcaffery, 1999)
3. The plan should include a return to abstinence when the other medical issues are resolved.

6 This Joint Statement was signed by: American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Pain Medicine, American Alliance of Cancer Pain Initiatives, American Cancer Society, American Medical Association, American Pain Foundation, American Pain Society, American Pharmaceutical Association, American Society of Anesthesiologists, American Society of Law, Medicine and Ethics, American Society of Pain Management Nurses, American Society of Regional Anesthesia and Pain Medicine, Community-State Partnerships to Improve End-of-Life Care, Drug Enforcement Administration, Last Acts, Midwest Bioethics Center, National Academy of Elder Law Attorneys, National Hospice and Palliative Care Organization, Oncology Nursing Society, Partnership for Caring, Inc., and University of Wisconsin Pain and Policy Studies Group. However, not all law enforcement agencies act in accordance with this statement.

7 Pseudo-addiction refers to behaviors indicative of uncontrolled pain or fear of uncontrolled pain. These behaviors include demanding behavior, "clock-watching," and hoarding of opioid analgesics. The behaviors resolve when the pain is effectively treated. (Mcaffery, p. 173)

Guidelines for the Chemically Dependent Nurse in Pain

The nurse should be aware that detoxification treatment may be necessary to support a return to sobriety. (Mcaffery, 1999) New medications, unexpected activity and/or a change in diet often requires a diabetic to take steps to reduce serum glucose back to normal levels; similarly, a chemically dependent person administered analgesics to support recovery from surgery must take steps to regain abstinence. This is not intended as a penalty but part of the treatment necessary to manage a serious illness. The nurse is ultimately accountable for his/her conduct and practice.

1. The nurse should continue to meet all terms and conditions of a board disciplinary order or the alternative program monitoring contract including meeting attendance, identification of prescribed medication, and submission to random drug screens performance evaluations and monitoring reports.
2. The nurse should provide documentation from the treating health care provider indicating the reason for the prescribed controlled substance, the name and dosage of the controlled substance being prescribed, and the anticipated duration of use. (Ziegler, 2007)
3. The nurse may be required to submit a negative drug screen before the nurse can return to work. (Brown, 2007)
4. Participating in nurse support groups and seeking support from one's sponsor have been shown to be effective strategies. An increase in attendance at support meetings should be promoted as soon as medically possible.
5. The nurse should not be in possession of the controlled substance. Any medication for a controlled substance should be "held" by a trusted family member, friend, or sponsor who understands the need for caution with the medication and is readily accessible.
6. The nurse may be expected to discontinue active nursing practice until evidence is provided that controlled substance use has been discontinued.

If a nurse is unable to discontinue use of controlled substances, the situation must be evaluated on a case-by-case basis. The needs of a diagnosed chemically dependent nurse who has had a relapse are very different from the same chemically dependent nurse whose medical condition requires ongoing pain control. (Weissman, 2005) These situations need customized evaluation and interventions.

The Role of the Board of Nursing

The board's role in the management of nurses with dual diagnoses of chemical dependence and pain must address both issues.

When a board uses a non-disciplinary alternative program to manage the nurse with both chemical dependency and pain, appropriate program oversight is essential and includes:

- To have in place policies that articulate board expectations when recovering nurses are dealing with pain issues.
- To periodically review program policies and procedures.
- To deal with cases referred for board discipline.
- When a board uses the disciplinary process to address cases involving chemical dependency and pain, evaluations support informed decisions.
- To use evaluator's recommendations to support board decisions regarding a nurse's ability to practice safely, including whether the nurse should be separated from practice or can continue to practice or re-enter nursing practice.

- To use the evaluator's recommendations to develop requirements for monitoring compliance with the board's order.
- To identify any discrepancies between the board's findings and the outcomes of the evaluation, and to provide additional information to the evaluator if needed.
- To protect the public by basing disciplinary actions on the behavior and the resulting harm or risk of harm.
- To be responsible for determining the outcome of a case.

An evaluation report addressing the nurse's chemical dependency and pain management can be used to assist board members in making an informed decision. As with the nurse in pain, disciplinary action should be based on the behavior and the resulting harm or risk of harm. The evaluator's recommendations can be incorporated into the final order in relation to the requirements for continued recovery, pain management, monitoring, and staying in or re-entering nursing practice. If there is discrepancy between the board's findings and the outcomes of the evaluation, the board may need to provide additional information and request re-consideration by the evaluator.

Conclusion

As noted in the previous section, situations involving pain management are challenging cases for boards of nursing. Adding an overlay of chemical dependency increases the complexity of the situation. It is imperative that a chemically dependent nurse inform all health care providers that he/she is in recovery, as well as advising to other unique health needs. The nurse should consult a health care provider who understands chemical dependency, prescribes appropriately and will support the nurse's recovery. If a nurse is unable to discontinue use of controlled substances, the situation must be evaluated on a case-by-case basis. These situations need customized evaluation and interventions, and may ultimately impact safety to practice.

The opinion of a professional evaluator, addressing both pain and chemical dependency issues may be assistive in identifying any safety to practice implications for the chemically dependent nurse in pain. The nurse must have insight into how the combination of chemical dependency, pain, and pain treatment is affecting his/her ability to practice safely. When this insight is lacking, final authority rests with the board. The licensee must understand that while the board is the final decision maker, ultimately, the nurse is accountable for his/her practice and professional behavior.

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SECTION NINE:

Standards of Pain Management Nursing

Many nursing organizations develop professional standards to guide specific areas of nursing practice. The American Nurses Association (ANA) and American Society for Pain Management Nursing (ASPMN) have developed Standards of Practice for Pain Management Nursing. (ANA and ASPMN, 2005) These standards provide guidance in the areas of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation (see appendix for more information about these standards, as well as other pain resources). These standards provide guidance for the nurse who tailors nursing care to each unique patient situation. Boards of nursing often refer to professional standards of practice to support decisions.

Standards of Pain Management Nursing

Documentation of assessment, treatment outcomes, and ongoing follow-up is important for patient safety and communication with other health team members. The ASPMN and ANA standards of pain management nursing practice include:

- Assessment – the collection of comprehensive data pertinent to the pain problem.
- Analysis – of the assessment data to determine pain diagnoses or problems.
- Outcome identification – for an individualized care plan for the patient in pain.
- Planning – developing a plan that prescribes strategies and alternatives to attain expected outcomes.
- Implementation – of the pain management plan, including documentation of implementation and modifications, including changes or omissions.
- Coordination of care – including the pain management plan, health teaching/promotions and consultation.
- Evaluation – of progress toward attainment of acceptable outcomes. (ASPMN/ANA, 2005, 11-21)

In addition, the ASPMN/ANA include standards of professional performance, addressing the:

- Quality of nursing practice – including documentation, evaluation, creativity and innovation in nursing practice to improve pain management.
- Education (ongoing competency) – attaining knowledge and competency reflecting current pain management practice.
- Professional practice evaluation in relation to standards, guidelines, relevant statutes, rules, and regulations – self-evaluation of one's own nursing practice compared to expected standards.
- Collegiality (interaction with and contribution to professional development of others) – including sharing knowledge with others, maintaining caring relationships and contributing to a supportive and health workplace.
- Collaboration with patient, family and others – to involve them in planning and implementation of pain management.
- Integration of ethical standards – to protect patient autonomy, dignity and rights, maintain confidentiality, develop effective therapeutic relationships, deal with ethical issues and report illegal, incompetent, and/or unsafe pain management practices.

- Use of research findings – integrating pain research findings into clinical practice.
- Resource utilization – by considering factors related to safety, effectiveness, cost and impact on practice.
- Leadership – including direct coordination of care (including oversight of licensed and unlicensed staff in assigned or delegated tasks) and promotion of health work environments to better meet desired patient outcomes. (ASPMN/ANA, 2005, 23-33)

Standards of Pain Management Nursing for the APRN

The ASPMN/ANA Standards also address practice of the APRN. They include:

- Assessment – initiation and interpretation of diagnostic tests and procedures.
- Diagnosis – uses data and information from patient interview, physical examination, and diagnostic procedures; and compares and contrasts complex clinical findings with normal and abnormal variation along with developmental events to formulate an individual diagnosis.
- Outcome identification – that incorporates scientific evidence, support the use of clinical guidelines, and are achievable through evidence-based practices; and considers cost and clinical effectiveness, patient satisfaction; and promotes continuity and consistency of care.
- Planning – assessment, diagnostic testing, and therapeutic interventions in the pain management plan that reflect current evidence and clinical guidelines.
- Implementation – collaborates with nurses and other disciplines to use systems and community resources to implement the pain management plan, including documentation of implementation and modifications, including changes or omissions.
- Coordination of care – provides leadership in the coordination of interdisciplinary health care team for integrated delivery of the pain management plan and coordinates resources to enhance delivery of pain care across systems.
- Consultation – influences the management of pain, enhances the ability of others, involves patients and families in decision-making, and communicates recommendations to facilitate understanding, enhance work of others, and effect change.
- Prescriptive authority and treatment – uses authority in accordance with state and federal laws and regulations to prescribe evidence-based treatments and therapies based on the clinical pain indicators, the patient status and needs, and the results of diagnostic and laboratory tests.
- Evaluation – the accuracy of diagnosis and effectiveness of interventions as well as the impact on the patient, family, and community; and recommend/make process or structural changes, including policy, procedure, or protocol documentation as needed. (ASPMN/ANA, 2005, 11-21)

In addition, the following APRN professional performance standards are identified:

- Quality of practice – obtains/maintains professional certification in pain management and evaluates self, environment, and the quality of pain nursing care in relation to existing evidence.
- Education – continues to expand clinical skills, enhance role performance, and increase knowledge of pain management.
- Professional practice evaluation – uses a formal process to seek feedback regarding one's practice from patients, peers, professional colleagues, and others.

- Collegiality – models expert pain management practice, mentors other nurses, and participates with interdisciplinary teams who contribute to APRN role development and healthcare.
- Collaboration – facilitates an interdisciplinary process to enhance patient care through education, consultation, management, technological development, and research; documents changes and rationale in plan of care; and pursues collaborative discussions to improve pain management.
- Ethics – informs patients of risk, benefits, and outcomes of pain management plan and participates in interdisciplinary teams that address ethical risks, benefits and outcomes of pain management plan.
- Research – contributes to pain management nursing knowledge by conducting or synthesizing research and disseminates research findings.
- Resource utilization – uses organizational and community resources, and develops innovative solutions that use resources effectively while maintaining quality.
- Leadership – provides direction, initiates, and revises pain management protocols or guidelines to reflect evidence-based practice, accepted changes, and addresses emerging pain management problems; promotes communication of information and advances profession through writing, publishing, and presentation to lay or professional audiences; and works to influence decision-making bodies to improve pain management. (ASPMN/ANA, 2005, 23-33)

These professional standards provide guidance for the nurse and advanced practice nurse addressing pain management issues. Their application in patient situations should be customized to the individual patient needs and situation. All nurses need to understand state and federal laws related to their practice; keep current in knowledge and skills; establish and maintain appropriate therapeutic boundaries; and adhere to professional, behavioral and ethical standards. Nurses who do these things, with caring and common sense, can enhance a patient's quality of life by meeting their needs for safe and effective pain management.

Conclusion:

Boards of nursing often refer to established professional standards when making licensure decisions. Boards expect nurses to be knowledgeable, skillful and follow professional, behavioral and ethical standards of nursing practice. Nurses who adhere to nursing standards for pain management and practice within the appropriate nursing role are likely to avoid violations of Nurse Practice Acts.

Work Cited:

American Nurses Association and the American Society for Pain Management Nursing, (2005). *Pain management nursing: scope & standards of practice*. Silver Springs, MD: nursebooks.org.

SECTION TEN:

Regulatory Implications: the Role of the Nurse in Pain Management

The under-treatment of pain is a serious public health issue in the U.S. (Pain and Policy Studies Group, 2007) An estimated 50 million Americans suffer from persistent pain each year according to the American Pain Foundation. Many of them do not receive effective pain relief. Pain can hinder patient recovery from injury and disease and affect the patient physically, psychologically, socially, spiritually, and economically.

Boards of nursing fully support the nursing role in the thorough assessment, interventions, and effective management of pain. A board's mandate of public protection includes a

responsibility to protect the public from either over- or under-treatment of pain. If pain is managed appropriately, the patient can recover more quickly. In meeting the needs of patients in pain, nurses fulfill the classic nursing role as a patient advocate by promoting and implementing collaboration with health care professionals to provide pain management for patients in pain.

The role of the RN is to first have an understanding of pain. The RN identifies pain and assesses the patient's condition. The RN implements the pain management regimen by safely and accurately administering pain medications and treatment as ordered and on time. The RN is a patient advocate and provides a patient safety net by seeking clarification of unclear orders and questioning risky treatment. The role of the LPN/VN is to contribute to the planning of care, monitoring of patient conditions, and implementing ordered pain treatment. The LPN/VN assists in providing a patient safety net by recognizing condition changes and reporting observations to the RN or physician. The LPN/VN also can advocate for the patient and assist in educating patients. (NCSBN, 2004) The role of the APRN is discussed under a separate heading in this document.

What the Board Needs to Know

Effective treatment of pain requires nurses to be aware of patient needs and to become skillful at the assessment of pain. The nurse needs to be knowledgeable about available treatment options and ordered protocols. Expanding knowledge and emerging new technologies require the nurse to maintain current information about pain management standards and topics relevant to the nurse's practice role.

> In all types of facilities and homecare, the nurse typically has the most direct contact and spends the most time with patients. The nurse has the opportunity to assess the various physical, psychological and social elements that can complicate effective pain management. *As the patient advocate who recognizes the importance of the patient's values, goals and preferences, the pain management nurse uses effective communication skills and coordinates the pain plan of care with the patient/family, physician and other healthcare providers.* (ANA, ASPMN, 2005, p.5)

Boards also need to be aware that patients, family members, and other members of the lay community may not understand the need for pain management. Patients may also fear addiction or being thought of as addicts. Other fears may include:

- Pain means the patient's condition is worse.
- Reporting pain will distract from the treatment of the underlying disease (this often results in patients behaving stoically, trying to be a "good patient" who does not complain).
- Serious side effects may result from the use of pain medications, especially opioids.
- Using the medication now will limit its effectiveness in the future, "when really needed." (Mcaffery, p. 10)

Several state boards of nursing have addressed expectations regarding pain management. The California Board of Registered Nursing adopted a standard of care for California RNs assessing pain and evaluating response to pain interventions using a standard pain management scale. Patient self-reports and pain assessment are to be recorded with each set of vital signs for each patient. (CA BORN, 1999) The Oregon Board of Nursing developed a pain management position statement in 2004 that addresses the role of the RN and APRN in assessment of pain and administration of relief measures. The Minnesota and Kansas Boards of Nursing have developed joint statements with their respective state boards of medicine and pharmacy regarding the importance of adequate pain control (see Appendices for links to these and other board of nursing statements).

North Carolina also collaborated with medical and pharmacy boards to develop a statement that addresses how pain management is essential at the end-of-life. Scott Fishman, MD, Chief of the Division of Pain Medicine and Associate Professor of Anesthesiology at the University of California, Davis, observes:

> *When someone is dying, time is a luxury and wait-and-see is not an option. What matters most in the final days is that patients are free of crippling pain and unbearable suffering so that they can finish their lives in ways that bring comfort, peace, and completion. Concerns about lasting side effects or diminished physical capacity from months of using a drug become secondary to making a patient comfortable. No one has to die in pain."* (Discovery Health, 2008)

Resources such as the *American Pain Society Statement on Treatment at the End-of-Life* are available to educate board members and staff regarding the role of pain management in palliative and end-of-life care.

The Federation of State Medical Boards (FSMB) indicated in *Model Policy for the Use of Controlled Substances for the Treatment of Pain* that the following circumstances contribute to the prevalence of under-treated pain:

- Lack of knowledge of medical [and nursing] standards, current research, and clinical guidelines for appropriate pain treatment;
- The perception that prescribing [or administering] adequate amounts of controlled substances will result in unnecessary scrutiny by regulatory authorities;
- Misunderstanding of addiction and dependence;[8] and
- Lack of understanding of regulatory policies and processes. (FSMB, 2004)

These circumstances relate to nursing as well as medicine. Employers, boards of nursing, the Drug Enforcement Agency (DEA), and others, including patients and their families, may communicate differing, or even conflicting, expectations. Nurses may feel unsure about pain management because these differing expectations seem to pull in different directions. In addition, nurses may be concerned about possible side effects or fear patients will become tolerant or addicted to controlled drugs.

Other groups that may not be adequately informed about pain management are law enforcement and prosecutors. There have been situations when a prosecutor became alarmed because of high and increasing doses of controlled substances for a group of patients, not understanding that this is a pattern that is expected in a hospice or palliative care setting. Bringing actions against medical personnel for over-treatment of pain contributes to the fear of being investigated for over-administering or over-prescribing controlled substances for pain. This fear can pose a barrier to effective pain management. Nursing boards can be effective educators for law enforcement and prosecutors as well as consumer groups.

The Role of the Board of Nursing: Framework for Proactive Board of Nursing Functions

Boards of nursing are charged with regulating the practice of nursing by assuring the competency, safety, and accountability of nurses. Traditionally, this work has been accomplished through the licensure process (requiring individuals to meet requirements before being authorized to practice nursing) and the disciplinary process (responding to problems brought to the attention of the board through board action). Boards are beginning to develop other proactive strategies to address the regulatory aspects of pain management. The elements that provide the foundation for proactive board functions include:

8 Addiction is a primary, chronic disease while physical dependence is a state of adaptation that is manifested by signs and symptoms produced by abrupt session or rapid dose reduction. Physical dependence does not equate with addiction. (FSMB, 2004)

- State Statutes and Administrative Rules provide the board's authority to regulate nursing. Specific areas that can support pain management:
  - Nursing education approval – most boards of nursing approve nursing education programs in their jurisdiction. Rules should provide flexibility and support the inclusion of the following elements in nursing education:
    - Theory and clinical experience in pain management (usually presented as part of an integrated nursing curriculum).
    - Balance between promoting pain relief and protecting against drug abuse.
  - Continued competence – pain management is an important topic to be addressed in ongoing professional development activities. (e.g., one state legislature has mandated pain management continuing education for all licensed health care providers, including nurses. A mandatory online program introduces the pain management domain in Oregon. Nurses are then required to acquire at least seven additional hours of continuing education within their license renewal period.) (OR BON)
  - Disciplinary process – holding nurses accountable for practice:
    - Authority to require physical, mental and/or chemical dependency evaluations upon the demonstration of cause;
    - Investigations of alleged violations of the Nurse Practice Act;
    - Actions required when nurse's pain or treatment for pain impairs the ability to practice safely;
    - Actions required when a chemically dependent nurse in pain impairs the ability to practice safely; and
    - Actions required when a nurse fails to meet expectations for managing patients' pain effectively.
- The Board's Mission Statement and Strategic Goals articulate the goals of the board and how they are to be achieved, including the expectations that:
  - Public protection includes access to effective patient care and assurance of the competency and accountability of nurses.
  - Boards of nursing need to have knowledge about the complexity of pain management, understanding that:
    - Under-treatment of pain is a critical public health problem;
    - Standards of practice for pain management have been articulated;
    - An array of therapies and tools are available for use in pain management;
    - Nurses may fear scrutiny by regulators, fearing disciplinary action for administering too much pain medication; and
    - Under-treatment of pain decreases patient functional status and quality of life, just as over-treatment can result in serious patient harm. The balance of promoting appropriate pain management with inappropriate use of pain medications and patient safety, while those who fail to provide adequate pain interventions may be subject to disciplinary action for failing to meet professional standards.
- Identification of who is involved/affected – stakeholders affected by or involved in the regulatory issues of pain management could include board members, board staff,

nursing educators, nursing employers, professional evaluators, nurses, students, policy makers, the public and others depending on the type of regulatory issue involved.

- Expectations – examples of desired outcomes include demonstrated nurse competence, patient advocacy/safety, and adherence to laws and rules. Specifically, boards may articulate expectations regarding pain management and provide support for practicing nurses through board statements, guidelines, and other resources.
- Collaboration with others with an interest in public protection, best health care practices, patient advocates:
  - Promoting and implementing collaboration with other healthcare team members to provide effective pain management, so continuing education in communication, teamwork and advocacy are also desirable.
  - Boards, educators and nursing service can work together to assure that students, novice and experienced nurses are exposed to current standards and practice expectations, the latest research and clinical guidelines, the whole range of tools to mange pain (not only medications), and provide the opportunity to learn about the difference between drug dependence, drug addiction, and other concepts of pain management.
- Assurance of appropriate intervention, decision-making when problems are reported – once a board has identified that a nurse has failed to meet the expectations of nursing standards, the board must determine the appropriate course of action.
  - To provide remedies that may include education, monitoring and other requirements customized for the nurse's situation.
  - To base disciplinary actions on the behavior and the resulting harm or risk of harm.
  - To be responsible for determining the outcome of a case.
- Education regarding pain management – boards may provide information for nurses and employers regarding the accountability of nurses, including any specific duty to report violations. Boards may offer information when law enforcement and prosecutors confuse appropriate nursing activities with overmedicating patients. Boards can reach out to patients regarding what they should expect as recipients of nursing care.
- Resources for further information about pain management – boards may share materials and resources related to the regulatory implications of pain management (see Appendix).

Conclusion

It is vital that boards of nursing understand the roles of licensed nurses in pain management and controlled substance administration, as well as the other complexities of this aspect of nursing care. The role of the RN is to first identify pain and assess the patient's condition. The RN implements the pain regimen by safely and accurately administering pain medications treatment as ordered and on time. The RN is a patient advocate and provides a patient safety net by seeking clarification of unclear orders and questioning inappropriate treatment. RNs can recognize when pain strategies are not effective, and then collaborate with other providers to modify the pain management plan. They play an important role in educating patients, families and the public regarding pain management. The role of the LPN/VN is to monitor patient conditions and implement ordered pain treatment. The LPN/VN assists in providing a patient safety net by recognizing condition changes and reporting observations to the RN or physician. The LPN/VN also contributes to planning, assists in educating patients and families, and can advocate for patient needs.

Boards can undertake proactive activities, such as educating nurses, identifying pain management resources, and developing guidelines regarding the regulatory implications. And while it is the responsibility of the individual nurse to pursue ongoing education appropriate to his/her practice setting and patient population, when violations of the Nurse Practice Act are proven, boards of nursing are responsible for holding nurses accountable.

Boards may obtain feedback regarding proactive strategies from the many stakeholders interested in the regulatory aspects of pain management. The ideal result is the nursing regulation that functions as a support, not a barrier to the implementation of pain management by nurses who uphold standards of care and quality. When these conditions coexist, the public optimally benefits from the unique skills and knowledge of nurses.

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SECTION ELEVEN:

Regulatory Implications: the Advanced Practice Registered Nurse in a Pain Management Primary Care Role

The scope of practice of the APRN is unique in the nursing profession. The APRN practices as an independent primary care provider in a majority of states, with nearly all states conferring controlled substances prescribing authority upon APRNs, in conjunction with the DEA. In the role of primary care provider or licensed independent provider (LIP), the APRN is held to a high standard of education and practice in patient care.

In providing treatment for pain, the APRN is charged with the responsibility to diagnose the causes of pain, intervene with a variety of therapies, and evaluate the effectiveness of pain treatment being prescribed. The APRN is responsible for appropriate, accurate and complete documentation of assessment, treatment plan, informed consent and ongoing review of efficacy.

Introduction to Specific Regulatory Aspects

The Federation of State Medical Boards stated in *Model Policy for the Use of Controlled Substances for the Treatment of Pain,* that the following circumstances contribute to the prevalence of under-treated pain:

- Lack of knowledge of medical standards, current research, and clinical guidelines for appropriate pain treatment;
- The perception that prescribing [or administering] adequate amounts of controlled substances will result in unnecessary scrutiny by regulatory authorities;
- Misunderstanding of addiction and dependence; and
- Lack of understanding of regulatory policies and processes. (FSMB, 2004)

Several boards of nursing have addressed expectations regarding pain management. The Arizona and Alaska Boards of Nursing have published Advisory Opinions regarding the use of controlled substances for the treatment of chronic pain by APRNs, providing guidance regarding assessing and treating pain with controlled substances, including clear expectations regarding how the APRN is expected to comply with laws and regulations. (AZ BON, 2004; AK BON, 2006). The California Board of Registered Nursing adopted a standard of care for California RNs of assessing pain and evaluating response to pain interventions using a standard pain management scale, using patient self-report and documentation of pain assessment each time that vital signs are recorded for each patient. (CA BORN, 1999) The Oregon Board of Nursing developed a pain management position statement in 2004, addressing the distinct roles of both the RN and APRN in assessment of pain and administration of relief measures, as well as the APRN role in prescribing opioid analgesics and other interventions (see Appendices).

APRNs need to be knowledgeable about the regulation of advanced practice nursing and the significant variations in APRN scope of practice from state to state.

Professional Standards and Practice Expectations

Promoting pain relief, while at the same time preventing abuse of pain medications, becomes a balancing act. Preventing drug abuse is an important societal goal, but there is consensus by law enforcement agencies, health care practitioners, and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve. (Joint Statement of the DEA et al., 2001)

The APRN, like all primary care providers, must work collaboratively with the patient for the best outcome. It is important for the patient to be fully informed concerning side effects as well as realistic expectations for pain relief. There are settings and situations where standards of pain management are unique, i.e. end-of-life care or disaster management.

The APRN treating acute or chronic pain is responsible for understanding the physiology of pain; treatment options, including surgical, physical therapy, pharmacologic and non-pharmacologic interventions; the pharmacokinetics, adverse effects and interactions of the medications selected for treating pain; and the appropriate documentation of treatment choices. While the use of opioid analgesics to treat pain is a legitimate medical use, there is additional responsibility for understanding the complex pharmacokinetics of these medications. Optimal pain management encompasses the correct medication, available in the correct dose, via the correct route of administration, at the correct time, with minimal and manageable side effects.

The field of pain management is rapidly evolving, with improved interventions and greater knowledge of the pharmacokinetics and molecular biology of medications. The APRN must be aware of pain treatment options, which may include aspirin, morphine, antidepressants or anticonvulsants and others, reversible interventions (such as local anesthetics, steroids, nerve blocks, trigger point injections), and irreversible interventions (such as surgery, nerve destruction). Many alternative interventions may be used in conjunction with other therapies, including acupuncture, nerve stimulation, physical therapy, and psychology. Implantable nerve stimulators and infusion pumps may be used for chronic, intractable pain. New technologies

are continually being developed, which requires the APRN to be knowledgeable about the appropriate combinations of pharmacologic and non-pharmacologic treatments.

Acute Pain

Acute pain, resulting from injury or surgical intervention, typically lasts less than three months. The principles of pain relief include the importance of titrating medication to the desired effect of pain relief, taking into account the time needed for the medication to take effect, as well as factors affecting length of effect. Co-morbidities can prolong or shorten pain relief onset and/or duration.

Chronic Pain

Chronic pain is generally defined as lasting longer than three months. Medications, opioid and nonopioid, are frequently used to treat chronic pain. Ineffective pain management may be the outcome when concerns regarding potential addiction impact decisions on the use of opioids.

Opioids are not always the first line of treatment for chronic pain. Some chronic pain syndromes do not respond to opioid medications. APRNs treating chronic pain require knowledge of a variety of categories of medications that can relieve pain. For example, neuropathic pain may respond better to antidepressants, anticonvulsants, or alpha-2 adrenergic agonists. Non-pharmacologic interventions may be helpful. Notwithstanding, the best efforts on the part of clinicians; not all patients will experience optimal relief from chronic pain, despite the appropriate use of analgesic interventions.

Some Guidelines for Documentation of Assessment and Care

There is no objective measurement of pain (MGH Handbook of Pain Management). However, appropriate assessment of history and physical findings, coupled with an understanding of pain pathophysiology guides rational, appropriate treatment. Documentation of assessment, treatment outcomes and ongoing follow-up is important for patient safety and communication with other health care providers.

Consistent with accepted standards (FSMB), accurate, legible and complete records include:

- Pain history that includes:
  - The onset and character of the pain, such as description, quality, intensity, duration, and impact of the pain on function;
  - Treatment history;
  - Relevant psychological history (including screening for anxiety, depression, somatoform disorder, coping style, and personality traits);
  - Vocational and medical legal issues;
  - General medical history;
  - Patient's perception about the cause of the pain; and
  - Patient's goals and expectations.
- Physical examination that includes an appropriate examination for the symptoms. This may be a more thorough examination in the case of acute pain or initial evaluation for chronic pain. A directed examination in ongoing chronic pain management would include:
  - Musculoskeletal;
  - Neurological;

  - Skin; and
  - Psychological.
- Psychological evaluation should be included in initial evaluation, with regular reassessment, addressing:
  - Screening for depression, anxiety, substance abuse;
  - Prior psychological evaluation and treatment review; and
  - History of alcohol or other drug addiction, including treatment by addiction specialists.
- Functional status – self-reported and/or objective evaluation.
- Laboratory testing and imaging as appropriate.
- Diagnosis, including contributing medical and psychiatric co-morbidities.
- Treatment plan, including:
  - Specific, measurable, realistic goals;
  - Rationale for interventions;
  - Documented discussion with the patient of risks, benefits, and alternatives;
  - Medications selected, with dose and quantity prescribed;
  - Patient education;
  - Patient agreements or contracts;
  - Plan for consultation, when needed; and
  - Plan for re-evaluation.
- Outcomes, including:
  - Pain reduction;
  - Physical function changes;
  - Psychosocial function changes;
  - Work status;
  - Medication use; and
  - Ability to self-manage pain with non-pharmacologic interventions.

In the management of chronic, nonmalignant or malignant pain,[9] a written agreement between the APRN and the patient may be helpful when opioid analgesics are prescribed. Typical elements of a medication management agreement are:

- Regular office visits at a prescribed interval;
- Informed consent, outlining the potential risks, benefits and alternatives of the medications being prescribed;
- Limit prescription to one prescriber only;
- Limit refills to only a specified number and frequency, with no early refills;
- Use one pharmacy only, giving the name of that pharmacy;

9 Malignant pain refers to pain caused by metastatic growth.

- Random drug screens, urine or serum, when requested;
- Pill counts, when requested;
- Permission to speak with family members about the effects of the medications being prescribed;
- Psychological counseling as deemed necessary by the APRN; and
- Potential of discontinuation of controlled substance prescriptions.

A written agreement may not be necessary in the management of acute pain, anticipated to last less than three months. This is appropriately determined on a case-by-case basis, taking into account the individual's physical and psychological history.

Periodic review of the effectiveness of the treatment plan is critical. The APRN should reassess the appropriateness of the current plan, altering it as necessary. The treatment of chronic pain is complex and often consultations and referrals are needed for additional evaluation and treatment.

Specialized Knowledge and Skills of the APRN

The treatment of malignant and non-malignant chronic pain, as well as acute pain, is complex, requiring increased awareness and specialized education by the treating APRN. Education must include how to solicit pain level from patient, the phenomena of addiction, pseudo-addiction, tolerance, and dependence, the variety of treatment options, which include non-pharmacologic therapies, and the safe use of controlled substances and other medications.

Specialized education in pain management is the responsibility of the individual practitioner to pursue, appropriate to their practice. Graduate education and preceptors/mentors can work together to assure that graduate students, novice, and experienced APRNs are exposed to current standards and expectations regarding pain management, the latest research and clinical guidelines, the whole range of therapeutic interventions available to manage pain, and the distinctions between drug dependence and drug addiction.

Education is needed to equip APRNs to understand regulatory policies and processes and their implications for day-to-day practice. In addition to expertise in the pain management modalities, APRNs must develop competence in the expected standards of pain management. The state of Oregon has implemented statute requiring a one-time pain management continuing education course for all healthcare providers in the state.

The Role of the Board of Nursing

Many health care practitioners, including APRNs, fear being investigated for over-administering or over-prescribing controlled substances for pain. This fear can pose a barrier to effective pain management. Regulatory boards must consider the balance of promoting appropriate pain management against deterring inappropriate use of pain medications. Under-treatment of pain decreases patient functional status, safety, and quality of life.

The APRN may feel pulled in different directions by expectations of the employer, licensing board, legal requirements of the Drug Enforcement Agency (DEA), expectations of other health care team members, and the optimal care for the patient. APRNs who effectively manage pain contribute to improved quality of life for individuals, while those who fail to provide adequate pain interventions may be subject to disciplinary action for failing to meet professional standards.

Boards need to be aware that patients, family members, and other members of the lay community may not understand the need for pain management, which adds to the complexity of effective treatment. Patients may fear addiction or being thought of as an addict. They may fear that pain, especially the need for opioid medications, means that their

condition is worse. Patients may think that reporting pain will distract from the treatment of the underlying disease, so they may try to be a "good patient" who does not complain. They may be reluctant to take medications, expecting serious side effects. Sometimes those with chronic pain think that using the medication now will limit its effectiveness in the future, "when really needed." As a result, patients may still be in pain. Caregivers are afraid of causing harm and may be conflicted between wanting to ease the patient's pain but also being worried about addiction and side effects.

There have been situations when a prosecutor becomes alarmed because of high and increasing doses of controlled substances for a group of patients, not understanding that this is a pattern that might be expected in a hospice or palliative care setting and in some patients with persistent pain. Boards of nursing can be effective educators related to the implementation of pain management by APRNs, while upholding standards of care and quality.

If a board has identified that an APRN has failed to meet the expectations of pain management standards, the board must determine the appropriate course of action.

- Boards of nursing are charged with public protection and recognize that this protection includes access to effective patient care and assurance of the competency and accountability of nurses, including APRNs.
- Boards of nursing need to have knowledge about the complexity of pain management, understanding that:
  - Under-treatment of pain is a critical public health problem;
  - Standards of practice for pain management have been articulated;
  - An array of therapies and tools are available for use in pain management;
  - APRNs and other health care practitioners may fear scrutiny by regulators; and
  - APRNs and other health care practitioners may fear disciplinary action for administering too much or too little pain medication.
- Boards of nursing have an opportunity to collaborate with graduate program educators and preceptors to support pain management practice through education about the:
  - Standards of pain management; and
  - APRN authority to prescribe, including:
    - Prescribing controlled substances.
- Guarding against misuse of prescription forms:
  - Balance between promoting pain relief and preventing drug abuse; and
  - Regulatory process and disciplinary implications when an APRN fails to meet expectations for managing patients pain effectively.
- Boards of nursing expect APRNs to:
  - Maintain their knowledge of the complexities and challenges of pain management;
  - Implement pain management treatment standards, including pain assessment, intervention, documentation, and evaluation;
  - Appropriately consult with specialists;
  - Comply with state and federal Controlled Substances Law and Regulations;
  - Advocate for patient needs; and

- Collaborate and cooperate with other health team members in addressing patient pain.

Conclusion

As independent primary care providers, APRNs are responsible for providing compassionate, evidence-based healthcare. When statutes and regulations permit, APRNs may accept the additional responsibility for prescribing controlled substances for pain management. To assure competence, APRNs are accountable for acquiring and maintaining the knowledge and clinical expertise to provide this type of healthcare.

Boards of nursing are charged to protect the public through the regulation of safe nursing practice. It is vital that boards of nursing understand the complexities of pain management and controlled substance prescribing. The ideal result is implementation of nursing regulation that function as a support, not a barrier, to the implementation of pain management by APRNs, while upholding standards of care and quality. When these conditions coexist, the public optimally benefits from the unique skills and knowledge of APRNs.

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SECTION TWELVE:

Appendices

A. Links to Member Board Pain Resources

B. Summary of Literature Review

C. Characteristics of Alternative Programs Compared to Characteristics of Disciplinary Process

D. Regulatory Implications of Pain Management: Critical Questions

E. Pain Management Questions for Board Policy Discussions

F. Other Resources

Appendix A:

Links to State Board of Nursing Pain Management Resources

A number of boards of nursing have developed resources related to the regulatory implications of pain management. This list identifies those Member Boards and provides the link to their resources.

Alaska Board of Nursing Advisory Statement:
The Use of Controlled Substances for the Treatment of Pain by Advanced Nurse Practitioners
http://www.dced.state.ak.us/occ/pub/nur1808.pdf

Arizona State Board of Nursing Advisory Opinion:
The Use of Controlled Substances for the Treatment of Chronic Pain
http://www.azbn.gov/Documents/advisory_opinion/AO%20Controlled%20Substances-Use%20for%20Treatment%20of%20Chronic%20Pain.pdf

California Board of Registered Nurses
The Nurse's Role in Pain Management
http://www.rn.ca.gov/pdfs/regulations/npr-i-32.pdf

Kansas Board of Nursing (with Board of Healing Arts and Board of Pharmacy)
Joint Policy Statement of the Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled substances for the Treatment of Pain
http://www.ksbn.org/positionstatements/joint_policy_statement.pdf

Maryland Board of Nursing
Pain Management Nursing Role/Core Competency – A Guide for Nurses
www.MBON.org/practice/pain_management.pdf

Michigan Board of Nursing
Guidelines for the Use of Controlled Substances for the Treatment of Pain
http://www.michigan.gov/documents/mdch_nurseguidelinesusecspain_139444_7.pdf

Minnesota Board of Nursing (with Boards of Medical Practice and Pharmacy)
Joint Statement on Pain Management Minnesota Boards of Medical Practice, Nursing and Pharmacy
http://www.state.mn.us/mn/externalDocs/Nursing/Joint_Statement_on_Pain_Management_091704014840_Jointstatement.pdf

New Mexico Board of Nursing
Administrative Rule 16.12.9 *Management of Chronic Pain with Controlled Substances*
http://www.bon.state.nm.us/pdf/nmacpart9.pdf

North Carolina Board of Nursing (with Boards of Medicine and Pharmacy)
Joint Statement on Pain Management in End-of-Life Care
http://www.ncbon.com/content.aspx?id=888&terms=Pain+management

North Dakota Board of Nursing
Role of the Nurse in Pain Management Practice Statement
http://www.ndbon.org/opinions/role%20of%20nurse%20in%20pain%20mgmt.shtml

Oregon State Board of Nursing
Position Statement for Pain Management
http://www.oregon.gov/OSBN/pdfs/policies/pain_management.pdf

Utah Board of Nursing
Rules for all practitioners with prescribing authority: Subsection 58-1-502 (6) it is

unprofessional conduct for failing, as a practitioner, to follow the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

Wisconsin Board of Nursing White Paper
Pain Management
http://drl.wi.gov/boards/nur/pap/pap14.pdf

APPENDIX B

Literature Review

Much has been studied and written about the topic of pain – there are textbooks and many books on the subject. Some of the articles reviewed by the NCSBN Disciplinary Resources Committee were published in academic journals; others were in the popular press and more on the internet. Selected article abstracts, grouped by specific aspect of pain management, are below.

Pain Background

- In the early 1990s, the Agency for Health Care Policy and Research, Public Health Service, and the U.S. Department of Health and Human Services conducted expert panels to develop a number of clinical guidelines on a variety of health topics, including pain management. The guidelines describe principles of patient care derived from a systematic analysis of the scientific literature and from opinions of expert panels. In addition to the clinical guidelines, AHCPR developed a quick reference for clinicians and a patient and family practice guideline. Although dated, these references are included because of the process used for development and the historical value of the documents (a snapshot of pain management 20 years ago).
- A Robert Wood Johnson Foundation article stated that untreated or inadequately treated pain is one of the worst medical problems in the U.S. and that we face an epidemic of untreated and inadequately treated pain. While the tools are available to treat most pain effectively, many people continue to suffer. The article discusses reasons for this, and discusses the results of a 1999 Gallup survey about Americans and pain.
- The Joint Commission (2001) presented an institutional approach to pain assessment and management. It addresses issues of under-treatment; the rights and ethics of pain management; pain assessment, care, and education; and how to improve organizational performance. How pain assessment and management is addressed in Joint Commissions surveys and case studies.

Pain Management Nursing

- McCaffery and Pasero's *Pain: a Clinical Manual* is a classic textbook on nursing pain management. Content ranges from reasons for the under-treatment of pain; the anatomy and physiology of pain; types of pain; harmful effects; pain assessment; pharmacological treatment-how different analgesics work;non-pharmacological approaches to pain; pain in different age groups; selected pain problems; pain and addiction; and how to build institutional commitment to improving pain management.
- Compton and Mcaffery (2001) responded to a question about treating acute pain in addicted patients that one should never withhold opioids from someone in acute pain who suffers addictive disease. No scientific evidence exists to show that providing opioid analgesia to these patients worsens the addiction. Acute pain should be treated immediately with opioids and with analgesia around the clock to maintain blood levels. The authors note that a patient tolerant to opioids will likely need more pain control than someone who is not. As acute pain decreases, plan with the patient to taper the analgesic gradually.

- Mcaffery, Grimm, Pasero, Ferrell and Uman (2005) investigated the term "drug seeking" and found that nurses believed that term was likely to mean the patient was addicted, was abusing drugs or was manipulative. Their findings indicated there is a high level of confusion and stigma likely to be present in the care of a patient who is labeled "drug seeking." A better description would be "concern-raising behaviors. They recommend a differential diagnosis be done when questionable behaviors occur during the course of pain management.
- Wisconsin Cancer Pain Initiative (1995) developed competency guidelines for cancer pain management in nursing education and practice. The following competency areas are identified: knowledge of basic principles, assessment, intervention, and side effects/ risk management.

Advanced Practice Registered Nurses and Pain Management

- Starck, Sherwood and McNeill (2003) identified factors in the mismanagement of pain, effective tools and best practices for pain management, including guidelines, assessment tools, report cards, and managing interactions with patients and families.
- Lazarus and Downing (2003) discuss elements related to pain management and regulatory factors that affect the treatment of pain. They provide an overview of the evolution of advanced practice nursing and research results about nurse practitioners in Alabama, including perceptions about prescriptive practices and pain management. They related experiences of the Alabama Board of Nursing in monitoring and investigating nurse practitioners for compliance with prescriptive authority. The study confirmed the belief that lack of prescriptive authority has delayed pain treatment. However, almost half of the Alabama nurse practitioners did not feel adequately prepared for prescribing controlled substances.

Pain Policy

- In 1999, researchers at the University of Wisconsin-Madison Medical School conducted a study of state law and regulatory policies that may promote or impede the use of morphine and other controlled substances for pain relief. Researchers at the Pain and Policy Studies Group at Wisconsin identified law and policies in 16 states and the District of Columbia that could affect pain management. They recommended that "balance" should be the central principle of policies related to pain relief (government policies to prevent abuse of controlled substances should not interfere with the use of controlled substances for the relief of pain).
- The Pain and Policy Studies Group of the University of Wisconsin School of Medicine and Public Health, Paul P. Carbone Comprehensive Cancer Center has issued three progress reports (including the 1999 work described above) on Achieving Balance in State Pain Policy, the third edition in 2007. They emphasize the need for balance between practitioners' ability to provide adequate pain management with the need to prevent drug diversion and abuse. States are rated on eight criteria that identify policy language with the potential to enhance pain management and eight criteria that identify policy language with the potential to impede pain management.
- Chan and Fishman reviewed the regulatory and legal aspects of the use of opioids in pain relief, concluding that the environment is in a state of flux. The article also looks at future trends concerning the regulation of chronic opioid treatment.
- Bolen discussed the role of law in medical decision making in opioid treatment and how to put legal and regulatory materials to work for the practitioner.
- Martino argued that a complex "ethic of under-prescribing" underlies the reluctance of many physicians to use opioids to treat chronic pain. She contends that the state medical boards are positioned to promote a new ethic for pain control, and that

success hinges on boards being able to change their approach to pain management and persuade a skeptical medical community that under-prescribing not only puts patients at risk, but that physicians can be disciplined for not meeting pain management standards. Effective pain management will better serve patient needs as well as assuring that the physician is meeting expected standards of care.

- Gilson and Joranson wrote about likely under-treatment of pain among patients with addiction disease as well as laws and regulations that pose barriers to effective treatment.
- Foley discussed how to dismantle the barriers so that practitioners can improve palliative and end-of-life care. These barriers include health care provider's fears and lack of knowledge (major medical and nursing texts devote only a few pages to pain and symptom control) as well as misguided legislation in some jurisdictions.
- Gilson, Joranason and Maurer (2003) state that since 1989, 41 states had adopted policies relating to controlled substances, written from multiple perspectives and largely inconsistent. In 1997, the Federation of State Medical Boards (FSMB) recognized the need for more consistency in state pain policies and convened a panel of experts to draft a model policy. The FSMB adopted the guidelines in 1998 and sent it out to state medical boards and asked them to consider adopting As of the writing of this article, 21 states had adopted all or part of the statement. Two additional states endorsed the policy. Many state medical boards have exhibited a willingness to promulgate board policy that encourages treatment of pain and work to remove barriers to pain management. Once a board adopts such a policy, it must be implemented. The authors suggest a three tiered process for implementation: the training of investigators about the current standards of pain management, disseminating the policy to licensees, and using radio and television to reach the general public.

Pain Statements and Positions

- American Nurse Association (ANA) and the American Society for Pain Management Nursing (ASPMN)
  ANA and ASPMN published *Pain Management Nursing: Scope and Standards of Practice* in 2005. These are discussed in the Standards section of this paper.
- American Society for Pain Management Nursing (ASPMN) and the American Pain Society
  This consensus statement encourages institutions to develop policies that provide practical information about pain management and promotes education for staff to facilitate competency and safety. Policies should not include explicit dosing recommendations nor should medical orders be open-ended (e.g., titrate to comfort). A pain medication order should specify an appropriate dose range and frequency of administration based on the pharmacokinetics of the opioid, the patient characteristics and the situation.
- American Society for Pain Management Nursing (ASPMN)
  ASPMN published a 2002 position statement on pain management in patients with addictive disease that emphasized the importance of the nurse advocacy role in pain management. ASPMN adopted a 2003 position statement on pain management at the end-of-life, stating the importance of the nurse to advocate for pain relief and symptom management to alleviate suffering, increase the quality of life and possibly prolong life.
- The American Society of PeriAnesthesia Nurses (ASPAN)
  ASPAN's position statement on pain management supports a collaborative plan between the anesthesia department and perianesthesia nurses to address pain management in the perianesthesia setting, with goals of relieving pain to allow activity, relaxation, complication prevention, and promotion of healing and optimal health.

- The Academy of Medical-Surgical Nurses (AMSN)
  AMSN recognizes freedom from pain as a basic human right, thus is committed to the identification of pain management as a patient care priority, and affirms that every patient will have access to the best level of pain relief that may be safely provided.
- Oncology Nurses Society
  ONS issued a 2006 position on cancer pain management, focusing on the cancer patient's right to optimal pain relief; the need for education of patients, families, and the public about therapies available to treat cancer pain; the need to eliminate regulatory, legislative, economic, and other barriers to effective cancer pain management; and the ethical responsibility of all healthcare providers to use evidence-based pain management guidelines. ONS states the need for a multidisciplinary and collaborative approach for addressing the physical, psychological, spiritual, and socio-cultural effects of unrelieved pain.
- Federation of State Medical Boards
  Model Policy for the Use of Controlled Substances for the Treatment of Pain provides guidelines for evaluating the patient in pain and developing a treatment plan. It discusses the need for informed consent for treatment, periodic review of the course of pain treatment, consultation, and medical records. The importance of complying with controlled substance laws and regulations is stressed. Originally adopted in 1998, the policy was revised in 2004 with an added emphasis on the concern that pain is often untreated. A number of medical licensing boards have adopted the model policy.

Pain Management Standards

- The American Nurse Association (ANA) and the American Society for Pain Management Nursing (ASPMN) published *Pain Management Nursing: Scope and Standards of Practice* in 2005. Pain is the most common nursing diagnosis, thus is important for the practice of all nurses standards for the RN address assessment, identification of pain problems (nursing diagnosis), outcomes identification, and developing a pain management plan. In addition, there are standards of professional performance, addressing the quality of nursing practice, education, professional practice evaluation, collegiality (interaction with and contribution to professional development of others), collaboration with patient, family and others – to involve them in planning and implementation of pain management and leadership (coordination of care and oversight of licensed and unlicensed staff). The same standards apply to APRN and there are additional measurement criteria for the APRN. In addition, a standard for prescriptive authority and treatment is provided for the APRN.
- The Joint Commission on Accreditation of Healthcare Organization's (now the Joint Commission) 2001 pain management standards state that every patient has a right to have his or her pain assessed and treated. These standards were the product of a two-year collaboration between the Joint Commission and the University of Wisconsin – Madison Medical School. PC.2.04.0 states that The [organization] assesses and manages [patient]s for pain.
- The Joint Commission published *Pain Assessment and Management: an Organizational Approach* in 2000. This book discusses the Joint Commission's expanded requirements for pain management in hospitals, long term care facilities, behavioral health care facilities, ambulatory care, and health care networks. It provides a step-by-step approach for achieving the organizational commitment needed to improve pain management by identifying and breaking-down organizational barriers to effective pain control.
- Chapman (2000) wrote in anticipation of the new standards for pain assessment and management expected to appear in the 2000-2001 Joint Commission standards manual

that require healthcare organizations to recognize the right of patients to appropriate pain assessment and management. The author, President of the American Pain Society, observes that healthcare professionals in a wide range of facilities need guidance and instruction about pain and its management. He advocated seizing the moment and stepping forward to help.

- Chapman (2000) presented a session at the 19th Annual American Pain Society Annual Meeting, reviewing the requirements for healthcare facilities and how they can be implemented. She described 10 steps to compliance and discussed how to implement the standards in the real world, providing examples from the hospital setting, ambulatory surgery, and a behavioral health setting.

Pain and Addiction

- Ziegler wrote about safe treatment of pain in patients with a substance abuse problem and describes the challenge to clinicians as how to help patients manage pain without exacerbating or reactivating the addictive disorder. She says for the acute pain caused by surgery, trauma, or extensive dental work, opioids may be indicated to control severe pain. The treating physician or dentist may reduce the dosage of opioids administered, but this is contrary to the effective approach of giving as large a dose needed to achieve good pain control. She emphasized that untreated pain can be as big a trigger as exposure to an intoxicant. She discusses in depth two case studies.
- Scholl and Weaver state that pain is often under-treated and provide tools for addiction screening. They addressed the psychological and behavioral consequences of chronic pain treated with opioids and present guidelines for prescribing opioids.
- Grant et al., state that providers tend to under-treat pain in the population with addictive disease due to biases, misconceptions, and systems issues. Inadequate pain relief is more apt to cause relapse than the use of opioids. They discuss a number of complications that can arise when pain is under-treated in the patient with addictive disease, as well as ways to improve pain control for this population.
- Markel describes a rigorous substance abuse treatment program for health care providers in Ann Arbor, Michigan. He stated the need for such a program to have a linkage to credible sanctions.
- Webster identified risk factors for an increased abuse potential in pain patients.
- Leavitt (2004) noted that pain and addiction share some common physiologic pathways in the brain, especially those involving opioids; hence the presence of pain may influence the development and course of opioid addiction and vice versa. The undertreatment of pain is an important concern for addicted persons. Some of the barriers to effective treatment include misguided institutional practices, inadequate physician training, reluctance to provide adequate pain medications to chemically dependent persons, clinician fears of regulatory sanctions, and a reluctance by these patients to seek care because of fear of drug relapse. The author encourages better communication between pain treatment specialists and addiction treatment specialists.
- Maher-Brisen (2007) described addiction as an occupational hazard in nursing and noted work-related factors that might be associated with the use and abuse of drugs, including: working nights or rotating shifts; critical care work; excessive overtime; musculoskeletal injuries and pain; and knowledge of medications. The author states that little attention is paid to addiction in schools of nursing, and that stereotypes and stigma persist. She discussed the legal and professional discipline implications of drug diversion.

Cognition and Neuropsychological Evaluation (NPE)

- Malik and McDonald describe types of NPE, who and when to refer patients for NPE, test selection, technical issues, and examples of testing.
- Ersek et al., (2004) wrote about the cognitive effects of opioids. This article reviews the empiric literature on opioids and cognitive functioning. In general, research reflects minimal to no significant impairments in cognitive functioning. Despite subjective experiences of mental dullness and sedation, objective tests of cognitive functioning do not always demonstrate marked changes following opioid administration.
- Brown et al., conducted a study on a sample of 1,009 patients treated by 235 primary care physicians. Patients on daily opioids experienced more side effects than those taking the medication intermittently. The authors suggest that psychological measures and pain severity are more predictive of decrements in cognitive function and advise physicians to closely monitor patients for adverse effects and adequacy of pain control.

Pain Education

- Robert Wood Johnson Foundation (2002) funded an effort led by the City of Hope National Medical Center to improve nursing education in pain and end-of-life issues. Project staff reviewed and critiqued 50 nursing textbooks, surveyed members of key nursing organizations, met with nursing licensure leaders, created and distributed resources, and sponsored a national conference. The textbook analysis revealed that just two percent of textbook content addressed end-of-life issues. A follow-up examination of the 50 textbooks previously reviewed showed that 40 percent of the authors and publishers had made changes or were in the process of doing so.
- The American Geriatrics Society Foundation for Health in Aging (2002) has developed an online Patient Education Forum on Persistent Pain. Presented in a question and answer format, it provides basic information about pain, over-the-counter medications, advises how to keep a pain diary, and other suggestions for making the most of time with health care providers.
- The American Medical Association (2007) offered online continuing education modules on pain. 12 modules cover topics that include pathophysiology of pain, pain management, and pain in several specific patient populations.

Media Coverage of Pain

Most of the major periodicals in the U.S. have looked at pain at one time or another. Here are some samples:

- Schrof, writing for *U.S. News and World Report* (March 17, 1997), told the story of a physician who lost his medical license after he prescribed narcotics for hundreds of patients. His medical board found that the physician' practice was too risky and his monitoring of patients was inadequate. He was treating patients from other states because doctors there would not prescribe narcotics. After the physician stopped practicing, two of his former patients committed suicide. The article suggests that drug regulators don't know about the latest scientific data on treating pain. Some states are beginning to develop policies that support vigorous pain treatment. The physician in this story is still pursuing his case.
- Meier, writing for the *New York Times*, looked at the "delicate balance of pain and addiction." He observed that for much of the 1900s, doctors believed that patients could easily become addicted to drugs resulting in many patients in pain were denied relief. Over the past decade, "doctors specializing in pain treatment and drug companies eager to broaden the market for such drugs" championed the view that drugs posed scant risk to pain patients. This too may have had unfortunate

consequences because physicians and patients may have developed a false sense of security about the use of drugs to control pain. Now, the focus is right in the middle of these two extremes. Medical experts agree that most pain patients can use narcotics without consequences. However, the addiction risk for chronic pain patients has not been studied and the long term results are really unknown.

- Kalb, writing for *Newsweek* magazine (May 19, 2003) did a cover story on "Taking a New Look at Pain," observed that patients are demanding that pain be seen as a condition in and of itself, not just a byproduct of injury, illness, or surgery. Congress has declared this the Decade of Pain Control and Research. New imaging technology allows researchers to begin to detangle the pain system at its molecular level. Medical scientists are developing new, targeted treatments. The author also addresses the spiritual, cultural, and emotional aspects of pain.
- Wallis, writing for *Time* magazine (Feb. 28, 2005), explored the right and wrong ways to treat pain. Presenting actual cases, looking at the cause of the pain, the patient's age, and how they are being treated, the author looked at the causes of chronic pain and the holistic approach being taken at leading pain management centers.
- Brody, writing for the *New York Times* (Nov. 6, 13 and 20, 2007), did a series on chronic pain, observing that pain that doesn't quite change a person. Delving into the causes of chronic pain the effects on families, she presents some ideas adapted from the American Chronic Pain Association's Family Manual, about what patients and families can do to cope. In the third article, she outlines medications and other non-drug approaches that can ease chronic pain.

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APPENDIX C

Comparison of Alternative Programs and Disciplinary Actions

There are two common approaches for regulatory management of nurses in pain, or chemically dependent nurses who have the additional challenge of pain. Many boards offer alternative or non-disciplinary programs for nurses who meet specified criteria. Whether a nurse can be referred to an alternative program or continue in an alternative program if already enrolled depends on the program's criteria for participation, the circumstances of the nurse's situation and the scope of the alternative program.

According to the *2007 NCSBN Member Board Profiles*, 43 boards reported having non-disciplinary alternative programs available for chemically dependent nurses who meet entry criteria. 13 of those programs also accept individuals with physical or health problems. The advantages of an alternative program include earlier identification, intervention, and treatment for a nurse with chemical dependency and pain issues. Nurses able to continue or return to nursing practice are monitored to assure compliance with program requirements. Nurses who comply with program expectations and complete the terms of an agreement/contract avoid having a disciplinary history associated with the nursing license. Nurses who do not comply with program agreements/contracts are referred to the board of nursing for disciplinary action.

Boards that do not offer alternative programs use the disciplinary process to manage a nurse's chemical dependency and pain issues. Discipline is also used in situations where a nurse does not meet a program's requirements for participation or does not comply with the terms of the alternative program agreement/contract. Although the discipline process takes longer, the board has the full force and effect of administrative law supporting their orders.

Figure 1 provides a comparison of important characteristics of most alternative programs and the discipline process. The major advantage of alternative programs is how quickly nurses are identified, undergo treatment, and have their practice monitored if working in a nursing role. There is an agreement executed between the nurse and the alternative program that can be accomplished in a short period of time, so the nurse's practice is monitored almost immediately.

The nurse's license to practice is considered a property right and boards must provide due process of law for the nurse who is under board scrutiny for possible violations of the Nurse Practice Act. This means the nurse must be provided proper notice of the allegations against her/him, an opportunity to challenge charges, and an objective decision maker. States vary a great deal in the details of the disciplinary process and each board must abide by the jurisdiction's Nurse Practice, Nursing Administrative Rules, the State's Administrative Procedures Act, and other state and federal statutes and rules relevant to the regulation of nursing. The time required for completing an investigation for a board of nursing ranges from a few months to a year or more. During the time of the investigation, the nurse's license is unencumbered and the nurse retains the authority to practice until the board takes disciplinary action.

Often, the terms of discipline orders require the same type of drug testing and monitoring of recovery and practice that are typically elements in alternative program agreements/contracts. Instead of a private, non-public agreement/contract with an alternative program, public disciplinary actions are taken against the nurse's license. Such administrative actions are required to be reported to federal databanks and agencies.

Figure 1. Comparison of Characteristics of Alternative Programs and Board Discipline

(NCSBN, 2004)

Characteristic	Alternative Programs	Board Discipline
Identification of problem	Some nurses refer themselves; others are referred by employers, family members, et al.	Usually via a complaint to the BON, can be from employer, patient, other nurse, law enforcement, et al.
Legal basis	Individualized agreement between program and nurse	Board discipline authority in Nursing Practice Act (NPA) and rules.
Classification of nurse's information	Not public[10]– only persons who need to know are informed	Board actions are public and required to be reported to national databanks. States vary on status of information during investigation and prosecution.
Communication with nurse	Nurse may make first contact when self-reporting; alternative program staff may contact nurse first	Varies by state, first contact can be letter from board, call from investigator, or a notice of allegations.
Collecting information	Interview with nurse, review of treatment records and other available information	Investigation varies with nature of allegations and state process; typically involves interviews with witnesses, interview with nurse, review of available records and other related information.
Evaluation	Either recommended to nurse or may be required for participation	Some states can order evaluation with cause; other states may request an evaluation during the course of an investigation.
Treatment	Nurse expected to comply with pain management plan and any CD treatment recommendations (to avoid or recover from relapse caused by pain or pain treatment)	Nurse may be ordered to comply with pain management plan (if has not already done so) as a condition for continuing or returning to nursing practice.
Time frame for beginning monitoring	In a matter of hours to a few days – as soon as nurse signs agreement	May be a few months, a year, or more – time is required to complete investigation, prosecution, or negotiation.

10 Many programs classify information as "confidential," however, a "not public" classification is recommended in the NCSBN Model Nursing Practice Act (because some people do need to know) as more descriptive of actual practice. (NCSBN, 2004)

Characteristic	Alternative Programs	Board Discipline
Can the nurse practice nursing?	Some programs may recommend a temporary period away from nursing, at least during early recovery. Specifics depend on nurse's situation, point in recovery, and other issues. Other nurses may continue to practice under monitoring.	Nurse has unencumbered license during investigation unless emergency action is taken or the nurse is willing to voluntarily surrender license during investigation. Board may determine that separation from practice until nurse meets specified requirements needed to protect the public, or if nurse is already in recovery, a board may restrict or put conditions on license or other discipline as authorized in NPA.
If out of practice, how does the nurse resume nursing practice?	Agreement may specify when the nurse may return to practice; timing may depend on nurse's progress toward recovery	Complies with requirements specified in order.
Monitoring Requirements		
Drug screening	YES	YES
Reports from self	YES	YES
Reports from pain management health care provider	YES	YES
Reports from employer	YES	YES
Reports from counselor or other CD treatment/ aftercare	YES	YES
Reports from AA or other support group attendance	YES	YES
Reports any prescribed medications	YES	YES
Periodic telephone interviews	Likely	Maybe
Periodic face-to-face interviews	Maybe	Not Likely
Return to work		
Work site	May be limited	May be limited
Hours	May be limited	May be limited
No overtime	Sometimes	Sometimes
Must inform supervisor of requirements	YES	YES
No access to controlled substances	Often for a designated period of time	Usually, with requirements to meet to regain access

Characteristic	Alternative Programs	Board Discipline
In case of Relapse		
Relapse plan	Encouraged to have in place	May be in order requirements
Effect of relapse on ability to practice	Serious relapse must be reported to board	Serious relapse by nurse under board order may result in additional action
Duration	2-5 years depending on program	Varies
Mobility – (Nurse's ability to move to another jurisdiction)	Ability to move to a different state depends on states and programs	Depends on elements of order and the boards involved

Conclusion:

Alternative programs offer a non-disciplinary approach for regulators addressing situations involving a nurse in pain, or a chemically dependent nurse in pain. The advantages include earlier identification and much earlier monitoring of the nurse who is continuing or returning to practice. The legal basis is the voluntary agreement between the program and the nurse. Board disciplinary action may be needed when a nurse does not meet alternative program entry requirements or chooses not to participate in a program. Disciplinary action is the approach used in states that do not have alternative programs. Nurses who do not meet the terms of their alternative program agreement are referred to the board for possible disciplinary action. Although the discipline process takes longer, the board has the force and effect of administrative law supporting their orders.

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APPENDIX D

Regulatory Implications of Pain Management: Critical Questions

These questions have been developed for use by board of nursing staff, investigators and attorneys when dealing with a discipline case involving one of the four pain issues identified in the *2007 Statement Regulatory Implications of Pain Management*. These questions could be useful when screening complaints, planning an investigation, holding a pre-hearing conference or other informal proceeding, or preparing for an administrative hearing.

The Nurse in Pain

- Where does the nurse work and what is his/her practice role?
- What is the nature of the nurse's pain?
- Is she/he being treated for pain?
- What is the pain management plan?
- Does the nurse have insight into his/her situation?
- Does the nurse recognize how pain or the treatment for pain may compromise his/her ability to practice safely?

- Are there familial, financial or employer issues that compel the nurse to work in spite of potential compromise to safety?
- Is there a need for a professional evaluation of the nurse's pain?

The Chemical Dependent Nurse in Pain

- Where does the nurse work and what is his/her practice role?
- Does the nurse acknowledge being chemically dependent?
- Is the nurse already in a monitoring program?
- Is the nurse presenting with dual diagnoses of CD and pain?
- What is the nature of the nurse's pain?
- Is she/he being treated for pain?
- What is the pain management plan?
- Does the nurse have insight into his/her situation?
- Does the nurse recognize how pain or the treatment for pain may compromise his/her ability to practice safely?
- Does the nurse understand how unrelieved pain can increase the risk of relapse?
- Does the nurse understand how being prescribed drugs with addictive potential can increase the risk of relapse?
- Are there familial, financial or employer issues that compel the nurse to work in spite of potential compromise to safety?
- Is there a need for a professional evaluation of the nurse's pain?
- Does the nurse have support systems in place to assist her recovery?

Nurse Role in Pain Management

- Where does the nurse work and what is his/her practice role?
- Does the nurse work with patients in pain?
- Is the nurse concerned about regulatory scrutiny of his/her practice and the administration of controlled substances?
- Is the nurse familiar with the standards of pain management nursing?
- Is the nurse familiar with the policies and procedures of the facility or agency relating to pain management?
- What professional development activities has the nurse pursued? Are any related to pain management?
- What is the nurse's attitude toward patients in pain?
- Does the nurse understand the difference between tolerance, dependence and addiction?
- Is the nurse knowledgeable about the laws and rules that govern the use of controlled substances?
- How does the nurse advocate for patients who need additional intervention for pain?

APRN Role in Pain Management

- Where does the APRN work and what is his/her practice role?
- Does the APRN work with patients in pain?
- Does the APRN have prescriptive authority and a DEA number for prescribing controlled substances?
- Is the APRN concerned about regulatory scrutiny of his/her practice and the prescription of controlled substances?
- Is the APRN familiar with the standards of pain management nursing and the additional standards for APRNs?
- Is the APRN familiar with the policies and procedures of the practice, facility or agency relating to pain management?
- What professional development activities has the APRN pursued? Are any related to pain management, pharmacology, and other treatment options for pain?
- What is the APRN's attitude toward patients in pain?
- Does the APRN understand the difference between tolerance, dependence, and addiction?
- Is the APRN knowledgeable about the laws and rules that govern the use of controlled substances?
- Does the APRN collaborate with other health team members to develop, evaluate, and adjust/change the pain management plan?
- How does the APRN advocate for patients in pain?

APPENDIX E

Pain Management Questions for Board Policy Discussion

1. Unrelieved pain is a serious public health problem in the U.S. Do you agree with this statement?
2. Do you think that pain management is recognized as an important part of nursing practice?
3. The *2007 Achieving Balance in State Policy*[11] describes a central principle of balance – that drug control and professional practice policies and their implementation should be balanced so that efforts to prevent diversion do not interfere with the medical/nursing use of opioids and other analgesics. Do you think that your state has achieved a good balance between practice expectation and drug control efforts?
4. There have been many pharmaceutical and technical developments in the last 25 years but the use of this knowledge in practice has been slow and is still incomplete. Why do you think there is this significant gap between what is known and what is done by all types of healthcare providers?
5. Do you think that nurses are concerned about regulatory scrutiny in your state? Why or why not?
6. As board members, do you believe you have a clear understanding of the difference between physical dependence, analgesic tolerance, and addiction?

11 Pain & Policy Studies Group. (2007). Achieving balance in state pain policy: A progress report card (3rd ed.) Madison, WI: University of Wisconsin School of Medicine and Public Health, Paul P. Carbone Comprehensive Cancer Center. Readers can check the report for specific jurisdictions by going to: http://www.painpolicy.wisc.edu/Achieving_Balance/PRC2007.pdf

7. Do you believe that opioids should be used as the pain treatment of last resort?
8. Should a nurse in recovery for chemical dependency be given opioids after surgery or serious injury? Why? Why not?
9. Do your state nursing practice statutes have any pain-specific (directly addressing pain management) statements? If so, where do they appear?
10. Do your state nursing administrative rules have any pain-specific statements? If so, where do they appear?
11. Do your state nursing practice statutes have any pain-related (do not directly address but contain provisions that could affect pain treatment) statements? If so, where do they appear?
12. Do your state nursing administrative rules have any pain-related statements (e.g., provisions for APRN prescriptive or controlled substance prescriptive authority)? If so, where do they appear?
13. Has your board developed a position statement, paper or guidelines to educate nurses and the public about the nurse's role in pain management? If so, how has it been used?
14. If your board has not developed a position statement, paper or guidelines, why not? Possible reasons include: no need identified, board does not have authority, limited resources, not on policy agenda, and other.
15. Does you board consider failure to provide appropriate pain management as grounds for professional discipline? Has your board ever decided such a case?

APPENDIX F

Other Resources

There are many organizations addressing pain issues. Many of these groups have developed resources with emphasis on different perspectives on the pain issue. Contact information is provided below:

American Chronic Pain Association
PO Box 850
Rocklin, CA 95677
Toll Free: 800.533.3231
Fax: 916.632.3208
e-mail: ACPA@pacbell.net

American Nurses Association
8515 Georgia Ave., Suite 400
Silver Spring, MD 20910-3492
Phone: 301.628.5000
Toll Free: 800.274.4ANA (4262)
Fax: 301.628.5001

American Pain Society
4700 W. Lake Ave.
Glenview, IL 60025
Phone: 847.375.4715
www.ampainsoc.org

American Society for Pain Management Nursing
PO Box 15473
Lenexa, KS 66285-5473
Phone: 913.895.4606
Toll Free: 888.34A.SPMN (342.7766)
Fax: 913.895.4652
e-mail: aspmn@goamp.com

American Society for PeriAnesthesia Nurses
10 Melrose Ave., Suite 110
Cherry Hill, NJ 08003-3696
Phone: 856.616.9600
Toll Free: 877.737.9696
Fax: 856.616.9601
e-mail: aspan@aspan.org
www.aspan.org

The AGS Foundation for Health in Aging
The Empire State Building
350 Fifth Ave., Suite 801
New York, NY 10118
Toll Free: 800.563.4916
www.healthinaging.org

American Pain Foundation
201 E. Charles St., Suite 710
Baltimore, MD 21201-4111
Toll Free: 888.615.PAIN (7246)
www.painfoundation.org

Arthritis Foundation
1330 W. Peachtree
Atlanta, GA 30309
Toll Free: 800.283.7800
www.arthritis.org

Federation of State Medical Boards of the U.S., Inc.
PO Box 619850
Dallas, TX 75261-9850
Phone: 817.868.4000
Fax: 817.868.4099

International Association for Pain and Chemical Dependency
101 Washington St.
Morrisville, PA 19067, USA
Phone: 215.337.6104
Fax: 215.337.0959
e-mail: info@iapcd.org

Institute for Healthcare Improvement
20 University Rd., 7th Floor
Cambridge, MA 02138 USA
Phone: 617.301.4800
Toll Free: 866.787-0831
Fax: 617.301.4848

Joint Commission
One Renaissance Blvd.
Oak Brook Terrace, IL 60181
Phone: 630.792.5000

601 13th St., NW
Suite 560 South
Washington, DC 20005
Phone: 202.783.6655
Fax: 202.783.6888

National Chronic Pain Outreach Association (NCPOA)
7979 Old Georgetown Rd., Suite 100
Bethesda, MD 20814-2429
Phone: 301.652.4948

National Headache Foundation
5252 N. Western Ave.
Chicago, IL 60625
Toll Free: 888.NHF.5552 (643.5552)
www.headaches.org

Oncology Nursing Society
125 Enterprise Dr.
Pittsburgh, PA 15275
Phone: 412.859.6100
Toll Free: 866.257.4ONS (4067)
Fax: 412.859.6162
Toll Free Fax: 877.369.5497
e-mail: customer.service@ons.org

Pain & Policy Studies Group
University of Wisconsin
Paul P. Carbone Comprehensive Cancer Center
World Health Organization Collaborating Center for
Policy and Communications in Cancer Care
406 Science Dr., Suite 202
Madison, WI 53711-1068
Phone: 608.263.7662
e-mail: ppsg@med.wisc.edu

Attachment B

Summary of Discipline Resources Review Findings

Resource	Date	Author	Information Current?	Information Accurate?	Topic Relevant?	Reference Up to Date?	Recommendations	
Chemical Dependency Handbook for Nurse Managers	2001	*Nursing Practice & Education Committee (NP&E) with L. Smith*	No	Much content is	Very	No	Major rewrite needed with updated references	Critical
Chemical Dependency Handbook for boards of nursing	1997	NP&E	No	Much content is	Very	No	Archive	Important historical document
Regulatory Management of the Chemically Dependent Nurse	1985	Nursing Practice & Standards Committee	No	No	Very	No	Keep archived	Important historical document
Sexual Misconduct Resources	1995 1996	NP&E Subcommittee	No	Much content is	Very	No	Revise and reformat	Important
Disciplinary Resources Notebook	1995	Discipline Subcommittee	No	Interesting content	Very	No	Keep archived	Historical document
Model Act/Rules (Discipline content)	2004 2005 2006	Model Revision Focus Group	Yes	Yes	Very	Yes	Current, but needs regular updating	Important
Drug Screening as a Regulatory Tool	2006	Discplinary Resources F.g. (D.R.F.G.)	Yes	Yes	Very	Yes	Current, but needs regular updating	Important
CBC Supporting Paper	1997	Greg Cooper and Vickie Sheets	No	Good Checklists and Background	Topic Is	No	Archive	Historical document
CBC as a Regulatory Tool	2005	D.R.F.G.	Yes	Yes	Yes	Yes	Current	Important
CBC Resource Pack	2006	D.R.F.G.	Yes	Yes	Yes	Yes	Current	Important
HIPDB Resources	2007	V. Sheets	Yes	Yes	Yes	Yes	Current	Important
Professional Challenges Videos	1999	J. Katz; V. Sheets	Yes	Yes	Yes	Dated	Used for e-learning	Important
Advisory Opinion/ Declaratory Statement Paper	1996	Advisory Opinion TF	No	No	No	No	Archive	Historical document

Report of the Finance Committee

Background

The Finance Committee advises the Board on the overall direction and control of the finances of the organization. The committee reviews and recommends a budget to the Board. The committee monitors income, expenditures, and program activities against projections and presents quarterly financial statements to the Board.

The Finance Committee oversees the financial reporting process, the systems of internal accounting and financial controls, the performance and independence of the independent auditors, and the annual independent audit of NCSBN financial statements. The committee recommends to the Board the appointment of a firm to serve as independent auditors.

The Finance Committee makes recommendations to the Board with respect to investment policy and assures that the organization maintains adequate insurance coverage.

Highlights of FY08 Activities

- Reviewed and discussed with management and the organization's independent accountant, Legacy Professionals LLP, the organization's audited financial statements as of and for the fiscal year ended Sept. 30, 2007. With and without management present, the Finance Committee discussed and reviewed the results of the independent accountant's examination of the internal controls and the financial statements. Based on the review and discussions referred to above, the Finance Committee recommended to the Board of Directors that the financial statements and the Report of the Auditors be accepted and provided to the Membership (see Attachment B).
- Reviewed and discussed the long range forecast and proposed NCSBN budget for FY08. Recommended approval of the FY08 budget to the Board.
- Reviewed and discussed the financial statements and supporting schedules quarterly and made recommendations to the Board of Directors to accept the reports and post them to the members section of the NCSBN website.
- Reviewed and discussed the performance of NCSBN investments with representatives from the organization's investment consultant, Becker Burke, and the organization's bond investment manager, Richmond Capital Management. Informed the Board of Directors that the current investment policy and strategy appear to be appropriate for NCSBN.
- Reviewed and discussed with the insurance brokers from USI Midwest the property and professional liability coverage for NCSBN. Informed the Board that insurance coverage for the organization was adequate.
- Reviewed and discussed with staff a report on the use of the Resource Fund by Member Boards. Informed the Board of Directors that usage of this fund continues to increase and a greater number of Member Boards are utilizing this resource.

Future Activities

- Review the budget proposal for the fiscal year beginning Oct. 1, 2008.

Attachments

A. Financial Summary Report for the Period Oct. 1, 2007 to March 31, 2008

B. Report of the Independent Auditors FY07

Members

Ruth Ann Terry, MPH, RN
California-RN, Area I, Treasurer

Elizabeth Lund, MSN, RN
Tennessee, Area III

Kathleen Sullivan, MBA, RN
Wisconsin, Area II

Ronald Lazenby, BS, CGFM
Alabama, Area III

Gayle Bellamy, BA
North Carolina, Area III

Stan Yankellow, BS
Maryland, Area IV

Rula Harb, MS, RN
Massachusetts, Area IV

Myra A. Broadway, JD, MS, RN
Maine, Area IV

Staff

Robert Clayborne, MBA, CPA
Director, Finance

Meeting Dates

- Dec. 3, 2007
- Feb. 4, 2008
- April 22, 2008
- July 8, 2008

Relationship to Strategic Plan

Strategic Initiative B:
Contributes to Member Board excellence by providing resources, communication, education, and technology.

Strategic Objective 3:
Assure integrity of fiscal management and responsiveness.

Attachment A

Financial Summary Report for the Period Oct. 1, 2007 to March 31, 2008

At March 31, 2008, the net cash position (cash and marketable securities less current liabilities) equaled $101 million. NCSBN has no significant long term liabilities except the lease for office space. Net assets increased by $7.3 million during the first six months of the fiscal year.

Revenue

NCLEX® examination revenue for the first six-months of fiscal year 2008 (FY08) increased by $1.5 million from the prior year for the same period. For the six-month period that ended March 31, 2008, 120,471 paid registrations were processed. This was a 16 percent increase over the FY07 count of 104,029. There were 12,731 registrations at international test sites during the first six months compared to 10,727 for the same period last year.

Thirty-five boards are currently using Nursys® for licensure verification. Fee revenue totaling $1.1 million for Nursys verifications is down 2 percent compared to the same period for the prior year.

NCSBN Learning Extension sales revenue increased by 21 percent for the first six months of FY08 compared to the same period for the prior year. Sales revenue has been growing annually at a rate between 18 and 20 percent for the last three years.

Although NCSBN had negative investment returns during the second quarter, the 1.2 percent total return on investments during the first quarter helped to provide positive year-to-date earnings of $1.3 million. Realized and unrealized gains on bonds offset the declines in stock values. Interest income from bonds, certificates of deposits, and money market accounts were primarily responsible for the positive earnings for the six-month period.

Expenditures

The FY08 budget includes almost $5 million for software development and computer purchases. Only $1 million was expended during the first-half of the fiscal year. It is expected that spending will catch up to the budget during the second-half of FY08.

$1.8 million of the budgeted $2.5 million for external research grants has been awarded for FY08.

Actual expenses for staff salaries and for occupancy continue to be near the budgeted amounts through the end of March, and are projected to be slightly favorable to plan for the full year. Depreciation expense will be lower than expected due to the delayed purchase of computer capital. NCLEX® processing costs are projected to exceed the budgeted amount due to the increased number of candidate registrations. Other operating expense variances are projected as timing differences and are expected to equal or be less than the budgeted amounts.

No significant unbudgeted expenses have been incurred or planned.

NCSBN Statement of Revenue and Expense

Revenue	Year to Date Actual at 3/31/08	Annual Budget	Projected Actual	Variance Favorable/ (Unfavorable)	Variance %
NCLEX revenue	26,003,750	57,600,000	61,900,000	4,300,000	7%
NCLEX program reports royalty	77,190	88,000	94,000	6,000	7%
NCLEX quick results	228,706	478,000	478,000	0	0%
NNAAP royalty income	123,506	230,000	230,000	0	0%
Learning Extension	819,666	1,616,000	1,843,000	227,000	14%
Nursys license verification fees	1,077,525	2,200,000	2,155,900	(44,100)	-2%
Nursys data query fees	5,800	10,000	10,000	0	0%
Meeting revenue	25,875	182,000	175,000	(7,000)	-4%
Membership fees	177,000	177,000	177,000	0	0%
NCLA Fees	43,000	43,000	43,000	0	0%
Government grants and other income	22,737	345,000	345,000	0	
Total Revenue	**28,604,755**	**62,969,000**	**67,450,900**	**4,481,900**	**7%**

Expense	Year to Date Actual at 3/31/08	Annual Budget	Projected Actual	Variance Favorable/ (Unfavorable)	Variance %
Salaries	2,698,868	5,681,000	5,581,000	100,000	2%
Fringe benefits	720,236	1,524,000	1,520,000	4,000	0%
NCLEX processing costs	13,263,322	29,305,000	31,737,000	(2,432,000)	-8%
Other professional service fees	1,874,508	4,651,000	4,451,000	200,000	4%
Supplies and materials	42,007	109,000	109,000	0	0%
Meetings and travel	898,968	2,687,000	2,687,000	0	0%
Telephone and communications	126,563	671,000	671,000	0	0%
Postage and shipping	84,906	206,000	206,000	0	0%
Occupancy	441,256	914,000	914,000	0	0%
Printing, copying and publications	131,575	617,000	617,000	0	0%
Library/Mmemberships	59,926	85,000	85,000	0	0%
Insurance	58,863	57,000	57,000	0	0%
Equipment rental and maintenance	850,486	1,369,000	1,369,000	0	0%
Depreciation and amortization	1,061,297	3,485,000	3,485,000	0	0%
External research grants	78,667	2,500,000	1,842,000	658,000	26%
Other expenses	159,305	720,000	720,000	0	0%
Total Expense	**22,550,753**	**54,581,000**	**56,051,000**	**(1,470,000)**	**-3%**
Operating surplus/(deficit)	6,054,002	8,388,000	11,399,900	3,011,900	
Investment Income	1,293,543	3,900,000	2,100,000	(1,800,000)	-46%
Capital	1,060,587	9,858,000	9,858,000	0	

This statement has not been audited. Projected amounts are estimates.

Attachment B

Report of the Independent Auditors FY07

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

FINANCIAL STATEMENTS

SEPTEMBER 30, 2007 AND 2006

CONTENTS

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Report of Independent Auditors	1
Statements of Financial Position	2
Statements of Activities	3
Statements of Cash Flows	4
Notes to Financial Statements	5

LEGACY
PROFESSIONALS LLP
CERTIFIED PUBLIC ACCOUNTANTS

REPORT OF INDEPENDENT AUDITORS

To the Board of Directors of
National Council of State
Boards of Nursing, Inc.

We have audited the accompanying statements of financial position of National Council of State Boards of Nursing, Inc. (NCSBN) as of September 30, 2007 and 2006, and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the NCSBN's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform an audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of National Council of State Boards of Nursing, Inc. as of September 30, 2007 and 2006, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Legacy Professionals LLP

December 21, 2007

30 North LaSalle Street | Suite 4200 | Chicago, IL 60602 | 312.368.0500 | 312.368.0746 Fax | www.legacycpas.com

National Council of State Boards of Nursing, Inc.

Statements of Financial Position

September 30, 2007 and 2006

	2007	2006
Assets		
Cash	$ 43,396,299	$ 27,785,453
Accounts receivable	281,767	271,110
Due from test vendor	5,815,288	4,895,016
Accrued investment income	669,196	518,971
Prepaid expenses	1,224,221	956,861
Investments	59,523,245	49,567,618
Net property and equipment	3,623,047	3,277,845
Cash held for others	223,704	439,651
Total assets	$ 114,756,767	$ 87,712,525
Liabilities and Net Assets		
Liabilities		
Accounts payable	$ 737,882	$ 459,531
Accrued payroll, payroll taxes and compensated absences	402,719	303,954
Due to test vendor	10,256,375	8,441,758
Deferred revenue	242,304	347,467
Grants payable	1,642,366	-
Deferred rent credits	398,359	473,058
Cash held for others	223,704	439,651
Total liabilities	13,903,709	10,465,419
Unrestricted net assets	100,853,058	77,247,106
Total liabilities and net assets	$ 114,756,767	$ 87,712,525

See accompanying notes to financial statements.

National Council of State Boards of Nursing, Inc.

Statements of Activities

Years Ended September 30, 2007 and 2006

	2007	2006
Revenue		
Examination fees	$ 61,113,670	$ 53,290,140
Other program services income	5,335,731	4,502,710
Net realized and unrealized gain on investments	1,371,162	428,805
Net realized (loss) on disposal of property and equipment	(9,686)	-
Interest and dividend income	4,820,748	3,105,970
Membership fees	177,000	177,000
Total revenue	72,808,625	61,504,625
Expenses		
Program services		
Nurse competence	34,820,112	30,784,338
Nurse practice and regulatory outcome	6,632,842	4,123,184
Information	5,407,653	5,294,590
Total program services	46,860,607	40,202,112
Supporting services		
Management and general	2,342,066	2,065,454
Total expenses	49,202,673	42,267,566
Net increase	23,605,952	19,237,059
Unrestricted net assets		
Beginning of year	77,247,106	58,010,047
End of year	$ 100,853,058	$ 77,247,106

See accompanying notes to financial statements.

National Council of State Boards of Nursing, Inc.

Statements of Cash Flows

Years Ended September 30, 2007 and 2006

	2007	2006
Cash flows from operating activities		
Net increase	$ 23,605,952	$ 19,237,059
Adjustments to reconcile net increase to net cash provided by (used in) operating activities		
Depreciation and amortization	1,795,733	1,622,619
Net realized and unrealized (gain) on investments	(1,371,162)	(428,805)
Net realized loss on disposal of property and equipment	9,686	-
Decrease in assets		
Accounts receivable	(10,657)	(31,478)
Due from test vendor	(920,272)	(2,303,562)
Accrued investment income	(150,225)	(120,193)
Prepaid expenses	(267,360)	(189,671)
Increase (decrease) in liabilities		
Accounts payable	278,351	(176,587)
Accrued payroll, payroll taxes and compensated absences	98,765	(87,267)
Due to test vendor	1,814,617	1,354,289
Deferred revenue	(105,163)	128,401
Grants payable	1,642,366	-
Deferred rent credits	(74,699)	(74,698)
Net cash provided by operating activitites	26,345,932	18,930,107
Cash flows from investing activities		
Purchases of property and equipment	(2,161,270)	(1,626,842)
Purchases of investments	(30,847,870)	(20,355,505)
Proceeds on sale of investments	22,263,405	21,881,247
Proceeds on sale of property and equipment	10,649	-
Net cash (used in) investing activities	(10,735,086)	(101,100)
Net increase	15,610,846	18,829,007
Cash		
Beginning of year	27,785,453	8,956,446
End of year	$ 43,396,299	$ 27,785,453

See accompanying notes to financial statements.

- 4 -

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 2007 AND 2006

NOTE 1. DESCRIPTION OF THE ORGANIZATION

The National Council of State Boards of Nursing, Inc. (NCSBN) is a not-for-profit corporation organized under the statutes of the Commonwealth of Pennsylvania. The primary purpose of NCSBN is to serve as a charitable and educational organization through which state boards of nursing act on matters of common interest and concern to promote safe and effective nursing practice in the interest of protecting public health and welfare including the development of licensing examinations in nursing.

The program services of NCSBN are defined as follows:

Nurse Competence - Assist Member Boards in their role in the evaluation of initial and ongoing nurse competence.

Nurse Practice and Regulatory Outcome - Assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role. Analyze the changing health care environment to develop state and national strategies to impact public policy and regulation affecting public protection.

Information - Develop information technology solutions valued and utilized by Member Boards to enhance regulatory efficiency.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting - The accompanying financial statements have been prepared on the accrual basis of accounting.

Basis of Presentation - Financial statement presentation follows the recommendations of the Financial Accounting Standards Board in its Statement of Financial Accounting Standards (SFAS) No. 117, *Financial Statements of Not-for-Profit Organizations*. Under SFAS No. 117, NCSBN is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets and permanently restricted net assets. Net assets are generally reported as unrestricted unless assets are received from donors with explicit stipulations that limit the use of the asset. NCSBN does not have any temporarily or permanently restricted net assets.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Investments - Investments are carried at fair value which generally represents quoted market price as of the last business day of the year. Money market funds and certificates of deposit are carried at cost.

Property and Equipment - Property and equipment are carried at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation is computed using the straight-line method over the following estimated useful lives:

Furniture and equipment	5 - 7 years
Course development costs	2 - 5 years
Computer hardware and software	2 - 5 years
Leasehold improvements	life of lease

Due from Test Vendor - Due from test vendor represents amounts owed by Pearson VUE for candidate applications received as well as rebates calculated on vendor performance and volume per contract. The amounts owed by Pearson VUE at September 30, 2007 and 2006 were $5,815,288 and $4,895,016 respectively.

Due to Test Vendor - Due to test vendor represents unpaid amounts to Pearson VUE for candidate testing, which includes approximately $6,966,000 at September 30, 2007 and $5,704,000 at September 30, 2006 for registered candidates who as of year end had not taken the exam. The amounts owed to Pearson VUE at September 30, 2007 and 2006 were $10,256,375 and $8,441,758 respectively.

Pearson VUE performs substantially all testing services for NCSBN.

Deferred Revenue - Deferred revenue consists of membership fees of $177,000 for 2007 and $177,000 for 2006 and online course revenue of $65,304 for 2007 and $170,467 for 2006.

Grants Payable - Represents Nurse Practice and Regulatory Outcome research grants that are generally available for periods of one to two years. NCSBN awarded nine grants ranging in amounts from $116,000 to $299,000 during the current year. $1,256,371 is due within one year and $385,995 is due within two years.

Deferred Rent Credits - Deferred rent credits were established in conjunction with taking possession of new leased office space in 2003. The landlord abated a portion of the monthly rent and made cash disbursements to NCSBN in connection with the lease. These amounts are amortized to reduce rent expense over the term of the lease.

Bad Debt Expense - NCSBN uses the direct write-off method for bad debts. An allowance for uncollectible accounts is considered unnecessary and is not provided. There was no bad debt expense for the years ended September 30, 2007 and 2006.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Statement of Cash Flows - For purposes of the statement of cash flows, NCSBN considers all marketable securities as investments. Cash includes only monies held on deposit at banking institutions, petty cash and certificates of deposit with a maturity date of less than three months when purchased. It does not include cash held for others.

Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

NOTE 3. TAX STATUS

NCSBN is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (Code) and is exempt from federal income taxes on income related to its exempt purpose pursuant to Section 501(a) of the Code and has been classified as an organization which is not a private foundation under Section 509(a).

NOTE 4. CASH CONCENTRATIONS

The cash balance as of September 30, 2007 and 2006 consisted of the following:

	2007	2006
JP Morgan Chase		
Checking account	$ 4,807,491	$ 9,202,558
Money market account	-	5,556,369
Certificates of deposit	38,328,527	12,849,144
Wells Fargo Bank:		
Checking account	231,140	168,458
Credit card merchant accounts	28,891	8,674
Petty cash	250	250
Total	$ 43,396,299	$ 27,785,453

NCSBN places its cash with financial institutions deemed to be creditworthy. Cash balances may at times exceed the insured deposit limits.

NOTE 5. INVESTMENTS

The composition of investments at September 30, 2007 and 2006 is as follows:

	2007	2006
U.S. Government and Government Agency obligations	$ 13,930,820	$ 15,404,798
Corporate bonds	21,732,084	20,452,563
Mutual funds:		
DWS Equity 500 Index Fund	9,564,629	6,693,045
Spartan Extended Market Index Fund	2,404,945	1,603,997
Spartan International Inded Fund	2,709,987	1,764,475
Others	15,243	-
Money market fund	5,165,537	55,983
Certificates of deposit - JP Morgan Chase	4,000,000	3,592,757
Total	$ 59,523,245	$ 49,567,618

On September 27, 2007 NCSBN transferred $5,000,000 to ING Clarion Partners to purchase shares of the Clarion Line Properties Fund. The $5,000,000 was placed in a money market fund until October 1, 2007.

NOTE 6. PROPERTY AND EQUIPMENT

The composition of property and equipment at September 30, 2007 and 2006 is as follows:

	2007	2006
Property and equipment		
Furniture and equipment	$ 1,324,457	1,155,528
Course development costs	271,729	271,729
Computer hardware and software	10,942,921	9,477,770
Leasehold improvements	369,614	325,998
	12,908,721	11,231,025
Less accumulated depreciation and amortization	(9,285,674)	(7,953,180)
Net property and equipment	$ 3,623,047	$ 3,277,845

Depreciation was $1,795,733 and $1,622,619 for the years ended September 30, 2007 and 2006, respectively.

NOTE 7. OPERATING LEASE

NCSBN has a lease agreement for office space which expires January 31, 2013. The following is a summary by year of future minimum lease payments required under the office lease as of September 30, 2007:

Year ending September 30,	
2008	$ 491,910
2009	506,950
2010	522,343
2011	538,011
2012	554,276
Thereafter	186,668
Total	$ 2,800,158

Rent expense for the years ended September 30, 2007 and 2006 was $837,356 and $837,396 respectively.

NOTE 8. RETIREMENT PLANS

NCSBN maintains a 403(b) defined contribution pension plan covering all employees who complete six months of employment. Contributions are made at 8% of participants' compensation. NCSBN's policy is to fund accrued pension contributions. In the year ended September 30, 2007, NCSBN instituted a 457(b) non-qualified deferred compensation plan. Eligibility is limited as it is considered top hat plan. Retirement plans expense was $423,853 and $379,895 for the years ended September 30, 2007 and 2006, respectively.

NOTE 9. COMMITMENTS

NCSBN has entered into contracts for services and accommodations for future meetings. These contracts include penalty clauses which would require NCSBN to pay certain amounts if a meeting were to be canceled or guarantees for room blocks are not fulfilled.

NCSBN has also entered into various contracts for futures services. At September 30, 2007, the requirements to fulfill these commitments approximated $352,000 and are expected to be completed within one year.

Report of the Institute of Regulatory Excellence Committee

Background

The Institute of Regulatory Excellence (IRE) Committee is charged with developing, implementing, and evaluating the IRE. The IRE was established in 2004 to meet the educational and professional development needs of nursing regulators. The IRE offers annual conferences and a four-year fellowship program. The goals of the IRE are to:

- Conduct annual institutes of graduate level regulatory education.
- Expand the body of knowledge related to regulation through research and scholarly work.
- Develop the capacity of regulators to become experts and leaders.
- Build a network of regulators to collaborate on research questions and improve regulatory practices and outcomes.

Highlights of FY08 Activities

- Selected the 2008 IRE Fellowship participants.
- Produced a comprehensive set of recommendations to enhance IRE Fellowship Program.
- Developed the IRE Fellowship Program guidelines, the fellowship program policy and selection criteria.
- Assisted the identification and selection of mentors for the fellowship participants.
- Conducted the 2008 Annual IRE Conference: Public Policy Development and the Role of Nursing Regulators in Austin, Texas, on Jan. 7-9, 2008.
- Hosted the IRE Poster Presentation Session at the 2008 NCSBN Midyear meeting.
- Planned for the 2009 Annual IRE Conference: Practice Violations and Discipline, Charleston, SC, on Jan. 12–14, 2009.
- Established a public IRE Web site.
- Conducted the first cohort-specific seminar.
- Reviewed and discussed the IRE marketing plan.

Future Activities

- Select 2009 IRE Fellowship participants and mentors.
- Approve fellowship project proposals and final reports.
- Advise staff on issues related to the implementations of the IRE Fellowship Program.
- Advise staff regarding the annual IRE Conference and the annual induction ceremony.

Attachments

A. IRE Fellowship Guidelines

B. IRE Fellowship Program Policy

C. Selection Criteria for IRE Participants

D. Guidelines for the Mentored Experience

Members

Connie Kalanek, PhD, RN, FRE
North Dakota, Area II, Chair

Mary Bowen, JD, DSN, CRNP, CNAA
Pennsylvania, Area IV

Roseann Colosimo, PhD, MSN, RN, CLNC
Nevada, Area I

Patricia Welch Dittman, PhD, RN, CDE
Florida, Area III

Judith Hiner, BSN, RN, CNA
Kansas, Area II

Barbara Morvant, MN, RN
Louisiana-RN, Area III

Teri A. Murray, PhD, RN
Missouri, Area II

Faith Fields, MSN, RN
Arkansas, Area III, Board Liaison

Staff
Maryann Alexander
Chief Officer, Nursing Regulation

Meeting Dates

- Oct. 16-17, 2007
- Dec. 13-14, 2007
- Feb. 19-20, 2008
- May 13, 2008 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative B
NCSBN contributes to Member Board excellence by providing resources, communication, education and technology.

Strategic Objectives 1
Recognize Member Board excellence

Strategic Objectives 2
Continuously provide and evaluate education, information sharing and networking opportunities

Attachment A

IRE Fellowship Guidelines

PURPOSE OF THE PROGRAM

The Institute of Regulatory Excellence (IRE) Fellowship Program is a four-year comprehensive educational and professional development program designed for nursing regulators, current or former, who desire to enhance their knowledge and leadership in nursing regulation. The IRE Fellowship Program includes experiences in analyzing issues involving public policy and regulation, strategic planning, patient safety, and communication. It also requires the application of evidence-based concepts in decision-making and leadership. The IRE Fellowship Program graduate is expected to be a leader in nursing regulation who has expertise in evidence-based regulation.

SPECIFIC OBJECTIVES FOR THE FELLOWSHIP PARTICIPANTS

1. Critically assess, analyze, and evaluate regulatory issues in health care.
2. Synthesize knowledge from various domains to form evidence-based decisions.
3. Generate and disseminate multidisciplinary knowledge that has an impact on nursing regulation.
4. Utilize evidence-based approaches to initiate change and improve nursing regulation.
5. Develop leadership skills to influence regulatory policy development and implementation.
6. Utilize innovative strategies for effective collaboration with internal and external stakeholders.

FELLOWSHIP APPLICANTS

The applicants most suitable for the IRE Fellowship Program are regulators who desire to further their professional development and growth in advancing regulatory excellence. The program is appropriate for persons working in regulation who have a clearly delineated area of interest. Although the program is specifically designed to meet the educational and professional development needs of NCSBN Member Boards, Associate Members may also apply for participation in the fellowship program.

PROGRAM CURRICULUM

Each year the IRE Fellowship Program will select a cohort of participants (maximum 10) to participate in the four-year program. Major components of the program include (see Table 1 for the IRE Program-at-a-Glance and Table 2 for Key Timelines):

- Individual learning plan;
- Annual IRE conference;
- Four cohort-specific seminars;
- Mentored experience;
- Fellowship project; and
- Ongoing individualized support from the IRE staff.

1. Individual learning plan:

The fellowship participant will create a learning plan to guide development activities over the four-year fellowship. The development plan needs to contain two main components:

(1) specific learning goals and objectives; and (2) one prospective project description. Learning goals must be clear and tangible addressing the question of what the participant wants to accomplish by the end of the fellowship program. For the prospective project, the participant will identify a problem or issue that requires a change in regulation or regulatory practice. The identified problem must have relevance to current or emerging regulatory issues. The topic the participant identifies must be the basis for the fellowship project and congruent with the learning goals.

2. Annual IRE Conference:

The goal of the IRE annual conference is to increase and enhance the knowledge, skills and leadership of regulators. The following themes of the Institute are rotated on a four-year cycle: Public Protection/Role Development of Nursing Regulators; Discipline; Competency and Evaluation/Remediation Strategies; and Organizational Structure/Behavior.

3. Four Cohort-Specific Seminars:

Each participant will participate in a total of four two-hour seminars via teleconference/ Webinar over the course of the fellowship experience. The seminars will be cohort specific. These seminars are designed to enhance individual research and leadership skills and provide opportunities to share experiences in small group discussions. Each seminar will be devoted to the discussion of a particular topic and the participants' reflection on their individual progress and experiences. The seminars will be hosted by NCSBN staff and invited guest speakers.

The seminar topics are as follows:

1. Creating a professional development plan

   A critical skill for leaders is the ability to design a professional and leadership self-development plan and manage their own learning. To conduct this seminar an expert in leadership development will be invited to explore the skills needed by participants to enable them to develop their learning goals and objectives for the fellowship. In preparation for discussion leadership self-assessment tool(s) recommended by the expert will be assigned to participants to complete prior to attending the seminar.

2. Developing a project proposal

   This seminar will focus on project development. The participants will learn about project development from an expert in writing proposals. Complex project development issues including design, methods and evaluations will be addressed by offering participants practical solutions to challenges in project development.

3. Issues associated with implementing major projects

   This seminar will provide participants with an opportunity for discussion of issues related to project implementation. The seminar will emphasize strategic skills needed to analyze and address these issues. Other selected issues such as data collection, analysis and report writing will also be included.

4. Writing for publications

   This seminar will focus on issues related to publishing in peer-reviewed journals. Emphasis is on publishing journal articles and abstracts. A nursing journal editor may be invited as the guest speaker.

4. Mentored experience:

The mentored experience is one component of the fellowship program. Mentors serve as advisors and consultants to the fellowship participants. The mentor, identified by the participant and approved by the IRE Committee, will be selected from established professional leaders. The mentor commits time and expertise in assisting the participant to achieve self-directed learning goals and completing the fellowship project as part of the requirement of the fellowship. Both mentors and participants are responsible for working together throughout the fellowship program. Each participant will have one designated mentor and each mentor will have no more than one participant to mentor during the fellowship experience.

Mentor Responsibilities

- Assist the participant in selecting realistic, meaningful, and specific goals within the framework of the objectives of the fellowship program.
- Guide the participant in developing research and leadership skills.
- Provide feedback to the participant throughout the fellowship experience.
- Facilitate the development and completion of fellowship project.
- Approve the participant's fellowship project proposal and final report before the participant submits it to the IRE for review.

Qualifications for Mentors

- Possess knowledge of patient safety, health care policy, and/or regulation.
- Has expertise in an area that relates to the participant's fellowship project.
- Possess extensive leadership experiences.
- Willingness to commit time to mentoring.
- Ability to share knowledge and experiences.

Time Commitment

Time commitment of a mentor will vary depending on the needs of the participant. It is recommended that all fellowship participants meet, either face-to-face or by teleconference, with their mentors at least every four to six months.

To further involve and motivate their participation and dedication, mentors will receive financial support to attend one IRE conference within the four-year period of time. To help the participants identify a mentor, a list of potential mentors will be compiled for the participants to consider.

5. Fellowship Project:

One large-scale fellowship project is required to be completed before the end of the four-year fellowship program. The project component of the fellowship experience offers the participant the opportunity to be innovative and self-directed while adding to the body of knowledge in nursing regulation. The fellowship project allows the participant to gain knowledge and expertise focused on a specific topic area. The project is not required to be a research project, but must be a meaningful project in nursing regulation. The participant will be provided funding up to $3,000 to support his/her project.

During the first year of the fellowship, the participant is required to conduct a preliminary literature search to increase and obtain knowledge on the topic of their choice. The participant will then submit the topic with its rationale to the IRE staff. The IRE Committee Chair and the IRE staff will determine whether the issue/topic meets the requirements of the program.

Once the topic is approved, the participant will conduct a more expansive literature review on the topic. The review of literature is a critical evaluation of published work that pertains to the topic. The purpose of the review is to help the participant in the mastery of the relevant area and help to establish the ability to carry out the proposed project. The participant is required to prepare a manuscript on the literature review. Once the literature review is completed, the participant will develop the project proposal utilizing the information obtained from the literature review.

The participant will be required to submit the proposal, including the budget request (not to exceed $3,000), to the IRE staff by June 1st of year two on the topic previously approved. The proposal is expected to be 10-12 pages in length including a bibliography. The project proposal must be reviewed and approved by the mentor before being submitted to the IRE Committee for review. The proposal must be approved by the IRE Committee before June 30th of the second year of the program.

If the proposal is not approved, the IRE Committee may require that the proposal be revised and resubmitted for further consideration before approval. Once the proposal is approved, the participant will implement the project as planned. The IRE staff will need to be informed of any subsequent major changes to the project plan before changes can be implemented.

During the project implementation phase, the participant is required to report progress at each of the cohort specific seminars. The participant is also required to provide a formal presentation of the progress of their project at the annual IRE conferences.

6. Ongoing individual support from the IRE staff:

The IRE professional staff will provide ongoing individual support to the fellowship participants including advising the fellowship participants on the suitability of a topic, reviewing and advising on the design of a proposal, and providing regular feedback throughout the fellowship project.

Table 1. IRE Fellowship Program At-A-Glance

Year 1	Year 2	Year 3	Year 4
▪ Participate in the IRE annual conference in January ▪ Develop and submit an individual learning plan ▪ Refine the area of interest and submit a topic for the fellowship project ▪ Participate in Year 1 introductory seminar ▪ Develop an issue paper based on the literature review on the topic of choice and receive feedback from the mentor and IRE staff ▪ Submit the issue paper for publication ▪ Ongoing interaction with mentor and staff	▪ Participate in the IRE annual conference in January ▪ Present issue paper at the IRE conference ▪ Develop the fellowship project proposal including budget (not to exceed $3,000), submit for review and receive feedback from staff ▪ Participate in the Year 2 cohort-specific seminar and present proposal to the same cohort for feedback ▪ Refine the project proposal and receive approval of the proposal and project funding ▪ Submit proof of Institutional Review Board Approval of the project, if it is research in nature ▪ Begin implementing the project plan ▪ Ongoing interaction with mentor and staff	▪ Participate in the IRE annual conference in January ▪ Present fellowship project at the IRE annual conference ▪ Participate in the Year 3 cohort seminar and present the progress of the project ▪ Continue to implement the project plan ▪ Ongoing interaction with the mentor and staff	▪ Participate in the IRE annual conference in January ▪ Present fellowship project at the IRE annual conference ▪ Participate in the Year 4 cohort-specific seminar and present progress of the project ▪ Submit written report and financial status report (Due May 1) ▪ Ongoing interaction with the mentor and staff

Table 2. Key Timelines

Year 0	**Activities**
September 1	Application deadline
November 1	Notification of admission to the program
December 1	Notification of acceptance to the program, guidelines and policies by the applicant with signed contract and submission of a recommended mentor
Year 1	
January 1	Fellowship begins
March 1	Submission of individual-learning plan
September 1	Submission of draft of the literature review/ issue paper
December 1	Submission of the final issue paper in the form of a manuscript*
Year 2	
January	Presentation of the issue paper at the annual conference
June 1	Submission of project proposal
Year 3	Project implementation
January	Presentation of project update at the annual conference
Year 4	
January	Presentation of project update at the annual conference
March 1	Submission of draft for final report
March 1	File for fellowship induction
May 1	Submission of final report
August (date TBA)	Induction ceremony

* The manuscript must be submitted for publication in a peer-reviewed journal; the manuscript needs to be directly related to the fellowship project.

Attachment B

IRE Fellowship Program Policy

OVERVIEW

The Institute of Regulatory Excellence (IRE) Fellowship Program has set forth polices that will assure success in the program. The fellowship policies are established by the National Council State Boards of Nursing (NCSBN) and will be applied as appropriate. The fellowship participant shall agree in writing to comply with the requirements set forth in the program guidelines and the policy documents. Following admission to the fellowship program, a participant must maintain satisfactory progression until all requirements for the fellowship are met. Participant's progress in the IRE Fellowship Program is reviewed and evaluated regularly.

PARTICIPATION

Participants are expected to participate in all learning activities at the times specified in the fellowship program guidelines. The participant must attend all sessions of the annual conferences and all parts of cohort-specific seminars. If compelling circumstances prevent participation, the participant is responsible for notifying the IRE staff of the intended absence in writing prior to the occurrence of a planned learning activity. All missed activities must be made up with alternative learning activities, which consist of reviewing learning materials and addressing related questions in writing. The participant is required to complete alternative learning activities within six months of the original time of the planned activity. If the participant misses more than one annual conference, the participant will be administratively withdrawn from the program.

FELLOWSHIP PROJECT

Participants are expected to complete an individual fellowship project. Participants can work and collaborate on a similar subject area with other participant(s) but each must design and complete a mutually exclusive project. The completion of the fellowship project is an individual learning opportunity for professional development and growth. Multiple participants working on one project diminishes the learning opportunity of individuals in experiencing all aspects of designing and completing a fellowship project.

Fellowship participants must receive written approval for their project proposal from the IRE Committee in order to progress to implementing the project. If the proposal is not approved, the IRE Committee will require that the proposal be revised and resubmitted for further consideration before final approval. The participant is prohibited from implementing the project before final approval of the proposal is granted. The IRE staff will need to be informed of and approve any subsequent major changes to the project before changes can be implemented. Conducting a project without receiving project approval from the IRE Committee will result in the project not being accepted as a fellowship project. The participant must adhere to all required guidelines established by the IRE Committee, including guidelines designed to protect the rights of human research study participants.

MENTORED EXPERIENCE

The participant's mentor is responsible for guiding and supporting the participant through the fellowship project. The mentor must approve the participant's fellowship project proposal and final report before the participant submits it to the IRE Committee for review. The participant is required to provide evidence, when the project proposal and final report are submitted for review, that they have been approved by the mentor. The submitted works will not be accepted for review if no such statement is attached with the submissions.

SUBMISSION OF REQUIRED WORKS OR REPORTS

Participants are expected to submit their work at the times specified in the fellowship program guidelines. The participant may request an extension of time to complete of the unmet fellowship requirement. The IRE staff will establish a specific time frame within which the participant must complete expected work, based on the circumstances. Any extension to the original timelines will not be longer than three months. The status of "delayed" is given when extenuating circumstances prevent completion of the expected submission and a time extension is granted. A participant who fails to submit their work within a specified period of time and does not obtain a "delayed" status will be at risk for being administratively withdrawn from the program.

LEAVE OF ABSENCE

A participant who must interrupt the fellowship experience for exceptional circumstances may apply for a one-year leave of absence. Applications for leaves of absence should be submitted in advance of the interruption in the program. A leave of absence must be approved by the IRE staff. Upon the participant's return from a leave of absence, the participant must submit an updated fellowship project plan and timeline before resuming participation in the program. The participant must comply with all policies and requirements in effect at the time of return. If a participant does not return from an approved leave of absence by the expected return date, the participant will be considered as administratively withdrawn from the fellowship program.

WITHDRAWAL FROM THE FELLOWSHIP PROGRAM

Voluntary withdrawal: Any participant who wishes to withdraw from the program should submit a letter advising the IRE staff of such decision.

Administrative withdrawal: A participant who fails to meet any requirements within a specified period of time will be administratively withdrawn from the program after two written warnings from the IRE staff. A participant who is terminated from their state board of nursing or board staff position and is no longer affiliated with a board of nursing will also be administratively withdrawn.

READMISSION TO THE FELLOWSHIP PROGRAM

Any participant who has voluntarily withdrawn or has been administratively withdrawn from the fellowship program may apply for readmission by submitting a new application by the published deadline (Sept. 1, annually). The readmitted participant is subject to all program requirements and policies in effect at the time of readmission. Learning activities completed during any previous admission will not be applied toward the requirements for completion of the fellowship program upon readmission.

FINANCIAL SUPPORT

The IRE provides financial support for participants to attend four IRE annual conferences, through waiver of conference registration fees and reimbursement of related travel and accommodation expenses. Participants will receive a meeting invitation from NCSBN prior to each of the annual IRE conferences. After receiving the invitation, the participant is responsible for making their travel arrangements. The participant is expected to comply with NCSBN Travel Policy, which is available at NCSBN Member Only Web site: https://www.ncsbn.org/NCSBNTravelPolicy0205.pdf

The IRE also provides financial support towards the fellowship project in an amount not to exceed $3,000. The participant must receive approval from the IRE Committee for the fellowship project proposal, which includes a proposed budget, prior to receiving fellowship project funds. The funds must provide direct support for the participant's fellowship project

and cannot be used for other purposes. Allowable expenses include costs such as for data collection and processing, statistical analysis, consultation, reproduction/distribution of surveys or other tools, travel related to dissemination of data, hiring a research assistant, and other expenses directly related to the fellowship project.

The fellowship project funds will be administered by NCSBN and the participants are expected to comply with the requirements delineated as follows. The approved expenses related to the fellowship project will be paid by the IRE participants and submitted for reimbursement. To receive reimbursement, expense reports must be completed and submitted to NCSBN Accounting department within 30 days of incurring the expense. Items received after 30 days will not be processed. All expenses included on the expense report must be accompanied by a valid receipt and a brief explanation of the expense. Failure to provide the receipt and explanation will result in denial of reimbursement. Expenses incurred in a foreign country will be reimbursed based upon the U.S. currency.

USE OF TITLE OF "FELLOW"

Only participants who have satisfactorily completed all the requirements of the IRE Fellowship Program will be inducted into the NCSBN Institute of Regulatory Excellence as Fellows of the Institute of Regulatory Excellence (FRE).

Attachment C

Selection Criteria for IRE Participants

A. Eligibility for the IRE Fellowship Program
In order to be eligible for the Fellowship Program, applicants must meet three requirements:

- Have at least one year of experience in nursing regulation;
- Have a master's degree or above or is enrolled in a graduate program; and
- Have a clearly delineated area of interest in nursing regulation.

B. Application for the IRE Fellowship Program
Each year the program will select a cohort of a maximum of 10 qualified individuals to participate in the program. The applicant must submit:

- A completed application form;
- A statement of applicant's goals for personal growth and why the applicant is seeking this experience;
- A description of a clearly delineated area of interest in nursing regulation;
- A curriculum vitae or resume; and
- Two letters of recommendation, at least one of which is from the executive officer or the president of their nursing regulatory agency.

C. Selection Criteria for IRE Fellowship Participants
Applicants to the IRE Fellowship Program will be selected based on the following criteria:

- A commitment to four consecutive years of structured and self-directed learning and fellowship project activity;
- Demonstrate desire to advance knowledge and leadership in nursing regulation;
- Possess potential to have significant impact on current and emerging regulation;
- Capable of critical thinking and effective communication;
- Extent to which the fellowship program will support the applicant's goals for professional growth in nursing regulation;
- Relevance of the identified area of interest to the mission of NCSBN; and
- Overall strength of the applicant's qualification as demonstrated by letters of recommendations, curriculum vitae or resume, and statements of goals and area of interest.

D. Selection Process
The IRE staff reviews applications to the fellowship program based on the eligibility and selection criteria and makes recommendations for selection of fellowship participants to the IRE Committee. Qualified applicants from NCSBN membership will be given priority in the selection process. Telephone interviews may be conducted as part of the selection process. The IRE Committee selects the final participants.

Attachment D

Guidelines for the Mentored Experience

The Institute of Regulatory Excellence (IRE) Fellowship Program is a four-year comprehensive educational and professional development program designed for regulators, current or former, who desire to enhance their knowledge and leadership in nursing regulation. The mentored experience is one component of the fellowship program. Mentors serve as advisors and consultants to the fellowship participants. The mentor, identified by the participant and approved by the IRE Committee, will be selected from established professional leaders. The mentor commits time and expertise in assisting the participant to achieve self-directed learning goals and completing the fellowship project as part of the requirement of the fellowship. Both mentors and participants are responsible for working together throughout the fellowship program. Each participant will have one designated mentor and each mentor will have no more than one participant to mentor during the fellowship experience.

MENTOR RESPONSIBILITIES:

- Assist the participant in selecting realistic, meaningful and specific goals within the framework of the objectives of the fellowship program;
- Guide the participant in developing research and leadership skills;
- Provide feedback to the participant throughout the fellowship experience;
- Facilitate the development and completion of fellowship project; and
- Approve the participant's fellowship project proposal and final report before the participant submits it to the IRE for review.

QUALIFICATIONS FOR MENTORS:

- Possess knowledge of patient safety, health care policy, and/or regulation;
- Has expertise in an area that relates to the participant's fellowship project;
- Possess extensive leadership experiences;
- Willingness to commit time to mentoring; and
- Ability to share knowledge and experiences.

TIME COMMITMENT:

Time commitment of a mentor will vary depending on the needs of the participant. It is recommended that all fellowship participants meet, either face-to-face or by teleconference, with their mentors at least every four to six months.

To further involve and motivate their participation and dedication, mentors will receive financial support to attend one IRE conference within the four-year period of time. To help the participants identify a mentor, a list of potential mentors will be compiled for the participants to consider.

BENEFITS OF SERVING AS A MENTOR:

There are many compelling reasons for becoming a mentor. The mentoring experience:

- Provides an opportunity to share your leadership and research experiences with an individual in the IRE Fellowship Program;
- Connects you with regulatory networks at state and national levels;

- Provides an opportunity to hone your skills in coaching and providing feedback;
- Gain the satisfaction of guiding someone in developing their research and leadership skills;
- Establishes a close relationship with a colleague in nursing regulation; and
- Receive funding to attend one annual IRE conference.

THE INSTITUTE OF REGULATORY EXCELLENCE FELLOWSHIP PROGRAM MENTOR IDENTIFICATION PROCESS

The mentor of an IRE Fellowship participant must be identified by the participant and approved by the IRE Committee through the mentor identification process. To apply for mentor approval, the participant must:

1. Submit the attached Mentor Information Form.
2. Provide a brief statement addressing the qualifications of the mentor for the participant using the following criteria. The mentor must:
    a. Possess knowledge of patient safety, health care policy, and/or regulation;
    b. Have expertise in an area that relates to the participant's fellowship project;
    c. Possess extensive leadership experiences;
    d. Be willing to commit time to mentoring; and
    e. Have the ability to share knowledge and experiences.
3. Submit the mentor's CV or resume.
4. The IRE Committee will evaluate the submitted materials for approval of the mentor based on the above stated criteria.

Institute of Regulatory Excellence Fellowship Program Mentor Information

The IRE Participant Information

Name: _____

State Board of Nursing: _____

Year entered the program: _____

Preferred Phone: _____ Fax: _____

Preferred email: _____

Preferred address: _____

Mentor Information

Name: _____ Credentials, Degrees: _____

Title: _____

Preferred Phone: _____ Fax:_____

Preferred E-mail: _____

Preferred Address: _____

Name of Employer: _____

Address of Employer: _____

Report of the Member Board Disaster Preparedness Committee

Background

The NCSBN Board of Directors appointed the Member Board Disaster Preparedness Committee in September 2007. The group's charge was:

1. Identify Member Board needs regarding disaster preparedness.

2. Develop Member Board model disaster preparedness plan.

The committee had two face-to-face meetings and one conference call. They also utilized e-mail to refine the model disaster preparedness plan. The committee sent out a survey to all Member Boards asking them to identify their needs regarding disaster preparedness and provide their disaster plans as applicable. Discussion by the group also focused on how to address those identified needs through the model guidelines and other avenues. Most of the committee's time was devoted to developing new guidelines for all hazards emergencies and discussing ways Member Boards could best be educated about the plan.

Highlights of FY08 Activities

- Survey and discussion of Member Board needs related to disaster preparedness.
- Discussion and development of a model disaster preparedness plan.
- Suggestions related to further education of the plan and additional resources. (i.e., development of an e-learning Wiki titled, "All-Hazards Emergency Operations" that will maintain current operational and policy information for Member Board utilization. Additionally, it can be used for training Member Boards on the new model guidelines).
- Staff is working to provide Member Boards with guidance on utilizing Nursys® in times of emergency; specific information about disaster-related communication technology options and plans to host all Boards of nursing emergency plans on its server as an additional back-up for Member Boards.
- Staff will begin to investigate developing best practices for boards of nursing interested in recruiting volunteers through initial/renewal licensure.
- Potential development on a standard licensure verification format for boards to use in times of emergency.

Future Activities

This committee has completed its charge.

Attachment

A. All-hazards Emergency Operations Guidelines for Boards of Nursing

B. Member Board Input Regarding Disaster Preparedness

Members

Mary Tello-Pool, LPN, CHSIII
North Dakota, Area II, Chair

Pamela Autrey, PhD, MBA, MSN, RN
Alabama, Area III

Diane Hanley, MS, RN, BC
Massachusetts, Area IV

Brenda McDougal, BS
North Carolina, Area III

Baerbel Merrill, MS, BSN, CIC
Wyoming, Area I (term expired during committee appointment)

Katherine Weinkam, MS, RN, CNS
California-RN, Area I

Lola Pouncey
Florida Department of Health

Nancy McKelvey, RN
American Red Cross (representing)

Jennifer Hannah
Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) (representing)

Staff

Kristin Hellquist
Director, Policy and Government Relations

Andrew Hicks
Coordinator, Policy and Member Relations

Meeting Dates

- April 10-11, 2008
- Jan. 31 – Feb. 1, 2008
- Nov. 26, 2007 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative A:
NCSBN strategically advances health and safety for the welfare of the public.

Strategic Objective 4:
Assists Member Boards with disaster preparedness.

Attachment A

ALL-HAZARDS EMERGENCY OPERATIONS GUIDELINES FOR BOARDS OF NURSING

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B. Preparing Your Business for the Unthinkable (http://www.redcross.org/services/disaster/beprepared/unthinkable2.pdf)

C. Open for Business – A Disaster Planning Toolkit for the Small to Mid-Sized Business Owner (http://www.ibhs.org/docs/OpenForBusiness.pdf)

D. Federal Emergency Management Agency (http://www.fema.gov/)

E. Emergency Management Assistance Compact (EMAC) (http://www.emacweb.org/)

F. Emergency System for the Advanced Registration of Volunteer Healthcare Professionals (ESAR-VHP)

G. The American Red Cross (www.redcross.org)

H. Altered Standards of Care in Mass Casualty Events (http://www.ahrq.gov/research/altstand/)

I. Uniform Law for Emergency Healthcare Volunteers (http://www.uevhpa.org/DesktopDefault.aspx)

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All-hazards Emergency Operations Guidelines for Boards of Nursing

I. BACKGROUND/OVERVIEW

This document provides guidance and direction to the boards of nursing (BON) ongoing activities of preparedness, response, and recovery in the event of an emergency or crisis situation.

An emergency is any unplanned event that can cause death or significant injury to employees, customers or the public; or that can shut down your business, disrupt operations, cause physical or environmental damage, or threaten the facility's financial standing or public image.

One assessment of the BON's strength is its ability to respond quickly, professionally, and supportively to board members, staff, licensees and the general public during and after a crisis, as well as its ability to resume business functions within a reasonable timeframe. Since every possible scenario for every crisis cannot be predicted, these guidelines are flexible to allow for fast adaptation to events as they unfold. The following guidelines are divided into three sections; Emergency Preparedness, Response, and Recovery.

Because it is impossible to write detailed plans covering every contingency, this is a living document that provides broad guidelines and references, rather than specific procedures and policies.

Your plan should include the following basic components:

Executive Summary: The executive summary gives management a brief overview of:

- The purpose of the plan;
- The facility's emergency management policy;
- Authorities and responsibilities of key personnel;
- The types of emergencies that could occur; and
- Where response operations will be managed.

Emergency Management Elements: This section of the guidelines briefly describes the facility's approach to the core elements of emergency management, which are:

- Direction and control;
- Communications;
- Life safety;
- Property protection;
- Community outreach;
- Recovery and restoration; and
- Administration and logistics.

Implement the Plan: Implementation means more than simply exercising the plan during an emergency. It means acting on recommendations made during the vulnerability analysis, integrating the plan into company operations, training employees, and evaluating the plan.

Note: BONs should review inter-state procedures for receiving volunteers in times of declared disasters and other special emergencies where in-state licensure/registration is not necessarily required. Additionally, BONs should devise a process for accepting, verifying, and investigating public complaints (e.g., ombudsman office/800 #) regarding emergency volunteers and working with law enforcement on issues involving criminal behavior.

II. PURPOSE

To provide for a comprehensive framework for the management of emergency prevention, preparedness and recovery that addresses the needs of BON's members, employees, licensees and the public.

III. OBJECTIVES

- To provide for the safety and well-being of individuals in the BON's offices at the time of an emergency;
- To maintain, test and implement a systematic plan which enables the BON to survive and continue its critical operations in the event of a state-of-emergency or crisis situation;
- To provide a contingency plan to guide a methodical approach to full recovery and recommencement of normal BON operations and activities in a time efficient manner;
- To establish management succession and emergency powers; and
- To assure offsite storage, maintenance and availability of data critical to the BON's operations.

IV. VULNERABILITY ASSESSMENT

A. TYPES OF EMERGENCIES MOST LIKELY TO AFFECT THE BOARD OF NURSING

Events considered emergencies include:

- Fire;
- Hazardous materials incident;
- Flood or flash flood;
- Hurricane;
- Tornado;
- Winter storm;
- Earthquake;
- Communications failure;
- Radiological accident;
- Technological;
- Civil disturbance;
- Loss of a key supplier or customer;
- Explosion;
- Biological; and/or
- Chemical.

For the purpose of these guidelines, an emergency is defined as a situation creating imminent danger to the BON:

1. Lives and health of employees, visitors or guests;

2. Physical property or assets; and/or

3. The ability of the BON to reasonably carry on with normal operations.

Emergencies could be caused by natural or man-made disasters; pandemic or epidemic infectious diseases; as well as other violent or threatening behaviors by an individual or group.

Hazard	Vulnerability			2007 Project
	Low	Medium	High	
Hurricane			X	High
Flooding			X	High
Winter Storms			X	High
Wildfire	X			Low
Landslide	X			Low
Tornado		X		Medium
Earthquake	X			Low
Fire		X		Medium
HazMat Accident		X		Medium
Computer System Failure/ Crash		X		Medium
Power Outage		X		Medium
Infectious Diseases		X		Medium
Add others as needed for individual BON				

V. BUSINESS AND FISCAL IMPACT ASSESSMENT

The purpose of this business and fiscal impact assessment is to determine the potential economic impact of emergencies upon the BON financially and to determine the "pain threshold" (i.e. length of time the BON can survive without access to systems, services, and office).

SAMPLE:

The BON maintains liquid assets equal to the cost of office operations for a 30-day period. Theoretically, the office could go without processing receipts for a 30-day period. In accordance with fiscal policies, invoices and other payables must be processed within a 30-day timeframe.

SAMPLE:

The ongoing migration and conversion of the BON's licensure applications to online services via Internet with e-commerce payment options reduces the impact of the need for staff to process paper applications in the vital licensure revenue streams.

Funds for all online applications can be processed and settled in the finance department by one individual.

VI. IDENTIFICATION OF CRITICAL FUNCTIONS (ESSENTIAL SERVICES)

Listed below are the critical functions of the BON, which must continue in the event of an emergency.

Critical Functions:

- Computer system operations;
- Validation of credentials of nurses entering the state;
- Review and issuance of licenses;
- Financial management;
- Communications;
- Enforcement;
- Human resources; and/or
- Other.

The BON's business continuity is very dependent on the functioning of its information technology systems and the security/protection of computerized mission critical records and files. Dependence on information technology resources is driven by many of the office's primary functions to include licensure, financial management, and communications. Information technology plays a central role in the BON's day-to-day business operations, as well as recovery efforts following an emergency.

VII. EMERGENCY/DISASTER PREPAREDNESS

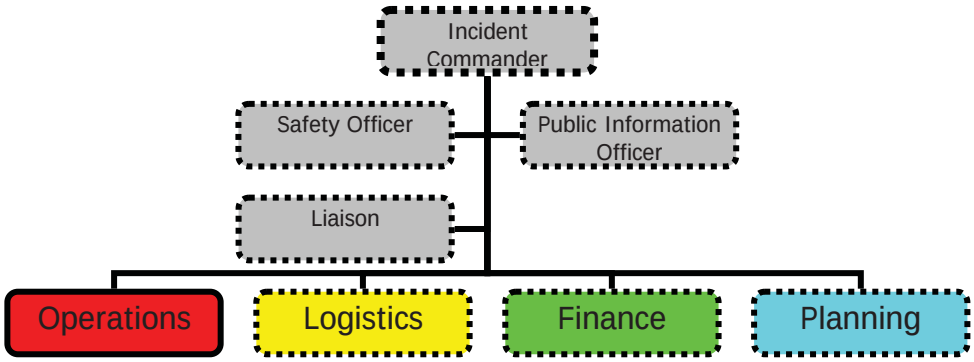
A. COMMAND AND CONTROL/DECISION MAKING PROTOCOL

The Incident Command System (ICS) was developed specifically for the fire service, but its principles are being applied to all emergencies. The ICS provides for coordinated response and a clear chain of command and safe operations. The Incident Commander (IC) is responsible for front-line management of the incident, for tactical planning and execution, for determining whether outside assistance is needed and for relaying requests for internal resources or outside assistance through the Emergency Operations Center (EOC). The IC can be any employee, but is usually a member of management. Please see the FEMA Web site listed in the resources section

SAMPLE:

In the event the executive director/executive officer is incapacitated during an emergency or as a result of other circumstances, the associate executive director-operations and associate executive director– programs shall share joint responsibility for office operations, as designated, until the BON appoints an interim replacement.

BOARD OF NURSING INCIDENT COMMAND CHART



B. OFFICE SAFETY: OFFICE ACCESS MANAGEMENT AND SECURITY

Some facilities are required to develop emergency escape procedures and routes, procedures for employees who perform or shut down critical operations before an evacuation, procedures to account for all employees, visitors and contractors after an evacuation is completed, rescue and medical duties for assigned employees, procedures for reporting emergencies, and names of persons or departments to be contacted for information regarding the plan. In an emergency, all personnel should know:

1. What is my role?
2. Where should I go?

SAMPLE:

The BON utilizes a security system as its security consultant and monitoring services. The BON issues an unmarked keyless entry access device to each employee that provides for entry into the main doors of the building, as well as the BON's suite of offices. The office's main entrance door is opened automatically at 8:00 am and closed at 5:00 pm, Monday-Friday on a routine basis. Doors are programmed to remain closed during holidays and inclement weather days. The following processes are applied:

1. The associate executive director-operations maintains a roster of keyless devices issued to employees. Upon separation, each employee returns the device and the vendor deactivates access.
2. The security system is regularly monitored and tested.
3. Lost devices are reported to the associate executive director-operations immediately.

   Note: In the event an emergency occurs during the workday and the office is being closed-the vendor must be contacted to secure the premises.

SAMPLE: OFFICE GUESTS/VISITORS

The following security procedure is utilized when staff receives guests and visitors in the BON office:

1. Upon arrival of guests and visitors to the BON office, the receptionist requests each person to register in the daily log of BON visitors and guests and then notifies the appropriate staff member of their arrival.
2. Staff members greet the guests in the reception area and escort them through the office to the appropriate location (conference room, office, etc.). Under no circumstance are visitors allowed to go unescorted.
3. At the completion of the visit, the staff member shall escort the visitor to the reception area where the visitor signs out on the daily log.

SAMPLE: LOCKED DOORS AND LIMITED ACCESS

1. The front doors (double doors) to the suite shall remain unlocked during the workday. All other entrance doors to the office remain locked.
2. Locked entrance doors to the office should not be propped or caused to remain open under any circumstance.
3. All doors are locked at 5:00 pm daily.

SAMPLE: EMERGENCY ALARM SYSTEM

An emergency alarm device is housed at the receptionist desk. A remote panic device is available for use by board members or staff, as needed within BON offices or offsite meeting locations. The remote device is maintained by the operations coordinator. Both

instruments are capable of activating a buzzer and flashing lights in the cubicle areas and simultaneously dialing 911 automatically for assistance. In the event of an emergency, the following procedure shall be implemented:

1. Receptionist or member presses alarm button;
2. Designated staff responds to the alarm, all other staff should remain in their office;
3. Designated staff evaluates the situation in accordance with training received;
4. Proper authorities respond to the 911 call.

SAMPLE: LIMITED ACCESS AND/OR QUARANTINE

Employee access to the BON offices may be denied and/or restricted in response to the need to limit employee exposure during a pandemic, epidemic infectious disease, or other emergency. BON management will comply with all local, state and national guidelines/directives to protect staff members. Staff members are expected to follow all access instructions as disseminated by BON management.

In the event limited access becomes necessary due to quarantine, isolation or other methods of community containment as invoked by public health agencies, a remote work infrastructure may be implemented by the BON, as appropriate.

C. INSURANCE COVERAGE

SAMPLE: The BON maintains corporate insurance policies to cover damages resulting from an emergency. The coverage is tailored to meet the organizational needs of the BON and is reviewed annually, during renewal, to reflect the BON's fixed assets.

The types of relevant insurance coverage include property, fire, general liability and worker's compensation.

The general timeframe for submitting and receiving payment of claims for property damage/destruction following an emergency ranges from 30-60 days, as reported by the state's Department of Insurance or other state agency.

D. DESIGNATED RISK MANAGEMENT FUND

SAMPLE: The BON earmarks monies annually to insure timely continuity of the BON's mission critical functions in the event of an emergency. Such funds are available to pay for fit-up of office space and purchase/rental of furniture, equipment, and supply items pending payment of insurance claims.

E. OFF-SITE STORAGE OF INFORMATION TECHNOLOGY SYSTEM FILES

Records Preservation: Vital records may include:

- Financial and insurance information;
- Engineering plans and drawings;
- Product lists and specifications;
- Employee, customer, and supplier databases;
- Formulas and trade secrets; and/or
- Personnel files.

Preserving vital records is essential to the quick restoration of operations. Analyzing vital records involves:

1. Classifying operations into functional categories, e.g., finance, production, sales, administration.

2. Determining essential functions for keeping the business up and running, such as finance, production, sales, etc.
3. Identifying the minimum information that must be readily accessible to perform essential functions, e.g., maintaining customer collections may require access to account statements.
4. Identifying the records that contain the essential information and where they are located.
5. Identifying the equipment and materials needed to access and use the information.

Next, establish procedures for protecting and accessing vital records. Among the many approaches to consider are:

- Labeling vital records;
- Backing up computer systems;
- Making copies of records;
- Storing tapes and disks in insulated containers;
- Storing data off-site where they would not likely be damaged by an event affecting your facility;
- Increasing security of computer facilities;
- Arranging for evacuation of records to backup facilities;
- Backing up systems handled by service bureaus; and/or
- Arranging for backup power.

SAMPLE: The board of nursing computer system files are backed up daily and secured with an off-site storage vendor. Nurse licensure data files are updated daily with Nur*sys*. This redundancy in files insures mission critical data is maintained in a safe environment and may be easily accessed for restoration of data if needed.

VIII. EMERGENCY RESPONSE

A. LEVELS OF EMERGENCY RESPONSE

SAMPLE: The executive director or designee determines a level of severity based on the information received and standard operating procedures. The levels are defined as:

Level 1: Minor incident or closing due to short-term loss of power or inclement weather conditions.

Level 2: Serious events that involve threat to people, property, or data. May involve evacuation for a limited period.

Level 3: A fairly large event that requires significant evacuation, may involve injuries, but not fatalities. Requires significant coordination with city and county emergency services.

Level 4: A major event that impacts a sizable portion of the area and surrounding regions and is beyond the scope of the BON's emergency response capabilities. Adhere to directives, ordinances, and regulations of local and federal emergency agencies.

B. EMERGENCY RESPONSE TEAM

SAMPLE: FIRST RESPONDERS

In case of an emergency event during the workday, which causes injuries to employees, visitors or guests, call 911. The BON's licensed nurses will administer first aid, emergency

care and provide triage functions in conjunction with EMS personnel, as appropriate.

The BON's Emergency Response Team (BERT) is comprised of the following individuals:

- Executive director or designee;
- Associate executive director – operations;
- Information technology director; and
- Licensure/listing manager.

This team's responsibility, in the event of an emergency, is to manage business continuity and recovery efforts.

C. EMERGENCY EVACUATION

Life Safety: Protecting the health and safety of everyone in the facility is the first priority during an emergency.

Evacuation Planning: One common means of protection is evacuation. In the case of fire, an immediate evacuation to a predetermined area away from the facility may be necessary.

Shelter: In some emergencies, the best means of protection is to take shelter either within the facility or away from the facility in a public building.

Family Preparedness: Consider ways to help employees prepare their families for emergencies. This will increase their personal safety and help the facility get back up and running. Those who are prepared at home will be better able to carry out their responsibilities at work.

SAMPLE: The BON maintains evacuation and shelter plans for the safe and orderly evacuation and sheltering of employees, visitors and guests from its premises in case of fire or other emergency events. The plan is tested, periodically, through the use of emergency drills. The plan's routes for evacuation and locations for sheltering are posted in highly visible locations throughout the office.

D. COMMUNICATIONS

Communications are essential to any BON business operation. A communications failure can be an emergency in itself, cutting off vital business activities. Communications are needed to report emergencies, to warn personnel of the danger, to keep families and off-duty employees informed about what's happening at the facility to coordinate response actions, and to keep in contact with customers and suppliers.

SAMPLE: The executive director or designee is responsible for all communication with the BON's chair, members, media, and the general public. The executive director is responsible for providing directions/instructions to be disseminated to members, staff, and the public. The executive director or designee will collaborate with the public information officer (PIO) as deemed appropriate.

The following communication methods/vehicles may be used as necessary to keep members, staff and the public informed:

General Public and Media:

In the event of an emergency circumstance, the following procedure will be followed:

1. Announcements will be placed on the BON's Web site;

2. Messages will be placed on telephone system; and

3. Press conferences and public service announcements (PSAs), as necessary.

BON Chair and Members:

SAMPLE:

Tier 1: Telephone System – 400 Mailboxes

In the event of an emergency, an emergency circumstance, or inclement weather that may cause a delay in opening or closing the office, the following procedure will be followed:

1. Call the BON main telephone number.

2. Enter 400 to access the Staff Inclement Weather Hotline.

3. Listen to the recorded message for information on office opening/closing.

Special Note: If the telephone system does not answer (i.e. the phone continues to ring), electrical power to the office is out.

Tier 2: Emergency message will be broadcast to personal e-mail of BON members and placed on the BON members Web site.

Tier 3: If a board meeting or conference call is necessary, members will be contacted by telephone.

Board Staff:

Tier 1: Telephone System – 400 Mailboxes

In the event of an emergency circumstance, or inclement weather which may cause a delay in opening or closing the office, the following procedure will be followed:

- Call the BON main telephone number.
- Enter 400 to access the staff Inclement Weather Hotline.
- Listen to the recorded message for information on office opening/closing.

Special Note: If the telephone system does not answer (i.e. the phone continues to ring), electrical power to the office is out.

Tier 2: Emergency message will be broadcast to personal e-mail of staff member.

Tier 3: BON's staff calling tree activated whereby each manager calls subordinates. Supervisors must maintain a current listing of staff accessible off premise.

Tier 4: Remote access to Intranet activated – post announcement on front page.

IX. EMERGENCY RECOVERY

A. RECOVERY

Business recovery and restoration, or business resumption, goes right to a facility's bottom line: keeping people employed and the business running. Maintain complete and accurate records at all times to ensure a more efficient emergency response and recovery. Certain records may also be required by regulation or by your insurance carriers or prove invaluable in the case of legal action after an incident. Emergency funding can be critical immediately following an emergency. Consider the need for pre-approved purchase requisitions and whether special funding authorities may be necessary.

SAMPLE: The BON contracts with a vendor for information systems emergency recovery provisions onsite. The contract contains provisions for critical information technology (IT) functions and serves as a "hot site" work group configuration with five workstations equipped with PCs and digital telephone sets. This modular temporary facility is designed

to allow for the continuity of the previously identified BON's critical business functions. In accordance with the deliverables in the contract, this self contained modular unit would be available at a designated BON location within 48 hours of notification of an emergency. Note: This deliverable is subject to emergency direction and ordinances of local, state, and federal government.

Telephone lines would be connected in the modular unit within 72 hours of an emergency by the telephone company, and the BON's lead telephone numbers forwarded to the temporary location. In the event that use of this facility becomes necessary, an abbreviated work schedule (shifts) for staff would be implemented to ensure critical functions are covered.

B. RESUMPTION OF CRITICAL FUNCTIONS

Sample of a board of nursing's Critical Business Functions:

Business Category	Essential Business Functions (Mission Critical Services)	Criticality
Information technology		
Computer system operations	Verification of licensure data	
	Access to Nursys database and other BONs for verification	
	Disseminate info via Web site	
	Electronic applications	
	Communication: e-mail	
	Financial management/ accounting	
	E-commerce transactions	
	Issuance of licenses	
	Data backup	
	License renewal/reinstatement via Internet	
	Secure alternate recovery facility	
Licensure Review/issuance of licenses/ listings	Electronic applications for endorsement/issuance of temporary licenses	
Verification	Validation of credentials of licensees/registrants entering jurisdiction	
Enforcement		
Finance	Financial transactions: e-commerce	
	Payroll	
	Accounts payable	
Operations	Telecommunication	
	Acquisition of temporary office space	
Other		

Below is a chart of the critical business functions that the BON must resume within a reasonable timeframe. A restoration priority code is included.

Criticality Ranking based on Restoration Priorities

A = Function must resume within 48 hours

B = Function must resume within 72 hours

C = Function must resume within one week

C. ALTERNATE FACILITIES

If the BON offices are deemed destroyed or damaged beyond safe occupancy, the BON should locate alternate facilities within 48 hours of notification. Logistically, the temporary recovery facility would be moved to the new alternate office location.

SAMPLE: FURNITURE/SUPPLIES

Using the quick delivery options of office furniture supply vendors, minimal fit-up furniture for office operations would be available within ten working days.

Equipment Rental

Copier and fax capability would be operational within ten working days.

Telecommunications

Voice telephone system would be operational within ten working days.

Alternate facilities suitable to accommodate all BON staff would be fit-up within 12-15 working days of loss of property.

D. PERMANENT FACILITIES

Upon completion of fit-up of alternate office space, designated staff will coordinate securing adequate permanent office space.

E. BUSINESS RECOVERY CHECKLIST

This checklist provides a task schedule for operationalizing the BON:

Senior Management (including the executive director):

- Remain visible to members, employees, public;
- Delegate recovery roles;
- Serve as media spokesperson;
- Direct, manage, and monitor the recovery;
- Avoid temptation to participate hands-on;
- Publicly praise success;
- Clearly communicate new roles, responsibilities;
- Rationally amend business plans, projections;
- Closely control media, analyst communications; and
- Re-assess/prioritize allocation of resources.

Technology/Management:

- Identify and prioritize critical applications;
- Prepare business impact analyses by unit;

- Re-assess original recovery plans;
- Continuously assess recovery site availability; and
- Recover/reconstruct all critical data.

Within the recovery environment:

- Assess the adequacy of information security;
- Assess the adequacy of system security;
- Re-assess recovery tolerance/timeframes;
- Evaluate recovery contingencies;
- Develop and test recovery plans; and
- Develop emergency plans for recovery staff.

Operations and licensure:

- Assess ability to resume licensing critical functions;
- Evaluate pros and cons of outsourcing opportunities;
- Refresh supply chain management;
- Analyze lease requirements/options;
- Establish new risk-mitigating controls;
- Formally notify insurers of claims;
- Seek interim relief from insurers; and
- Pay current insurance premiums.

Continuously re-assess the adequacy of:

- Temporary office facilities;
- Existing facilities and equipment;
- Communications; and
- Separately track losses, recovery costs.

Department Directors:

- Monitor productivity of personnel;
- Provide appropriate retraining;
- Monitor employee morale;
- Guard against employee burnout;
- Monitor for delayed stress/trauma; and
- Provide counseling and support.

Suppliers:

- Recover, reconstruct contracts, customer data; and
- Inquiries.

Financial management:

- Payroll and benefits processes;

- Accounts payable/receivable processes;
- External/internal reporting;
- Key reconciliations;
- Other financial controls;
- Meaningful key performance indicators; and
- Transaction controls/limits.

Re-assess:

- Cash flow projections;
- Budgeting and closing process/timing; and
- Timely pay to employees/beneficiaries.

X. DISTRIBUTE AND EXERCISE THE PLAN

Distribute the Plan: Maintain secure electronic and hard copy versions of the plan both on and off-site. The plan should be distributed to key staff/board members as determined by the executive officer.

Emergency planning must become part of the BON's culture. Look for opportunities to build awareness; to educate and train personnel; to test procedures; to involve all levels of management, all departments, and the community in the planning process; and to make emergency management part of what personnel do on a day-to-day basis. Provide guests with appropriate information regarding the plan for their safety.

SAMPLE: The All-Hazards Emergency Operations Plan will be reviewed and exercised annually. The plan will be revised as deemed appropriate. As revisions are incorporated into this plan, each recipient will be forwarded a package containing instructions for updating the plan as well as the changes with their respective revision dates.

Plan Reviewed/Revised: September 2005, September 2006.

Staff training:

- All staff: Sept. 26, 2006 (All Hazards Emergency Operations Plan)
- IT and Licensure staff: Jan. 10, 2007 (Critical functions – tabletop discussion with scenarios)
- All staff: Jan. 30, 2007 (In place sheltering, emergency evacuation, and social distancing during influenza outbreak with practical scenario)
- IT, Finance, Licensure staff (Critical functions – tabletop): Oct. 30, 2007 (Discussion of scenarios)
- All staff: Oct. 31, 2007 (Grubb Properties – emergency evacuation drill)

XI. APPENDICES

A. ADMINISTRATION

1. Administrative consultants and advisors
2. Board Member contacts
3. Evacuation shelters
4. Medical emergency
5. Public safety contacts

B. FINANCE

1. Financial consultants and advisors
2. Sources of emergency cash

C. INFORMATION SYSTEMS

1. Computer contact list
2. Essential computer equipment notes

D. OPERATIONS/LICENSURE

1. Backup operating facility
2. Insurance information
3. Staff contacts
4. Suppliers of equipment and supplies needed quickly in an emergency
5. Telecommunication

XII. RESOURCES

A. Emergency Management Guide for Business and Industry (http://www.cdc.gov/niosh/topics/prepared/pdfs/bizindst.pdf)

B. Preparing Your Business for the Unthinkable (http://www.redcross.org/services/disaster/beprepared/unthinkable2.pdf)

C. Open for Business – A Disaster Planning Toolkit for the Small to Mid-Sized Business Owner (http://www.ibhs.org/docs/OpenForBusiness.pdf)

D. Federal Emergency Management Agency (http://www.fema.gov/)

E. Emergency Management Assistance Compact (EMAC) (http://www.emacweb.org/)

F. Emergency System for the Advanced Registration of Volunteer Healthcare Professionals (ESAR-VHP)

G. The American Red Cross (www.redcross.org)

H. Altered Standards of Care in Mass Casualty Events (http://www.ahrq.gov/research/altstand/)

I. Uniform Law for Emergency Healthcare Volunteers (http://www.uevhpa.org/DesktopDefault.aspx)

Change #	Date Changed	Entered By	Date Entered
Revised and Updated EOP			

XIII. TOOLS

RECORD OF CHANGES

APPROVAL AND IMPLEMENTATION

Under the direction of _____ the ____Board of Nursing Emergency Operations Plan has been approved.

_____ _____

Executive Director Signature | Date

_____ _____

Board Chair Signature | Date

ACRONYMS, ABBREVIATIONS AND DEFINITIONS
(BONS SHOULD PLACE THE ONES SPECIFIC TO THEIR PLANS HERE)

BON Board of Nursing

THE FOLLOWING CONTAINS SOME SENSITIVE INFORMATION; PLEASE MAINTAIN THESE DOCUMENTS IN A SECURE MANNER.

Administrative Consultants and Advisors

Attorney
Firm: Contact:
Address:
Office Telephone:
Employee Assistance Program
Company:
Contact:
Address:
Office Telephone:

Evacuation Shelters

Shelters
Closest Shelter:
Address:
Next Closest:
Address:
Next Closest:
Address:
Next Closest:
Address:
Next Closest:
Address:

Medical Emergency

Hospitals
Closest Hospital:
Telephone:
Address:
Next Closest:
Telephone:
Address:

Public Safety Contacts

Police (Other than 911, which may be jammed)
Address:
Telephone:
Fire
Address (nearest department):
Address (headquarters):
Telephone (headquarters):

Rescue Squad/Ambulance
Contact:
Address:
Telephone:
Rescue Squad/Ambulance
Contact:
Address:
Telephone:
Poison Control Center
Contact Poison Center:
Address:
Telephone:
Federal Emergency Management Agency (FEMA)
Contact:
Address:
Telephone:
Red Cross
Address:
Telephone:
Centers for Disease Control
Telephone:

Financial Consultants and Advisors

CPA*
Contact:
Address:
Office Telephone:
E-mail:
Investment Advisor/Broker(s) (include account numbers)*
Contact:
Account Number:
Office Telephone:
E-mail:

Contact:
Account Number:
Office Telephone:
E-mail:
Telephone:

Sources of Emergency Cash

Bank 1:
Contact:
Account Number:
Office Telephone:
Account Number:
Type of Account:
Signators:

Computer Contact List

Computer Consultant or Primiary IT Staff Person
Contact:
Office Telephone:
Telephone:
Cellular Telephone:
E-mail:
Backup IT Staff Person – 1
Contact:
Office Telephone:
Telephone:
Cellular Telephone:
E-mail:
Backup IT Staff Person – 2
Contact:
Office Telephone:
Telephone:
Cellular Telephone:
E-mail:

IT Vendor Support – Network
Contact:
Office Telephone:
Cellular Telephone:
E-mail:
IT Vendor Support – Network
Contact:
Office Telephone:
Fax:
E-mail:
IT Vendors' Tech Support – Network
Contact:
Office Telephone:
Cellular Telephone:
Fax:
E-mail:
Web site:
IT Vendors' Tech Support – AS400
Contact:
Office Telephone:
Web site:
Backup Emergency Recovery Service Center
Contact:
Office Telephone:
Daily Backup Tape Storage and Courier Service
SC DATA CONTACT: TELEPHONE:
Personal Authorized to Declare and Verify Emergency to SC DATA, Inc.

Name	Cell Number/Pager	Office Number	Home Number

OFF-SITE STORAGE OF INFORMATION SYSTEM FILES

The following information system files are backed off and stored as depicted below.

Computer System	Files on Backup Media	Backup Frequency	Off-Site Location

Emergency Planning
Current level of readiness:

ESSENTIAL EQUIPMENT NOTES

Computer systems:

IBM AS/400

Currently in place:

Novell Network, Intranet Server, DMR system server, WOW development server

Document Imaging System

Telephone Verification – IVR

BON Web site

Equipment replacement capability
Insurance coverage
Replacement equipment availability and procurement IBM AS/400
Novell Network and Windows servers
Staff PCs
Telephone verification – IVR system

Suppliers of Computer Systems Needed Quickly in an Emergency

IBM AS 400
Vendor:
Contact:
Address:
Office Telephone:
Windows and Novell Servers
Vendor:
Contact:
Address:
Telephone:
Fax:

DMR System Recovery
Vendor:
Contacts:
Address:
Office Telephone:
Fax:
E-mail:
Financial Systems Recovery
Vendor:
Contact:
Address:
Telephone:
Fax:
Telephone Verification Systems Recovery
Vendor:
Contact:
Address:
Office Telephone:
E-mail:
Web Site Services, Online Licensure Services Recovery
Vendor:
Contacts:
Address:
Office Telephone: Fax:

Backup Operating Facility (Office Space)

New Location
Contact:
Address:
Office Telephone:
Note: Emergency space located within two business days
Repair and Cleanup Services
Contact:
(See landlord information)

Security Consultant:
Telephone:
Contact:
Address:
After 5:00 p.m. – Central Office:
Locksmith:
Telephone:
Fax:
Address:

Insurance Information

Property: 1 of 2 policies
Company:
Agent:
Address:
Office Telephone:
Cellular Telephone:
Coverage: Business Propoerty:
Money & Securities:
Deductible:
Type of Policy: Business Property:
Policy Number:
Property: 1 of 2 policies
Company:
Agent:
Address:
Office Telephone:
Coverage: Business Property and Fire:
All Risk:
Extended – All Risk:
Policy Number:

General Liability
Company:
Agent:
Address:
Office Telephone:
Cellular Telephone:
Coverage: General Aggregate:
Occurance Limit:
Tenant Liability:
Medical:
Policy Number:
Workers' Compensation
Company:
Agent:
Address:
Office Telephone:
Cellular Telephone:
Policy Number:

Staff Contacts

Key Officers
Contact: Executive Director
Address:
Home telephone:
Cellular telephone:
Contact: Associate Executive Director – Programs
Address:
Home telephone:
Cellular telephone:
Contact: Associate Executive Director – Operations
Address:
Home telephone:
Cellular telephone:
Key Staff
(See attached personnel roster)

Board Members
(See attached roster of board members)

Suppliers of Equipment and Supplies Needed Quickly in an Emergency

Supplier: (Quick Ship Option)
Contact:
Address:
Office telephone:
List of key items: office supplies, furniture
Supplier: (Quick Ship Option)
Address:
Office telephone:
List of key items: office supplies, furniture
Supplier:
Contact:
Address:
Office telephone:
Fax:
List of key items:
Supplier:
Contact:
Pager:
List of key items: Jobber printing (applications, NPA, envelopes)
Supplier (purchase and rental-postal equipment):
Address:
Service:
Service number:
Model number:
Postage by telephone:
Account number:
Meter service number:
Supplier (purchase and rental-copier):
Address:
Office telephone:

List of key items:
Equipment ID number:
Supplier (purchase and rental-office equipment):
Contact:
Address:
Office telephone:
Fax:
Pager:
Cellular telephone:
E-mail:
List of key items: office equipment rental
Supplier (purchase and rental-office furniture):
Address:
Office telephone:
Fax:
Web site:

Telecommunication: Voice/Video/Fax Communication Vendors

North Carolina Information Technology Services
Voice Lines
Company:
Contact:
Address:
Office telephone:
TI Digital Line and Video/Web Cast Equipment
Contact:
Address:
Office telephone:
Cellular telephone:
Installation/Service/Maintenance of Video/Web Cast/Presentation Equipment
Vendor:
Contacts:

Telephone Equipment and Engineering
Vendor: Site Code:
Contact:
Address:
Office telephone:
Fax
Company:
Contact:
Address:
Telephone:

* Maintains Video Conference/Web Cast/Presentation Program Documentation off-site by vendor.

**Offsite system program documentation for telephone, voicemail, and auto attendant maintained by vendor.

Attachment B

Member Board Input Regarding Disaster Preparedness: December 2007 Member Board E-mail Survey

State Board	Submitted plan	Identified needs outside disaster plan	Comments
Alabama	Yes		Plan is currently in "draft" status.
Alaska	No		
Arizona	No		
Arkansas	No	AR BON has identified two primary concerns: ▪ Re-establishing agency operations in the event that the disaster affects their physical location. ▪ Response to the disaster elsewhere in Arkansas related to verifications and addressing complaints against nurses involved in the disaster response.	AR BON does not have a disaster plan yet, but are working on it.
California-RN	Yes		Supplied worksheets and guidelines for all state agencies.
California-VN	No		
Colorado	No		The Colorado Disaster Preparedness Plan is incorporated under the State of Colorado Emergency Plan from the Governor. The CO BON does not have a separate plan.
Connecticut	No		
Delaware	No		
District of Columbia	No		
Florida	No		

State Board	Submitted plan	Identified needs outside disaster plan	Comments
Georgia -PN	No		
Georgia-RN	No		
Hawaii	No		
Idaho	No		
Illinois	No		
Indiana	No		
Iowa	No		Iowa has started working on a plan, but currently does not have one.
Kansas	No		KS BON also has a remote web hosting service that archive mirror copies of the www.ksbn.org Web page. This is located out of state and can be used to direct the public to gain information on KS BON should a mass disaster take place in the state of Kansas and current web hosts, which are located near KS BON offices, are not available. (response condensed)
Kentucky	Yes		
Louisiana-PN	No		
Louisiana-RN	No		
Maine	No		
Maryland	No		

State Board	Submitted plan	Identified needs outside disaster plan	Comments
Massachusetts	Yes	Other needs related to disaster preparedness that were identified include: ▪ Keeping boards abreast of disaster-related communication technology ▪ Standardization of license verification forms if Nursys isn't available ▪ Annual debriefing of boards by states that have experienced disasters to identify best practices – what worked and what didn't (and why/why not).	
Michigan	No		
Minnesota	No		
Mississippi	No		
Missouri	No		
Montana	No		
Nebraska	No		
Nevada	No		
New Hampshire	No		
New Jersey	No		The NJ BON does not have a Board specific plan.
New Mexico	No		
New York	No		
North Carolina	No		
North Dakota	No		
Ohio	Yes		
Oklahoma	No		
Oregon	No		
Pennsylvania	No		
Rhode Island	No		

State Board	Submitted plan	Identified needs outside disaster plan	Comments
South Carolina	No	No	South Carolina has a list of disaster volunteers which would be activated through the Red Cross.
South Dakota	No		
Tennessee	No		
Texas	No		
Utah	No		
Vermont	No		
Virginia	No		
Washington	No		Provided report on use of nursing students in event of disaster.
West Virginia-PN	Yes		
West Virginia-RN	No		
Wisconsin	No		
Wyoming	No		
American Samoa	No		
Guam	No		
Northern Mariana Islands	No		
Virgin Islands	No		

Other	Submitted plan	Comments
2002 NCSBN Model Plan	Yes	The template was presented to the Board of Directors in 2002.
2006 NCSBN Evacuation Plan	Yes	The plan to evacuate NCSBN staff and visitors from 111 E. Wacker in case of emergency.

Report of the NCLEX® Examination Committee

Background

As a standing committee of NCSBN, the NCLEX® Examination Committee is charged with providing psychometrically sound and legally defensible entry-level nurse licensure assessments to NCSBN Member Boards of Nursing. In order to accomplish this outcome, the committee monitors the NCLEX-RN® and NCLEX-PN® examination process to ensure policies, procedures, and standards utilized by the program meet and/or exceed guidelines proposed by the testing and measurement industry. The NCLEX® Examination Committee investigates potential future enhancements to the NCLEX® examinations, evaluates additional international testing locations for the Board of Director's, and monitors all aspects of the NCLEX examination process including: item development, examination security, psychometrics, and examination administration to ensure consistency with the Member Boards' need for examinations. The NCLEX® Examination Committee approves item development panels and recommends test plans to the Delegate Assembly.

Additionally, the committee oversees the activities of the Item Review Subcommittee (IRSC), which in turn assists with the item development and review process. Individual NCLEX® Examination Committee members act as chair of the IRSC on a rotating basis. Highlights of the activities of the NCLEX® Examination Committee and IRSC activities follow.

Highlights of FY08 Activities

CONTINUOUSLY IMPROVE DEVELOPMENT AND ADMINISTRATION OF THE NCLEX® EXAMINATIONS

NCLEX® Research

Investigation of the Chart/Exhibit type items continues to be conducted.

In addition, the committee reviewed research reports on comparing the administration methods of practice analyses. The following Practice Analyses were published, distributed to the Boards, and posted on the NCSBN Web site: *2005 RN Practice Analysis: Comparability of Survey Administration Methods, Report of the Findings from the 2006-2007 Continuous Practice Analysis*, and the *Report of Findings from the 2006 LPN/VN Practice Analysis: Comparability of Survey Administration Methods.*

The 2008 RN Practice Analysis

An RN Panel of Subject Matter Experts was selected to develop a comprehensive list of nursing activity statements that will be used to inform the test plan. In addition, panel members created knowledge statements (KSAs) to survey new graduates, faculty and supervisors. The knowledge survey will be used to inform item development. The surveys are scheduled to be completed by September 2008.

At the January 2008 meeting, the NCLEX® Examination Committee reviewed and approved a list of RN activity statements and the survey form that will be used for the 2008 RN Practice Analysis.

Joint Research Committee (JRC)

The JRC is a small group of NCSBN and Pearson VUE testing staff, along with a selected group of testing industry experts, which reviews and conducts psychometric research to provide empirical support for the use of the current NCLEX as well as to investigate possible future enhancements.

Members
NCLEX® Examination Committee

Sheila Exstrom, PhD, RN
Nebraska, Area II, Chair

Cheryl Anderson, MS, RN
California-VN, Area I

Louise Bailey, MEd, RN
California-RN, Area I

Doris Hill, PhD, CNOR, RN
Minnesota, Area II

Patricia Kay Hill, BSN, RN
North Dakota, Area II

Laurette Keiser, MSN, RN
Pennsylvania, Area IV

Susan Raph, MN, RN, CNAA
Montana, Area I

Debbie Ricks, MSN, RN
Mississippi, Area III

Patricia Spurr, EdD, MSN, RN
Kentucky, Area III

Barbara Zittel, PhD, RN
New York, Area IV

Kathy Malloch, PhD, MBA, RN
Arizona, Area I, Board-of-Director Liaison

Item Review Subcommittee

Pamela Ambush-Burris, MSN, RN
Maryland, Area IV

Claire Glaviano, MSN, RN
Louisiana-PN, Area III

Jean Houin, RN
Louisiana-PN, Area III

Lorinda Inman, MSN, RN
Iowa, Area II

Patricia Johnson, LPN
Arizona, Area I

Barbara Knopp, MSN, RN
North Carolina, Area III

Mary Ann Lambert, MSN, RN
Nevada, Area I

Nancy Mosbaek, PhD, RN
Kansas, Area II

Nancy Murphy, MS, RN
South Carolina, Area III

Judith Pelletier, MSN, RN
Massachusetts, Area IV

Connie Reichelt, MS, FNP, APRN
Montana, Area I

Donna Roddy, MSN, RN
Tennessee, Area III

G. Joan Sheverbush, MS, MN, RN
Kansas, Area II

Rhonda Taylor, MSN, RN
Washington, Area I

Staff

Anne Wendt, PhD, MSN, RN, CAE
Director, NCLEX® Examinations

Jennifer Gallagher
Operations Manager, NCLEX® Examinations

Lorraine Kenny, MS, RN
Content Manager, NCLEX® Examinations

Thomas O'Neill, PhD
Associate Director, NCLEX® Examinations

Michael Tomaselli
Administration Manager, NCLEX® Examinations

Meeting Dates

- Oct. 23-25, 2007 (NCLEX® Examination Committee Business Meeting)
- Dec. 4-7, 2007 (Item Review Subcommittee Meeting)
- Jan. 22-24, 2008 (NCLEX® Examination Committee Business Meeting)
- Feb. 6, 2008 (NCLEX® Examination Committee Conference Call)
- Feb. 19, 2008 (NCLEX® Examination Committee Conference Call)
- March 18-21, 2008 (Item Review Subcommittee Meeting)
- April 15-17, 2008 (NCLEX® Examination Committee Business Meeting)
- June 17-20, 2008 (Item Review Subcommittee Meeting)
- July 22-23, 2008 (NCLEX® Examination Committee Business Meeting
- Aug. 19-22, 2008 (Item Review Subcommittee Meeting)

Relationship to Strategic Plan

Strategic Initiative E
NCSBN is the premier organization to define and measure entry and continued competence.

Strategic Objective 1
NCLEX development, security, psychometrics, administration, and quality assurance processes are consistent with Member Boards needs for examinations.

Several new pieces of research have either been completed or are near a final draft stage. Examples include: the impact of several possible modifications to current pass/fail decision rules, an investigation into the memorableness of various innovative item types, an investigation into how chart/exhibit items are used, the comparability of item quality indices from sparse data matrices that result from computerized adaptive tests, the effects of item position on response time and the probability of a correct response, developing item variants and the impact of item compromise on the probability of passing the NCLEX.

The JRC has also approved, in some cases tentatively, research to be conducted on: indicators of item compromise on the NCLEX, the feasibility of various approaches to situated tasks as a format for new item types, and an analysis of how candidates interact with innovative item types.

ADA Advisory Panel

In 2007, an advisory panel was convened to facilitate the development of guidelines for Member Boards to use when reviewing requests for accommodations under the Americans with Disabilities Act (ADA). These ADA guidelines are in the process of being reviewed and edited and a final document is expected to be completed prior to Delegate Assembly.

Item Pool Rotation Plan

NCSBN has been working to reduce the amount of time that it takes to bring test items from conception to operational usage. Rather than having operational item pools deployed for six months, having them deployed for only three months at a time could reduce the amount of time it takes to get new items into operational usage. Security could also be enhanced by reducing the window of availability for any given operational item pool. Should items become compromised without detection by NCSBN, the amount of time those items would be available would be reduced.

Biometric Enhancements

NCSBN and Pearson VUE have been investigating two biometric enhancements. The first is an enhancement to the candidate photograph process. A new generation of cameras is available that will automatically format the candidates picture to ensure photo consistency. In addition a new technology, palm-vein recognition, will be implemented in FY09. This technology should prevent any proxy test taker from taking the test more than once and repeat proxy test takers will be identified before they ever enter the testing room. This biometric enhancement will be an addition to the current fingerprinting technology.

NCLEX® Innovations

The NCLEX® Examination Committee consistently reviews the present and future of the NCLEX® examinations with an eye towards innovations that would maintain the examination's premier status in licensure. In keeping with this plan, NCLEX® Examinations Content and Psychometric staff, in conjunction with Pearson VUE content staff, participated in developing audio and video items as part of a joint research project to develop innovative items. Pearson VUE is creating the proposed rollout plan for the innovative items.

NCLEX® Administration Enhancements

Pearson VUE is working on implementing a user interface on the NCLEX® Administration Web site that will give the Member Boards the ability to select an option on the printed score reports to either show or conceal the candidate's social security number. There is also a link on the home page of the NCLEX® Administration Web site that allows Member Boards to send either an e-mail or call the Pearson VUE NCLEX program staff with questions or comments regarding the NCLEX program.

Evaluated and Monitored NCLEX® Examination Policies and Procedures

The committee evaluated the efficacy of the Board of Directors examination-related policies and procedures as well as the NCLEX® Examination Committee policies and procedures. Revisions were made to pertinent policies and procedures in order to reflect improvements in processes that needed to be changed or refined during the fourteenth year of the administration of NCLEX via computerized adaptive testing.

MONITORED ALL ASPECTS OF EXAMINATION DEVELOPMENT

Conducted Committee and IRSC Sessions

To ensure consistency regarding the manner in which NCLEX examination items are reviewed before becoming operational, members of the NCLEX® Examination Committee continue to chair IRSC meetings. The committee and the subcommittee: (1) reviewed RN and PN operational and pretest items; (2) performed Face Validity of Real Exams; (3) provided direction regarding RN and PN alternate items; and (4) made decisions addressing revisions to content coding, Operational Definitions for Client Needs, Cognitive Codes and Integrated processes, and the NCLEX® Style Manual. In addition, the subcommittee and staff currently evaluate 100% of all validations for pretest items and 100% of all validations of master pool items scheduled for review.

Assistance from the IRSC continues to reduce the NCLEX® Examination Committee item review workload, facilitating the efforts of the NCLEX® Examination Committee toward achieving defined goals. As the item pools continue to grow, review of operational items is critical to ensure that the item pools reflect current entry-level nursing practice. At this time the number of volunteers serving on the subcommittee is 14, with representation from all four NCSBN geographic areas. Orientation to the subcommittee occurs annually and at each meeting.

Monitored Item Production

Under the direction of the NCLEX® Examination Committee, RN and PN pretest items were written and reviewed by NCLEX® Item Development Panels. NCLEX® Item Development Panels productivity can be seen in Tables 1 and 2. In addition, the IRSC reviewed real examinations for face validity and provided reports to the NCLEX® Examination Committee. As part of the contractual requirements with the test service, items that use alternate formats have been developed and deployed in item pools. Information about items using alternate formats has been made available to Member Boards and candidates in the *NCLEX® Candidate Bulletin* and on the NCSBN Web site.

NCSBN Item Development Sessions Held At Pearson VUE

Table 1. RN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Written	Review Sessions	Items Reviewed
April 02 – March 03	4	47	2611	7	1542
April 03 – March 04	2	23	1097	5	1446
April 04 – March 05	1	12	301	4	1415
April 05 – March 06	5	66	2514	7	2885
April 06 – March 07	3	47	1835	6	3195
April 07 – March 08	3	47	1815	5	2556

Table 2. PN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Written	Review Sessions	Items Reviewed
April 02 – March 03	3	33	1476	6	1547
April 03 – March 04	2	24	968	5	1611
April 04 – March 05	1	11	430	3	2124
April 05 – March 06	4	50	1938	5	3682
April 06 – March 07	3	45	2453	4	1661
April 07 – March 08	3	48	2378	6	3304

Pearson VUE continues to work with an increased number of participants at item writing sessions. The majority of these participants are rated as highly recommended or recommended to return based on their demonstrated skills. For the current year, there has been increased focus on the writing of innovative item types. The training session for writing of these item types has been lengthened by two additional hours. The difficulty of writing innovative items would explain the slight decrease in total number of items written for FY08.

Monitored Pretest Sensitivity Review

NCLEX® Pretest Sensitivity Review procedures are designed to eliminate item wording that could be elitist, stereotypical, have different meaning for different ethnic or geographic groups, or have an inappropriate tone. The composition of the panel has always had gender and ethnic/cultural representation as prescribed by committee policy. In an effort to ensure all sensitivity issues are addressed, additional members representing Americans with Disabilities and English as a Second Language candidates have been added to the potential panel makeup.

Evaluated Item Development Process and Progress

The NCLEX® Examination Committee evaluated reports provided at each meeting on item development sessions conducted by the test service. Committee representatives continue to staff each panel whenever possible, and alternately staff will monitor the panels as needed. The committee representative is either a member of the committee, subcommittee, or a staff member. The representatives monitored specific item development sessions and provided feedback to the committee and to the test service. Overall, panelists and NCLEX® Examination Committee representatives in attendance have rated item development sessions favorably.

Annually, the IRSC reviews the face validity of real exams. The IRSC and NCSBN staff viewed 10 real exams, 5 RN and 5 PN, to determine face validity. To insure congruence among reviewers, the categories and guidelines were defined and agreed upon by the NCLEX® Examination Committee. The NCLEX® Examination Committee instituted three additional face validity characteristics as determined from a survey of Member Boards regarding issues in regulation. The additional characteristics include: (1) critical thinking; (2) professional behaviors; and (3) professional boundaries. From a regulatory perspective, the reviewers were confident basing licensure decisions on the content presented in the examinations that were reviewed.

Monitored the Development of Operational NCLEX® Item Pools

The NCLEX® Examination Committee monitored the configuration of RN and PN operational item pools. The process of configuring operational item pools involves only a few variables; however, the quality control checks performed afterward are based upon both nursing content and psychometric variables. The resulting operational item pools were evaluated extensively with regard to these variables and were found to be within operational specifications. To ensure that operational item pools and the item selection algorithm were

functioning together as expected, simulated examinations were evaluated. Using these simulated examinations, the functioning of the algorithm was scrutinized with regard to the distribution of items by test plan content area; it was concluded that the operational item pools and the item selection algorithm were acting in concert to produce exams that were within NCSBN specifications and were comparable to exams drawn from previous NCLEX item pool deployments. These conclusions were reinforced by replicating the analyses using actual candidate data. The NCLEX® Examination Committee will continue to monitor performance of the NCLEX® examinations through these and other psychometric reports and analyses.

Monitored the Deployment of Operational NCLEX® Item Pools

Multiple steps are taken by Pearson VUE in advance of item pools being deployed for use. Errors were made in the April item pool deployment. The problem was identified and corrected on April 1, 2008. One of the problems was a failure to turn off (mask) RN and PN pretest and flawed operational items. The failure to mask pretest items resulted in exams freezing for some candidates. All candidates adversely affected by the freezing have been rescheduled or retested. The failure to mask certain flawed operational items also resulted in some candidates receiving items that should have been masked for a variety of reasons, ranging from typographical errors to multiple keyable answers. Upon careful analysis of the results of those candidates given items that should have been masked, the candidates' results were found to be valid and no candidate's pass/fail decision was affected.

Member Board Review of Items

Boards of nursing were provided opportunities to conduct reviews of representative examinations and NCLEX pretest items in April and October of 2007. Following the April review, boards referred items for NCLEX® Examination Committee review for one of the following reasons: not entry-level practice, not consistent with the nurse practice act, or for other reasons. Items referred for not entry-level practice reasons were reviewed by an additional item review panel in advance of the committee's review. Staff provided the committee with feedback on all items queried as part of the review process. The committee provided direction on the resolution of each Member Board item. No items were referred to the NCLEX® Examination Committee following the October review.

Staff provided Member Boards with feedback on the committee's decisions on all referred items. The NCLEX® Examination Committee encourages each Member Board to take advantage of the semiannual opportunities to review NCLEX items.

Item Related Incident Reports

Electronically filed incident reports may be submitted at Pearson Professional Centers when candidates question item content. Pearson VUE and NCSBN staff investigates each incident and reports their findings to the NCLEX® Examination Committee for decisions related to retention of the item.

MONITORED ALL ASPECTS OF EXAMINATION ADMINISTRATION

Monitored Procedures for Candidate Tracking: Candidate Matching Algorithm

The NCLEX® Examination Committee continued to monitor the status and effectiveness of the candidate-matching algorithm. On a semiannual basis, Pearson VUE conducts a check for duplicate candidate records on all candidates that have tested within the last six months. The most recent check covered the period from July 2007 through December 2007, and compared over 149,000 candidate records. The result of that check revealed that there were no duplicate candidate records and that no repeat candidate records were treated by the system as separate individuals.

Monitored the Security of the NCLEX® Examination Administrations and Item Pools

In the last year, the NCLEX® Examination Committee has continued to approach security proactively. The NCLEX® Examination Committee has worked to develop formal procedures to describe how certain categories of security-related investigations and actions are executed.

In addition to providing mechanisms and opportunities for people to inform NCSBN about issues, NCSBN has also enlisted the aid of two security firms to search the Internet for Web sites and Internet forums that might attempt to trade in NCLEX items. Also, NCSBN staff has visited many of the domestic centers and several of the international centers to review the physical and procedural security measures that are in place. NCSBN staff, Pearson VUE staff and the NCLEX® Examination Committee continue to be vigilant regarding the administration and the security of the NCLEX® examination in domestic and international test sites.

Compliance with the 30/45 Day Scheduling Rule for Domestic PPCs

The NCLEX® Examination Committee monitors compliance with the 30/45-day scheduling rule. For the period of Jan. 1, 2007, to Dec. 31, 2007, there were no candidates scheduled out of compliance in domestic sites, out of approximately 275,000 candidates testing. A dedicated department at Pearson VUE continues to analyze center utilization levels in order to project future testing volumes and meet the testing needs of all of their testing clients. As an early indicator of center usage, Pearson VUE reports to NCSBN staff on a weekly basis when sites go over 80 percent capacity levels.

Responded to Member Board Inquiries Regarding NCLEX® Examination Administration

As part of its activities, the committee and NCSBN NCLEX® Examinations department staff responded to Member Boards' questions and concerns regarding administration of the NCLEX® examinations.

More specific information regarding the performance of NCLEX test service, Pearson VUE, can be found in the Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX®) available in Attachment A of this report.

ADMINISTER NCLEX® EFFECTIVELY AND EFFICIENTLY AT INTERNATIONAL SITES

The international test centers meet the same security specifications and follow the same administration procedures as the professional centers located in Member Board jurisdictions. Please see Attachment A of this report for the 2007 candidate volumes and pass rates for the international testing centers.

STAKEHOLDERS ARE EDUCATED ABOUT THE NCLEX® EXAMINATION PROGRAM AND RELATED PRODUCTS/SERVICES

NCLEX® Research Presentations

At the 2008 American Educational Research Association (AERA) annual meeting, a paper, *Development and Evaluation of Innovative Test Items for a Computerized Nursing Licensure Exam*, was presented. AERA is an internationally recognized professional organization with the primary goal of advancing educational research and its practical application. Acceptance in these programs not only helps NCSBN share expertise on best testing practices worldwide, but also allows NCSBN to move ahead in psychometric testing solutions through the collective strength of internal and external stakeholders. Furthermore, collaborating on psychometric testing issues with external communities allows NCSBN to remain at the forefront of the testing industry.

Presentations

NCSBN NCLEX examinations staff conducted numerous NCLEX informational presentations and workshops. These included the following presentations: "Using NCLEX as Resource for Clinical and Classroom Instruction" and "Magic in Teaching," California Institute for Nursing and Health-Care (note—this presentation was given in October and February); "NCLEX Update," Mosby's Faculty Development Institute; and "How to Build an Item Bank," and "The NCLEX® Program and International Administrations," NOCA. In order to ensure NCSBN membership was kept current on the NCLEX program, the NCLEX® Examinations department also hosted two informational conference calls for Member Boards.

Additionally, as part of the departments outreach activities, content staff conducted three board of nursing sponsored regional workshops regarding the NCLEX. Regional workshops are presented for the purpose of providing information to educators preparing students to take the NCLEX® examination. The boards of nursing that hosted a regional workshop were: South Carolina, Nevada, and Missouri. These opportunities assist the NCLEX® Examinations department to educate stakeholders about the examination as well as recruit for NCSBN item development panels.

Publications

The committee continues to oversee development of various publications that accurately reflect the NCLEX examination process. This year the *2008 NCLEX-PN® Test Plan* and *NCLEX-PN® Detailed Test Plans* (Educator and Candidate versions) were published, distributed to Member Boards, and made available to the public at no charge on the NCSBN Web site. The following Practice Analyses were also published, distributed to the Boards and posted on the NCSBN Web site: *2005 RN Practice Analysis: Comparability of Survey Administration Methods, 2006-2007 RN Continuous Practice Analysis,* and the *2006 LPN/VN Practice Analysis: Comparability of Survey Administration Methods*.

Five other articles were written and published by NCSBN staff: "Investigation of the Item Characteristics of Innovative Item Formats," *CLEAR Exam Review*, Spring 2008; "An Analysis of Post Entry-Level Registered Nurse Practice," *CLEAR Exam Review*, Summer 2007; "How Many Nurses Does it Take To Develop the NCLEX-PN® Examination," *Journal of Practical Nursing*, Summer, 2007; "Continued Competence and the 2005 Post Entry-Level LPN/VN Practice," *Journal of Practical Nursing*, Fall, 2007; and "Recommending a Nursing-Specific Passing Standard for IELTS Examination," *Language Assessment Quarterly*, 2007.

Member Board Manual

NCSBN released an updated Member Board Manual. The changes included updates in the contact list for NCSBN and Pearson VUE, changes to candidate ID policy, revisions of the descriptions of automatic and statistical score-hold criteria and processes, and descriptions of the security processes used to handle violations of the candidate rules.

NCLEX® Invitational

Historically, the NCLEX Examinations staff has coordinated and hosted an NCLEX® Invitational in order to provide Member Boards, educators, and other stakeholders an opportunity to learn about the NCLEX Program. The 2007 NCLEX® Invitational was held at the InterContinental in Chicago, Illinois on Sept. 24, 2007, with approximately 250 participants. The 2008 NCLEX® Invitational is scheduled for Monday, Sept. 8, 2008, at the Omni in San Diego, California.

NCLEX® Program Reports

The committee monitored production of the NCLEX® Program Reports. Program Reports can be ordered, paid for, and downloaded via a Web-based system that permits program directors to receive reports faster and in a more portable, electronic format. Now subscribers will have the ability to e-mail the reports to those people who need it most—the faculty and

staff that design curriculum and teach students. Subscribers will have the ability to copy and paste relevant data, including tables and charts, into their own reports and presentations. This will be particularly beneficial if the program uses these reports to supplement the academic accreditation process.

NCLEX® Quick Results Service

Boards of nursing, through NCSBN, offer candidates the opportunity to learn their unofficial results (only official results are available from the boards of nursing) through the NCLEX® Quick Results Service. A candidate may call or use the Internet to access their unofficial result after two business days from completion of their examination. Currently, 44 boards of nursing participate in offering this service to their candidates. In 2007, approximately 145,000 candidates utilized this service.

Future Activities

- Conduct a continuous online RN practice analysis.
- Conduct an LPN/VN practice analysis.
- Continue to monitor all Administrative, Test Development, and Psychometric aspects of the NCLEX examination program.
- Develop a Web-based NCLEX® 101 for Member Boards.
- Evaluate all aspects of the NCLEX program and initiate additional quality assurance processes as needed.
- Evaluate NCLEX informational initiatives such as the NCLEX® Invitational, regional workshops, and other presentations.
- Evaluate ongoing international testing.
- Host the 2008 NCLEX® Invitational.
- Introduce sound and video into NCLEX Items.

Attachments

A. Annual Report of Pearson VUE for The NCLEX

Attachment A

Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX®)

This report represents information gained during Pearson VUE's fifth full year of providing test delivery services for the NCLEX® examination program to the National Council of State Boards of Nursing, Inc. (NCSBN). This report summarizes the activities of the past year.

Pearson VUE Organizational Changes

Effective January 2008, Kim Clausen assumed the role of NCLEX® Program Manager. Kim has six years of program management experience with Pearson VUE and was the NCLEX® Program Manager from 2002-2005. Kim is the main point of contact for NCLEX daily operations-related issues.

Effective Feb. 4, 2008, Jessica Bohlinger was hired as an associate program manager to help support the NCLEX program. Jessica has a wide range of experience in project and client management and works directly with Kim on program deliverables for the NCSBN.

Dr. Shu-chuan Kao and Dr. Huijuan Meng joined Dr. Tim Miller as psychometricians supporting the NCLEX program. They have recently graduated from Michigan State University and the University of Iowa, respectively, and both have substantial experience working with computer-based testing and item response theory.

Test Development

Psychometric and statistical analyses of the NCLEX data continue to be conducted and documented as required. We are continuing to develop multiple-choice items as well as items in alternate formats, such as multiple-response, drag-and-drop ordered response, and chart/exhibit items. We continue to focus on producing both the traditional and alternate-format items at targeted difficulty levels and in sufficient quantities to meet our contractual obligations.

NCLEX® Examination Operations

In addition to Pearson VUE delivering the NCLEX® examination in the U.S., NCSBN has approved Pearson VUE to deliver the NCLEX® examination at 18 international Pearson Professional Centers in 11 countries. The NCLEX is currently being administered in England, South Korea (last exam delivered May 20, 2007), Hong Kong, Australia, Canada, Mexico, Germany, Taiwan, Japan, Puerto Rico, India and the Philippines (began delivery Aug.23, 2007). These additions raise the number of Pearson Professional Centers delivering the NCLEX® examination to a current total of 222 locations globally.

Pearson VUE visits to the National Council

- Jan. 22, 2007, NCLEX® Development Group Meeting
- Jan. 24-25, 2007, NCLEX® Examination Committee Business Meeting
- March 22, 2007, NCLEX® Development Group Meeting
- April 2-4, 2007, Midyear Meeting
- April 18-19, 2007, NCLEX® Examination Committee Business Meeting
- June 26, 2007, Contract Evaluation meeting
- Aug. 6-10, 2007, Delegate Assembly
- Sept. 18-20, 2007, NCLEX-PN® Standard Setting Meeting

- Oct. 23-25, 2007, NCLEX® Examination Committee Business Meeting
- Oct. 26, 2007, Pearson VUE Business Review Meeting

Monthly Meetings/Conference Calls:

- Weekly conference calls with NCSBN, Test Development and Operations
- Monthly operations conference call with Pearson VUE and NCSBN
- Conference calls with Pearson VUE and NCSBN content staffs are held periodically as needed
- Other visits and conference calls are conducted on an as needed basis

Summary of NCLEX® Examination Results for the 2007 Calendar Year

Longitudinal summary statistics are provided in Tables 1 to 8. Results can be compared to data from the previous testing year to identify trends in candidate performance and item characteristics over time.

Compared to 2006, the overall candidate volumes were higher for both the NCLEX-RN (about +13.1 percent) and NCLEX-PN (about +5.80 percent). The RN passing rate for the overall group was 4.4 percentage points lower for 2007 than in 2006, and the passing rate for the reference group was 2.7 percentage points lower for this period compared to 2006. This change in passing rate could be attributed to the change in RN passing standard in April 2007. The PN passing rates dropped slightly from 2006; 0.3 percentage points for the overall group and 0.6 percentage points for the reference group. These passing rates are consistent with expected variations in passing rates and are heavily influenced by demographic characteristics of the candidate populations and by changes in testing patterns from year to year.

The following points are candidate highlights of the 2007 testing year for the NCLEX-RN® examination.

- Overall, 200,215 NCLEX-RN® examination candidates tested during 2007, as compared to 177,029 during the 2006 testing year. This represents an increase of approximately 13.1 percent.
- The candidate population reflected 119,574 first-time, U.S.-educated candidates who tested during 2007, as compared to 110,712 for the 2006 testing year, representing an 8.0 percent increase.
- The overall passing rate was 69.4 percent in 2007 compared to 73.8 percent in 2006. The passing rate for the reference group was 85.4 percent in 2007 and 88.1 percent in 2006. This slight decrease in the pass rate is likely attributable to the slight increase in the RN passing standard that was implemented in April 2007.
- Approximately 48.6 percent of the total group and 50.9 percent of the reference group ended their tests after a minimum of 75 items were administered. This is slightly lower than the 2006 testing year, in which 50.7 percent of the total group and 54.0 percent of the reference group took minimum-length exams.
- The percentage of maximum-length test takers was 15.4 for the total group and 14.5 for the reference group. This is slightly higher than last year's figures (14.3 percent for the total group and 12.7 percent for the reference group).
- The average time needed to take the NCLEX-RN® examination during the 2007 testing period was 2.5 hours for the overall group and 2.3 hours for the reference group (approximately the same as last year's average times of 2.5 and 2.2, respectively).

- A total of 59.0 percent of the candidates chose to take a break during their examinations (compared to 56.0 percent last year).
- Overall, 2.1 percent of the total group and 1.0 percent of the reference group ran out of time before completing the test. These percentages of candidates timing out were slightly higher than the corresponding percentages for candidates during the 2006 testing year (1.9 and 0.8 percent, respectively).
- In general, the NCLEX-RN® examination summary statistics for the 2007 testing period indicated patterns that were similar to those observed for the 2006 testing period. These results provide continued evidence that the administration of the NCLEX-RN® examination is psychometrically sound.

The following points are candidate highlights of the 2007 testing year for the NCLEX-PN® examination:

- Overall 74,933 PN candidates tested in 2007, as compared to 70,822 PN candidates who tested during 2006. This represents an increase of approximately 5.8 percent.
- The candidate population reflected 60,235 first-time, U.S.-educated candidates who tested in 2007, as compared to 56,946 for the 2006 testing year (an increase of approximately 5.8 percent).
- The overall passing rate was 78.5 percent in 2007, as compared to 78.8 percent in 2006, and the reference group passing rate was 87.3 percent in 2006 compared to 87.9 percent in 2006.
- There were 55.1 percent of the total group and 59.9 percent of the reference group who ended their tests after a minimum of 85 items were administered. These figures are slightly lower than those from the 2006 testing year in which 55.9 percent of the total group and 60.6 percent of the reference group took minimum-length exams.
- The percentage of maximum-length test takers was 16.8 percent for the total group and 14.1 percent for the reference group. These figures are slightly higher than last year's percentages.
- The average time needed to take the NCLEX-PN® examination during the 2007 testing period was 2.2 hours for the overall group, and 2.0 hours for the reference group (not appreciably different from last year's times of 2.1 and 2.0 hours, respectively).
- Overall, 1.8 percent of the total group and 0.9 percent of the reference group ran out of time before completing the test (compared to last year's figures of 1.6 and 0.8 percent, respectively).
- In general, the NCLEX-PN® examination summary statistics for the 2007 testing period indicated patterns that were similar to those observed for the 2006 testing period. These results provide continued evidence that the administration of the NCLEX-PN® examination is psychometrically sound.

Table 1: Longitudinal Technical Summary for the NCLEX-RN® Examination: Group Statistics for 2007 Testing Year										
	Jan 07 – Mar 07		Apr 07 – Jun 07		Jul 07 – Sep 07		Oct 07 – Dec 07		Cumulative 2007	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	44,516	26,923	49,305	31,379	72,952	51,424	33,442	9,848	200,215	119,574
Percent Passing	73.0	89.1	70.8	87.6	72.5	83.5	55.5	78.6	69.4	85.4
Ave. # Items Taken	119.4	113.8	122.2	118.4	127.6	125.3	129.7	127.4	124.8	121.1
% Taking Min # Items	53.2	56.5	50.2	52.7	46.6	48.0	44.5	45.6	48.6	50.9
% Taking Max # Items	13.6	11.7	14.5	13.6	16.6	16.1	16.8	16.5	15.4	14.5
Ave. Test Time	2.50	2.20	2.41	2.12	2.51	2.33	2.86	2.55	2.54	2.26
% Taking Break	59.5	49.7	53.7	43.3	57.2	50.7	69.9	59.3	59.0	49.2
% Timing Out	2.1	0.9	1.9	0.7	1.8	1.0	3.3	1.8	2.1	1.0

Table 2: Longitudinal Technical Summary for the NCLEX-RN® Examination: Group Statistics for 2006 Testing Year										
	Jan 06 – Mar 06		Apr 06 – Jun 06		Jul 06 – Sep 06		Oct 06 – Dec 06		Cumulative 2006	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	36,513	23,280	46,531	30,964	65,369	47,491	28,616	8,977	177,029	110,712
Percent Passing	73.7	87.9	76.7	90.5	78.2	87.9	59.2	81.5	73.8	88.1
Ave. # Items Taken	119.5	113.6	118.4	112.3	121.8	118.5	128.7	123.6	121.5	116.1
% Taking Min # Items	52.6	56.5	52.6	56.5	50.0	52.0	47.0	49.9	50.7	54.0
% Taking Max # Items	13.5	11.8	13.0	11.3	14.4	13.5	17.2	15.3	14.3	12.7
Ave. Test Time	2.40	2.12	2.34	2.04	2.40	2.21	2.78	2.40	2.45	2.16
% Taking Break	53.8	44.7	52.3	41.8	54.8	48.4	67.7	54.5	56.0	46.3
% Timing Out	1.8	0.7	1.7	0.6	1.6	0.8	2.9	1.4	1.9	0.8

Table 3: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2007 Testing Year										
Operational Item Statistics										
	Jan 07 – Mar 07		Apr 07 – Jun 07		Jul 07 – Sep 07		Oct 07 – Dec 07		Cumulative 2007	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.20	0.08	0.20	0.07	0.19	0.07	NA	NA
Z-Statistic	0.34	2.21	0.35	2.29	0.47	2.53	NA	NA	NA	NA
Ave. Item Time (secs)	73.7	28.9	70.8	23.7	70.1	23.0	75.9	25.7	NA	NA
Pretest Item Statistics										
# of Items	489		519		1289		217		2514	
Ave. Sample Size	821		900		596		678		710	
Mean Point-Biserial	0.07		0.07		0.07		0.10		0.07	
Mean P+	0.56		0.56		0.55		0.53		0.55	
Mean B-Value	-0.17		-0.06		-0.04		0.02		-.07	
SD B-Value	1.43		1.46		1.62		1.58		1.55	
Total Number Flagged	215		237		583		73		1108	
Percent Items Flagged	44.0		45.7		45.2		33.6		44.1	

Table 4: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2006 Testing Year										
Operational Item Statistics										
	Jan 06 – Mar 06		Apr 06 – Jun 06		Jul 06 – Sep 06		Oct 06 – Dec 06		Cumulative 2006	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.20	0.08	0.19	0.08	0.19	0.08	NA	NA
Z-Statistic	0.30	2.55	0.29	2.32	0.38	2.57	0.18	2.07	NA	NA
Ave. Item Time (secs)	69.7	16.4	69.3	19.7	68.9	19.7	76.4	30.4	NA	NA
Pretest Item Statistics										
# of Items	347		403		984		246		1980	
Ave. Sample Size	1006		1057		667		542		790	
Mean Point-Biserial	0.08		0.09		0.07		0.08		0.08	
Mean P+	0.54		0.56		0.56		0.59		0.56	
Mean B-Value	0.00		-0.07		-0.12		-0.32		-0.11	
SD B-Value	1.44		1.46		1.46		1.30		1.44	
Total Number Flagged	129		137		410		104		780	
Percent Items Flagged	37.2		34.0		41.7		42.3		39.4	

Table 5: Longitudinal Technical Summary for the NCLEX-PN Group Statistics for 2007 Testing Year										
	Jan 07 – Mar 07		Apr 07 – Jun 07		Jul 07 – Sep 07		Oct 07 – Dec 07		Cumulative 2007	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	16,500	13,123	15,566	11,741	26,184	22,619	16,683	12,752	74,933	60,235
Percent Passing	77.9	87.0	74.9	86.1	83.3	89.7	74.4	84.3	78.5	87.3
Ave. # Items Taken	117.3	112.5	118.6	112.9	113.0	109.5	116.9	112.0	116.0	111.3
% Taking Min # Items	53.6	58.2	52.7	58.4	58.2	61.9	54.1	59.4	55.1	59.9
% Taking Max # Items	17.7	14.8	18.4	15.0	15.1	13.1	16.9	14.3	16.8	14.1
Ave. Test Time	2.15	1.97	2.30	2.09	2.11	1.97	2.4	2.21	2.21	2.04
% Taking Break	51.3	44.2	57.2	49.3	48.9	43.7	61.1	54.4	53.5	47.2
% Timing Out	1.5	0.8	2.1	1.1	1.4	0.7	2.4	1.3	1.8	0.9

Table 6: Longitudinal Technical Summary for the NCLEX-PN Group Statistics for 2006 Testing Year										
	Jan 06 – Mar 06		Apr 06 – Jun 06		Jul 06 – Sep 06		Oct 06 – Dec 06		Cumulative 2006	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	14,830	11,780	14,857	11,337	25,036	21,745	16,099	12,084	70,822	56,946
Percent Passing	78.3	88.2	75.9	86.9	83.9	90.0	74.1	84.6	78.8	87.9
Ave. # Items Taken	115.8	110.9	116.1	110.6	111.0	107.7	119.3	114.4	115.0	110.4
% Taking Min # Items	55.4	60.4	54.7	60.4	59.7	63.0	51.6	56.6	55.9	60.6
% Taking Max # Items	16.6	13.8	16.7	13.6	13.6	11.7	18.6	15.7	16.0	13.4
Ave. Test Time	2.17	1.98	2.21	1.99	2.02	1.89	2.25	2.05	2.14	1.96
% Taking Break	51.4	43.9	53.6	45.2	45.8	40.6	56.0	48.2	50.9	43.8
% Timing Out	1.5	0.7	1.9	0.8	1.2	0.7	1.9	0.9	1.6	0.8

Table 7: Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2007 Testing Year										
Operational Item Statistics										
	Jan 07 – Mar 07		Apr 07 – Jun 07		Jul 07 – Sep 07		Oct 07 – Dec 07		Cumulative 2007	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.20	0.08	0.21	0.08	0.20	0.08	NA	NA
Z-Statistic	0.17	2.43	0.17	2.31	0.27	2.38	NA	NA	NA	NA
Ave. Item Time (secs)	64	17.5	67.1	19.9	63.4	18.8	66.2	17.0	NA	NA
Pretest Item Statistics										
# of Items	488		408		1,040		461		2397	
Ave. Sample Size	631		719		542		685		644	
Mean Point-Biserial	0.10		0.12		0.10		0.13		0.11	
Mean P+	0.53		0.57		0.47		0.49		0.52	
Mean B-Value	-0.08		-0.28		0.36		0.19		0.13	
SD B-Value	1.33		1.31		1.66		1.94		1.62	
Total Number Flagged	167		102		404		149		822	
Percent Items Flagged	34.2		25.0		38.8		32.3		34.3	

Table 8: Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2006 Testing Year										
Operational Item Statistics										
	Jan 06 – Mar 06		Apr 06 – Jun 06		Jul 06 – Sep 06		Oct 06 – Dec 06		Cumulative 2006	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.19	0.07	0.20	0.07	0.20	0.08	NA	NA
Z-Statistic	0.18	2.56	0.14	2.11	0.26	2.16	0.16	2.43	NA	NA
Ave. Item Time (secs)	63.3	16	65.6	17.3	62.7	16.6	65.8	18.1	NA	NA
Pretest Item Statistics										
# of Items	198		198		683		594		1673	
Ave. Sample Size	1487		1424		760		507		835	
Mean Point-Biserial	0.11		0.09		0.09		0.10		0.10	
Mean P+	0.52		0.51		0.50		0.55		0.52	
Mean B-Value	-0.03		0.09		0.21		-0.19		0.03	
SD B-Value	1.46		1.31		1.60		1.29		1.46	
Total Number Flagged	63		76		274		212		625	
Percent Items Flagged	31.8		38.4		40.1		35.7		37.4	

Update of Testing Internationally

In addition to the PPC's that deliver the NCLEX® examination domestically, Pearson VUE has 18 international PPCs in England, South Korea* (last exam delivered May 20, 2007), Hong Kong, Australia, India, Taiwan, Japan, Canada, Mexico, Germany and Manila** (began delivery August 23, 2007). Represented in the tables below is international volume by: Table 1 – Member Board; Table 2 – Testing Center; Table 3 – Country of Education and Table 4 – Pass/Fail rate.

Table 1: NCLEX International Volume – by Member Board, January 1 – December 31, 2007

Name	Total	Banglaore, India	Burnaby, BC, Canada	Chennai, India	Tokyo, Japan	Frankfurt, Germany	Honk Kong, Hong, Kong	Hyderbad, India	London, England	Manila,** Philippines	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico	Seoul,* South Korea	Sydney, Australia	Taipei, Taiwan	Toronto, Canada	Yokohama City, Japan
Alabama	4	0	0	0	0	0	2	0	1	1	0	0	0	0	0	0	0	0	0	0
Alaska	4	0	0	0	0	0	1	0	1	1	0	0	0	1	0	0	0	0	0	0
American Samoa	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Arizona	324	32	3	57	8	4	49	16	37	45	0	1	8	55	0	1	0	3	5	0
Arkansas	14	1	0	0	0	0	3	0	2	5	0	0	0	0	0	0	1	0	2	0
California – RN	9701	91	94	110	23	30	3919	25	895	3685	2	21	100	188	0	31	59	317	103	8
California – VN	2	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Colorado	38	0	2	1	0	3	13	0	10	6	0	1	0	0	0	0	1	1	0	0
Connecti-cut	68	7	1	3	0	0	19	1	2	28	0	0	5	0	0	0	0	0	2	0
Delaware	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
District of Columbia	25	1	0	10	0	0	3	1	1	5	0	0	2	1	0	0	0	0	1	0
Florida	538	115	0	118	3	10	50	27	50	79	0	1	20	50	5	0	2	4	4	0
Georgia – PN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Georgia – RN	44	1	0	1	1	2	9	0	20	5	0	0	1	0	2	0	0	0	2	0
Guam	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Hawaii	35	1	0	0	2	1	9	6	12	4	0	0	0	0	0	0	0	0	0	0
Idaho	6	0	0	0	0	0	3	0	2	1	0	0	0	0	0	0	0	0	0	0
Illinois	319	9	0	9	2	1	86	1	24	162	0	0	6	4	0	8	1	2	4	0
Indiana	6	0	0	2	0	0	1	1	0	1	0	0	1	0	0	0	0	0	0	0
Iowa	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kansas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kentucky	25	5	0	5	0	0	3	3	0	1	0	0	7	0	0	0	0	0	1	0
Louisiana – PN	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0

Table 1: NCLEX International Volume – by Member Board, January 1 – December 31, 2007

Name	Total	Banglaore, India	Burnaby, BC, Canada	Chennai, India	Tokyo, Japan	Frankfurt, Germany	Honk Kong, Hong, Kong	Hyderbad, India	London, England	Manila,** Philippines	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico	Seoul,* South Korea	Sydney, Australia	Taipei, Taiwan	Toronto, Canada	Yokohama City, Japan
Louisiana RN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Maine	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Maryland	92	1	0	1	2	1	33	1	14	35	0	0	0	1	0	0	2	1	0	0
Massachu-setts	182	51	0	21	0	2	2	17	10	4	0	1	53	15	0	0	1	1	4	0
Michigan	223	51	4	13	0	2	52	17	9	35	0	0	20	11	0	0	3	0	6	0
Minnesota	295	1	82	1	2	1	10	0	1	8	0	33	0	1	0	0	0	0	155	0
Mississippi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Missouri	11	0	0	0	0	0	2	0	0	7	0	1	0	0	0	0	0	0	1	0
Montana	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nebraska	37	0	1	0	0	0	11	0	0	14	0	0	0	0	0	0	0	0	11	0
Nevada	115	5	1	7	3	0	37	5	8	40	0	0	1	2	0	3	0	2	1	0
New Hampshire	2	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0
New Jersey	168	7	0	4	1	1	61	6	11	60	0	0	8	3	1	3	2	0	0	0
New Mexico	2695	174	2	215	8	8	481	68	621	733	3	0	204	97	0	21	27	23	10	0
New York	2884	105	12	51	557	11	161	13	117	189	0	4	50	28	9	1144	9	380	38	6
North Carolina	99	12	3	5	0	8	25	5	7	17	0	0	5	6	0	0	0	0	6	0
North Dakota	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Northern Mariana Island	527	0	0	0	3	0	165	1	6	306	0	0	0	13	0	24	4	4	0	1
Ohio	28	1	0	2	0	0	6	2	7	3	0	0	2	1	0	0	3	0	1	0
Oklahoma	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oregon	27	0	2	0	0	2	11	2	0	8	0	1	0	0	0	0	1	0	0	0
Pennsylva-nia	124	13	2	13	0	1	4	6	41	18	0	1	11	7	4	0	2	0	1	0
Rhode Island	10	2	0	3	0	0	1	0	0	2	0	0	0	2	0	0	0	0	0	0
South Carolina	5	1	0	0	0	0	1	0	1	2	0	0	0	0	0	0	0	0	0	0

Table 1: NCLEX International Volume – by Member Board, January 1 – December 31, 2007

Name	Total	Banglaore, India	Burnaby, BC, Canada	Chennai, India	Tokyo, Japan	Frankfurt, Germany	Honk Kong, Hong, Kong	Hyderbad, India	London, England	Manila,** Philippines	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico	Seoul,* South Korea	Sydney, Australia	Taipei, Taiwan	Toronto, Canada	Yokohama City, Japan
South Dakota	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	9	0	1	0	0	0	4	0	1	2	0	0	0	0	1	0	0	0	0	0
Texas	193	8	2	11	0	2	23	8	39	67	1	0	13	4	6	2	2	2	2	1
Utah	2	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Vermont	4200	455	4	507	7	7	410	146	696	988	2	0	286	598	0	34	38	13	9	0
Virginia	151	27	0	56	0	0	4	10	8	11	0	0	20	14	0	0	1	0	0	0
Virgin Islands	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Washing-ton	13	0	8	0	1	0	0	0	0	1	0	0	0	0	0	0	0	2	1	0
West Virginia – RN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
West Virginia – PN	19	0	0	0	0	0	5	0	0	14	0	0	0	0	0	0	0	0	0	0
Wisconsin	22	3	0	6	0	0	1	0	0	3	0	0	2	4	3	0	0	0	0	0
Wyoming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	23290	1180	225	1232	623	97	5681	388	2655	6601	8	66	825	1106	31	1271	159	755	371	16

*** Seoul delivered the NCLEX exam until May 20, 2007**
**** Manila began delivery on Aug. 23, 2007**

Table 2: NCLEX International Volume – by Testing Center, January 1 – December 31, 2007

Site ID	City	Total	07-Jan	07-Feb	07-Mar	07-Apr	07-May	07-Jun	07-Jul	07-Aug	07-Sep	07-Oct	07-Nov	07-Dec
50497	Banga-lore	1180	88	103	139	121	113	126	93	48	28	106	112	103
50486	Burnaby	225	9	18	21	11	10	18	30	16	17	32	25	18
50498	Chennai	1232	86	110	115	107	123	109	118	98	88	88	94	96
50500	Tokyo	623	4	5	10	6	19	79	84	70	85	68	96	97
50491	Frankfurt	97	7	4	7	14	10	6	7	6	11	10	9	6
50493	Hong Kong	5681	669	522	573	578	597	664	705	553	241	231	242	106
50496	Hydera-bad	388	42	10	14	14	20	20	43	50	62	58	30	25
50140	London	2655	211	215	154	205	260	231	229	174	237	239	263	237
54555	Manila**	6601	0	0	0	0	0	0	0	488	1242	1733	1542	1596
50503	Mexico City	8	1	1	1	0	1	1	1	0	1	0	1	0
50485	Mon-treal	66	5	7	10	8	5	5	2	3	3	7	6	5
50494	Mumbai	825	59	41	74	71	79	78	72	95	103	84	27	42
50495	New Delhi	1106	89	99	115	84	86	68	87	126	98	90	94	70
47108	San Juan	31	4	2	5	1	6	3	1	1	3	2	3	0
50502	Seoul*	1271	251	286	274	164	296	0	0	0	0	0	0	0
50482	Sydney	159	8	8	25	13	16	13	16	16	10	14	14	6
50506	Taipei	755	25	26	37	43	40	63	114	91	80	82	78	76
50484	Toronto	371	24	31	36	30	29	31	31	32	36	33	31	27
50501	Yoko-hama City	16	1	1	1	0	1	0	0	3	2	1	1	5
	Total	23290	1583	1489	1611	1470	1711	1515	1633	1870	2347	2878	2668	2515

*** Seoul delivered the NCLEX exam until May 20, 2007**
**** Manila began delivery on Aug. 23, 2007**

Table 3: NCLEX International Volume – by Country of Education, January 1 – December 31, 2007

Name	Total	Banglaore, India	Burnaby, BC, Canada	Chennai, India	Tokyo, Japan	Frankfurt, Germany	Honk Kong, Hong, Kong	Hyderbad, India	London, England	Manila,** Philippines	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico	Seoul,* South Korea	Sydney, Australia	Taipei, Taiwan	Toronto, Canada	Yokohama City, Japan
Armenia	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Australia	39	0	3	0	1	1	0	0	3	0	0	0	0	0	0	2	29	0	0	0
Austria	2	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Barbados	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Belarus	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Belgium	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Botswana	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Brazil	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Cambodia	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Cameroon	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Canada	347	0	103	0	2	1	0	0	0	0	0	44	0	0	0	0	0	0	197	0
Chile	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
China	263	0	2	0	0	2	213	0	15	0	0	0	3	10	0	3	7	1	7	0
Colombia	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0
Croatia	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Czech Republic	3	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Denmark	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Egypt	2	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0
Ethiopia	35	0	0	1	0	2	0	0	0	0	0	0	32	0	0	0	0	0	0	0
Fiji	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
Finland	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0
France	2	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Germany	18	0	0	0	0	16	0	0	2	0	0	0	0	0	0	0	0	0	0	0
Ghana	24	0	0	0	0	0	0	0	19	0	0	0	3	0	0	0	0	0	2	0
Grenada	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Guatemala	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Guyana	10	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	2	0
Haiti	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Hong Kong	9	0	0	0	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	0
Hungary	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Iceland	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
India	5113	1142	6	1203	0	6	5	369	692	0	0	0	637	1019	0	0	17	1	16	0
Indonesia	4	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1	0

Table 3: NCLEX International Volume – by Country of Education, January 1 – December 31, 2007

Name	Total	Banglaore, India	Burnaby, BC, Canada	Chennai, India	Tokyo, Japan	Frankfurt, Germany	Honk Kong, Hong, Kong	Hyderbad, India	London, England	Manila,** Philippines	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico	Seoul,* South Korea	Sydney, Australia	Taipei, Taiwan	Toronto, Canada	Yokohama City, Japan
Iran	14	0	2	1	0	1	0	0	4	1	0	1	1	1	0	0	1	0	1	0
Ireland	8	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0
Israel	39	0	0	0	0	17	0	0	22	0	0	0	0	0	0	0	0	0	0	0
Italy	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Jamaica	23	0	0	0	0	0	0	0	19	0	0	0	0	0	1	0	0	0	3	0
Japan	29	0	0	0	23	0	0	0	1	0	0	0	0	0	0	0	0	1	0	4
Jordan	6	1	0	1	0	0	0	0	2	0	0	0	2	0	0	0	0	0	0	0
Kenya	59	1	0	0	0	1	1	0	18	0	0	0	34	3	0	1	0	0	0	0
Korea, North	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1	0	0
Korea, South	2130	0	8	0	545	0	61	0	1	7	0	0	0	0	0	1140	2	354	6	6
Kuwait	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Lebanon	5	0	0	0	0	1	0	0	1	1	0	0	2	0	0	0	0	0	0	0
Lesotho	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0
Malawi	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0
Malaysia	4	0	0	0	0	0	0	0	3	0	0	0	1	0	0	0	0	0	0	0
Mexico	4	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0
Moldova	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Myanmar	3	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	1	0	0
Nepal	10	0	0	0	0	0	0	0	3	0	0	0	0	7	0	0	0	0	0	0
Nether-lands	4	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0
New Zealand	16	0	1	0	0	0	0	0	2	0	0	0	1	0	0	0	12	0	0	0
Nigeria	55	0	0	0	0	3	1	1	40	0	2	0	3	2	0	0	0	0	3	0
Norway	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0
Oman	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pakistan	6	0	0	0	0	0	3	0	2	0	0	0	0	0	0	0	0	0	1	0
Peru	2	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0
Philippines	14033	23	85	16	49	14	5246	12	1445	6573	0	19	93	59	0	119	80	80	115	5
Pitcairn	2	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
Poland	2	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0
Portugal	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0

Table 3: NCLEX International Volume – by Country of Education, January 1 – December 31, 2007

Name	Total	Banglaore, India	Burnaby, BC, Canada	Chennai, India	Tokyo, Japan	Frankfurt, Germany	Honk Kong, Hong, Kong	Hyderbad, India	London, England	Manila,** Philippines	Mexico City, Mexico	Montreal, QC, Canada	Mumbai, India	New Delhi, India	San Juan, Puerto Rico	Seoul,* South Korea	Sydney, Australia	Taipei, Taiwan	Toronto, Canada	Yokohama City, Japan
Puerto Rico	29	0	0	0	0	0	0	0	2	0	0	0	0	0	27	0	0	0	0	0
Romania	16	0	1	0	0	11	0	0	3	0	0	0	1	0	0	0	0	0	0	0
Russian Federation	6	0	0	0	0	3	0	0	1	0	0	0	1	0	0	0	0	0	1	0
Saint Lucia	3	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0
Sierra Leone	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Singapore	25	1	0	4	0	0	10	1	0	0	0	0	2	0	0	0	1	6	0	0
South Africa	30	0	1	0	0	0	1	0	27	0	0	0	1	0	0	0	0	0	0	0
Spain	2	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Sri Lanka	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
St. Vincent and Grenadines	5	0	0	0	0	0	0	0	2	0	0	0	0	0	2	0	0	0	1	0
Sweden	5	0	0	0	0	1	0	0	4	0	0	0	0	0	0	0	0	0	0	0
Taiwan	297	0	0	0	0	0	1	0	3	0	0	0	0	0	0	0	0	293	0	0
Thailand	120	0	1	0	0	0	110	0	1	0	0	0	0	0	0	0	0	8	0	0
Trinidad and Tobago	4	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0
Tunisia	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Ukraine	17	0	0	0	0	1	0	0	14	0	0	0	0	2	0	0	0	0	0	0
United Arab Emirates	3	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0
United Kingdom	222	0	1	1	0	0	0	0	214	0	0	0	1	0	0	0	1	1	3	0
U.S.	115	10	11	4	3	8	13	4	20	15	1	1	3	2	1	4	2	5	7	1
Viet Nam	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Zambia	11	0	0	0	0	0	1	0	8	0	0	0	1	0	0	0	1	0	0	0
Zimbabwe	14	0	0	0	0	0	0	0	10	0	0	0	0	0	0	0	4	0	0	0
Total	23290	1180	225	1232	623	97	5681	388	2655	6601	8	66	825	1106	31	1271	159	755	371	16

*** Seoul delivered the NCLEX exam until May 20, 2007**
**** Manila began delivery on August 23, 2007**

Table 4: NCLEX International Volume by Pass/Fail Rate, January 1 – December 31, 2007

Site ID	City	Country	Total Taken	Total Passed	07-Jan (%)	07-Feb (%)	07-Mar (%)	07-Apr (%)	07-May (%)	07-Jun (%)	07-Jul (%)	07-Aug (%)	07-Sep (%)	07-Oct (%)	07-Nov (%)	07-Dec (%)
50482	Sydney	Australia	159	85	62.50	50.00	76.00	53.85	62.50	38.46	37.50	43.75	30.00	57.14	64.29	33.33
50486	Burnaby	Canada	225	109	44.44	55.56	42.86	63.64	70.00	66.67	36.67	37.50	58.82	56.25	28.00	44.44
50485	Montreal	Canada	66	28	80.00	42.86	50.00	37.50	20.00	40.00	50.00	66.67	66.67	0.00	50.00	40.00
50484	Toronto	Canada	371	153	41.67	35.48	30.56	46.67	34.48	64.52	48.39	46.88	19.44	60.61	35.48	33.33
50491	Frankfurt	Germany	97	56	85.71	75.00	42.86	71.43	60.00	50.00	42.86	16.67	54.55	70.00	55.56	50.00
50493	Hong Kong	Hong Kong	5681	2982	54.11	54.79	63.18	51.90	51.93	50.60	53.05	52.62	49.79	43.72	41.74	36.79
50497	Bangalore	India	1180	853	68.18	78.64	76.26	80.17	84.96	74.60	66.67	72.92	67.86	66.04	65.18	58.25
50498	Chennai	India	1232	905	87.21	77.27	73.04	79.44	77.24	72.48	73.73	69.39	69.32	73.86	64.89	62.50
50496	Hyderabad	India	388	270	78.57	90.00	78.57	64.29	65.00	55.00	62.7	68.00	75.81	67.24	60.00	76.00
50494	Mumbai	India	825	565	67.80	78.05	75.68	78.87	60.76	79.49	58.33	66.32	66.02	65.48	70.37	57.14
50495	New Delhi	India	1106	744	78.65	67.68	76.52	65.48	81.40	67.65	67.82	72.22	58.16	57.78	59.57	47.14
50500	Tokyo	Japan	623	390	75.00	40.00	60.00	33.33	52.63	69.62	58.33	60.00	64.71	60.29	66.67	62.89
50501	Yokohama City	Japan	16	10	100.00	100.00	100.00	0.00	0.00	0.00	0.00	0.00	100.00	0.00	100.00	80.00
50502	Seoul*	Korea, South	1271	715	57.77	58.04	57.66	50.61	55.07	0.00	0.00	0.00	0.00	0.00	0.00	0.00
50503	Mexico City	Mexico	8	2	0.00	0.00	0.00	0.00	0.00	100.00	0.00	0.00	100.00	0.00	0.00	0.00
54555	Manila**	Philippines	6601	3467	0.00	0.00	0.00	0.00	0.00	0.00	0.00	57.79	53.62	51.93	52.79	50.44
47108	San Juan	Puerto Rico	31	9	50.00	0.00	20.00	0.00	33.33	0.00	0.00	0.00	66.67	50.00	33.33	0.00
50506	Taipei	Taiwan	755	409	52.00	50.00	51.35	46.51	47.50	58.73	55.26	53.85	55.00	57.32	48.72	61.84
50140	London	United Kingdom	2655	1108	45.02	45.58	46.10	46.83	45.77	43.72	42.79	35.06	38.82	40.59	38.78	32.91
		Total	23290	12860	59.40	52.58	53.72	48.36	47.50	49.03	39.69	43.14	57.64	46.22	49.23	43.53

*** Seoul delivered the NCLEX exam until May 20, 2007**
**** Manila began delivery on Aug. 23, 2007**

Report of the Nursys® Committee

Background

The Nursys® Committee has received new charges from the NCSBN Board of Directors. Many of these charges are based on recommendations to the Board of Directors from the Nursys® Business Design Advisory Panel in FY07. The FY08 Nursys® Committee charges are:

- Develop Nursys customer service metrics and system performance statistics;
- Propose alternate financial models for licensure verification through Nursys;
- Investigate barriers and devise strategies to acquire licensure data from every Member Board; and
- Investigate development of a national unique identifier for the Nursys database system.

Highlights of FY08 Activities

- Recommend to the NCSBN Board of Directors to approve a national unique identifier using the NCLEX® candidate ID. This will allow Member Boards to identify a nurse in the absence of a social security number, date of birth, different spelling of first/maiden/last name, and other data elements which creates the possibility of multiple records of the same individual in the Nursys or their own database. Member Boards can use this unique identifier without any privacy breach concerns. Such unique identifiers will not compromise any state or federal privacy laws and has been successfully implemented by various industries in their own environment.
- Recommend to the NCSBN Board of Directors to approve changes to Nursys.com QuickConfirm, allowing employers to perform licensure verifications at no cost. Currently Nursys.com is the only place where an employer can verify if a privilege to practice discipline has been placed against a nurse's multi state license. Working with Member Boards, Nursys.com will be marketed through hospital associations, recruiting agencies and professional nursing organizations. Nursys.com will include more discipline details making it a one-stop shop for the public.
- Recommend to the NCSBN Board of Directors a revised Nursys verification fee model and providing the verification to a single state with no expiration date to facilitate workflow of license verification by Member Boards and the ability to provide enhanced reporting to Member Boards in regards to nurse workforce.
- Recommend to the NCSBN Board of Directors to approve inclusion of various data sets in Nursys to make the product better for Member Boards.

Future Activities

- The Nursys® Committee has been conducting interviews with Member Boards who do not participate in Nursys to better understand reasons for not submitting licensure data to Nursys and if those Member Boards would be interested in submitting licensure data for the purposes of building an unduplicated licensure database for research and benefit of all Member Boards without the possibility of giving up license verification fee. The information is being compiled in a report to be submitted to NCSBN Board of Directors at the August board meeting.

Attachments

None

Members

Adrian Guerrero
Kansas, Area II, Chair

Michelle Cartee
Missouri, Area II

Gino Chisari, MSN, RN
Massachusetts, Area IV, Board Liaison

Heidi Goodman
California-RN, Area I

DeWayne Hatcher
Oregon, Area I

Adam Henriksen
Arizona, Area I

Sandra Johanson, RN
Kentucky, Area III

Polly Johnson, MSN, RN, FAAN
North Carolina, Area III

Staff

Sandy Rhodes
Manager, Nursys® Program

Nur Rajwany, MS
Director, Information Technology

Meeting Dates

- Sept. 18, 2007 (Conference Call)
- Nov. 15-16, 2007
- Jan. 10-11, 2008
- March 10, 2008
- June 9, 2008 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative D:
NCSBN provides comprehensive data management for use by Member Boards and external stakeholders.

Strategic Objective 1:
Maintain a comprehensive national nurse licensure database.

Report of the TERCAP™ Committee

FY08 Board of Director Charges:

1. Provide resources to promote the use of TERCAP™ by Member Boards.
2. Advise staff on the content of a TERCAP™ Roundtable.
3. Analyze aggregated data submitted by Member Boards using TERCAP.

Background

The Taxonomy of Error, Root Cause Analysis Practice Responsibility (TERCAP™) Committee was appointed by the FY07 Board of Directors to bring the work of the Practice Breakdown Advisory Panel to Member Boards. The work involved the development of a data collection instrument that can be used by Member Boards to collect information for the purpose of identifying the root causes of nursing practice breakdown. The goal of the project is to learn from the experiences of nurses who have been involved in episodes of practice breakdown and to discover characteristics of the involved nurses, in addition to health care team behaviors and system components that may have contributed to the practice breakdown. The overall aim is to promote patient safety by better understanding nursing practice breakdown and using the information to improve the effectiveness of nursing regulation. The data collection instrument can be used by boards of nursing as an investigatory intake document to capture data on discipline cases that will be part of a national data set. Participating Member Boards will have access to their own data submitted online in TERCAP.

The major charge of the TERCAP™ Committee has been to provide resources to promote the use of TERCAP by Member Boards. Various and ongoing resources have been created or enhanced. Committee members and staff follow up with Member Boards that express an interest in using TERCAP. User conference calls were initiated and are held every other month. TERCAP, developed as an online data collection tool, has been improved based on comments from users. TERCAP remains available online only to Member Boards whose staff have participated in a TERCAP educational offering, generally through TERCAP™ Webinars. Executive officer permission is also required before online access to TERCAP, through NCSBN's Members Only Web site, is granted.

The TERCAP™ Committee members and staff planned and held the TERCAP™ Forum, "TERCAP Implementation – Taking it to the Next Level," on April 7, 2008, in Chicago. Twenty-seven different Member Boards participated, in person or via the live Webcast. Many questions were asked of the informative speakers, who were able to provide answers based on personal experience using TERCAP.

Between February 2007, when TERCAP was initially launched online, and May 2008, 11 Member Boards submitted 238 cases. Additional Member Boards have expressed an interest in implementing TERCAP. After an interim report was provided by the NCSBN Research Department, a few changes to the data collection instrument were made, which the Research Department staff advised would not change the inter-rater reliability. Case selection criteria were developed for acceptance into the TERCAP research project, so the data submitted for analysis was consistent and more complete. The case selection criteria include: 1) a nurse was involved in the practice breakdown; 2) patient involvement was with one or more identifiable patient(s); and 3) cases of practice breakdown involved board disciplinary action, enrollment in an alternative program, or letter of concern issued (i.e., any action other than case dismissal). The changes to TERCAP™ 2007 online, suggested by the committee and approved by the researchers, resulted in the creation of TERCAP™ 2008 online. The revisions were made to all of the TERCAP documents and have been shared with TERCAP users.

Members

Lisa Emrich, MSN, RN
Ohio, Area II, Chair

Charlotte Beason, EdD, RN, CNAA
Kentucky, Area III

Karla E. Bitz, PhD, RN
North Dakota, Area II

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Kevin Kenward, PhD
Director, Research

Elizabeth Zhong, PhD
Associate, Research

Qiana Hampton, MBA
Administrative Assistant, Practice and Regulation

Meeting Dates

- Aug. 27, 2007, Teleconference
- Sept. 24, 2007, Teleconference
- Oct. 31-Nov. 1, 2007
- Dec. 4, 2007, Teleconference
- Jan. 28-29, 2008
- March 6, 2008, Teleconference
- April 7, 2008, TERCAP™ Forum
- April 22, 2008, Teleconference
- June 25-26, 2008

Relationship to Strategic Plan

Strategic Initiative B
NCSBN Contributes to Member Boards excellence by providing resources, communications, education and technology.

Strategic Objective 2
Continuously provide and evaluate education, information sharing and networking opportunities.

Strategic Initiative C
NCSBN advances evidence-based nursing regulation and regulatory solutions for public protection.

Strategic Objective 1
Assist Member Boards in implementing regulatory best practices.

Strategic Initiative C
NCSBN advances evidence-based nursing regulation and regulatory solutions for public protection.

Strategic Objective 3
Conduct and support research that provides evidence regarding regulatory initiatives that supports public protection.

Highlights of FY08 Activities

- Provided assistance to the Member Boards submitting cases in TERCAP online.
- Promoted the use of TERCAP to other Member Boards.
- Requested the research program to perform an initial analysis of the available data using the 11 study questions-guidelines for the analysis of TERCAP generated data.
- Developed case selection criteria for cases submitted to be included into the NCSBN TERCAP research project.
- Gathered comments submitted concerning TERCAP throughout the first year of the online implementation and made some of the suggested changes.
- Created TERCAP™ 2008, an update to the online TERCAP™ 2007.
- Updated the TERCAP protocol.
- Updated the TERCAP policy manual.
- Updated the Word version of TERCAP.
- Updated the Frequently Asked Questions (FAQs) with answers.
- Created an electronic version of the TERCAP instrument for a Member Board to post on its boards of nursing web site. The electronic version is capable of: being printed; filled in manually; filled in electronically; saved with the answers provided electronically; printed with the answers provided electronically; and sent to a board via e-mail with the answers.
- Initiated bi-monthly conference calls for TERCAP users.
- Revised and updated the TERCAP Web pages.
- Created new jurisdiction specific reports for the cases submitted in TERCAP™ 2008, and created new reports as additional Member Boards become interested in using TERCAP.
- Prepared and presented TERCAP™ Webinars, including a new refresher webinar.
- Created a TERCAP story as an online link for use during TERCAP™ Webinars.
- Developed talking points for all committee members, to allow them to share the same information about TERCAP.
- Presented an update on TERCAP at the Midyear Meeting.
- Followed-up with Member Boards that expressed an interest in using TERCAP, including those at the Midyear Meeting.
- Provided assistance to fellow Member Boards, based on actual TERCAP experience at a Member Board.
- Created a performance assessment survey at the end of the online instrument as part of the quality improvement plan.
- Presented an update on TERCAP at the Board Investigator and Attorney Workshop
- Reviewed the article, from the Marketing Department concerning TERCAP, later published in *Leader to Leader*.
- Prepared a letter to be sent to the American Nurses Association and the Joint Commission to thank them for their constructive comments during TERCAP's development, some of which were incorporated into TERCAP, and provide an update on the activities towards TERCAP's implementation by NCSBN Member Boards.
- Executed the contract to publish the book, *Nursing Pathways for Patient Safety.*

FY09 Board of Director Charges

1. Provide Member Board resources for the use of TERCAP.

2. Advise staff on the content of the 2009 TERCAP™ Roundtable.

3. Determine the implications of the aggregated data analysis.

Future Activities

- Continue to promote the use of TERCAP by Member Boards and encourage Member Boards using TERCAP to continue using it to submit cases electronically.
- Continue to develop additional TERCAP resources and products for Member Boards, with the assistance of NCSBN's e-learning productions department, including: wikis; on demand videos of the TERCAP Forum; audio clips of questions and answers by experienced TERCAP users; training resources; and other resources as the identification and need arises.
- Review the comments submitted about TERCAP and use the data collection instrument to evaluate and determine if any future changes are needed to TERCAP, to provide a quality product and quality data for this ongoing NCSBN research project.
- Continue the user conference calls every other month.
- Offer hands on TERCAP learning opportunities at Member Boards.
- Continue to offer webinars.
- Update the TERCAP policy manual, if needed.
- Continue to update the TERCAP Web pages.
- Continue to asses any quality improvements that can be made to TERCAP online.
- Plan the Roundtable.

Attachments

A. TERCAP™ 2008 Data Collection Instrument

B. TERCAP™ Case Selection Criteria

Attachment A

TERCAP™ 2008 Data Collection Instrument

TERCAP™
Taxonomy of Error, Root Cause Analysis and Practice-responsibility

2008 Data Collection Instrument© 5/5/08

TERCAP Case ID Number _____

1. Full Name of Reviewer _____

Pick the incident that triggered the report to the board

2. State Board of Nursing _____ **3. Date of incident** _____ or □ Unknown

4. Patient age _____ or □ Unknown *If more than one patient was involved, report data for the patient with the most serious harm, or risk of harm*

5. Patient gender □ Male □ Female □ Unknown

6. Were the patient's family and/or friends present at the time of the practice breakdown?
□ Yes □ No □ Unknown

7. Indicate whether the patient exhibited any of the following at the time of the practice breakdown *Check all that apply*
□ Agitation /Combativeness □ Altered level of consciousness □ Cognitive impairment
□ Communication /Language difficulty □ Depression / Anxiety □ Inadequate coping /stress management
□ Incontinence □ Insomnia □ Pain Management □ Sensory deficits (hearing, vision, touch) □ None □ Unknown

8. Indicate the patient's diagnosis *Check no more than TWO diagnoses, those that contributed to the reported situation.*
□ Alzheimer's disease and other dementias (confusion) □ Arthritis □ Asthma □ Back problems □ Cancer
□ Congestive heart failure □ Depression and anxiety disorders □ Diabetes □ Emphysema □ Fractures
□ Gall bladder disease □ Gastrointestinal disorders □ HIV / AIDS □ Hypertension □ Infections
□ Ischemic heart disease (CAD, MI) □ Nervous system disorders □ Pneumonia □ Pregnancy
□ Renal / urinary system disorders □ Skin disorders □ Stomach ulcers □ Stroke (CVA)
□ Unknown diagnosis □ Other - please specify _____

9. What happened to the patient? *Check all that apply*
□ Patient fell □ Patient departed without authorization □ Patient received wrong medication
□ Patient received wrong treatment □ Patient received wrong therapy □ Patient acquired nosocomial (hospital acquired) infection
□ Patient suffered hemolytic transfusion reaction □ Patient suffered severe allergic reaction / anaphylaxis
□ Patient was abducted □ Patient was assaulted □ Patient suicide □ Patient homicide
□ Unknown (*If you select this option, do not select any other choices.*) □ Other - please specify _____

10. Patient Harm *Select ONLY one*
□ No harm - An error occurred but with no harm to the patient
□ Harm - An error occurred which caused a minor negative change in the patient's condition.
□ Significant harm - Significant harm involves serious physical or psychological injury. Serious injury specifically includes loss of function or limb.
□ Patient death - An error occurred that may have contributed to or resulted in patient death.

11. Type of community *Select ONLY one*
□ Rural (lowly populated, farm, ranch land communities 10,000 or less) □ Suburban (towns, communities of 10,000 to 50,000)
□ Urban (any city over 50,000) □ Unknown

12. Type of facility or environment *Select ONLY one*
□ Ambulatory Care □ Assisted Living
□ Behavioral Health □ Critical Access Hospital
□ Home Care □ Hospitals
□ Long Term Care □ Office - based Surgery
□ Physician / Provider Office or Clinic
□ Unknown □ Other - please specify _____

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13. Facility Size ***Select ONLY one***

☐ 5 or fewer beds ☐ 6-24 beds ☐ 25-49 beds ☐ 50-99 beds ☐ 100-199 beds
☐ 200-299 beds ☐ 300-399 beds ☐ 400-499 beds ☐ 500 or more beds ☐ Not applicable ☐ Unknown

14. Medical record system ***Select ONLY one***

☐ Electronic documentation ☐ Electronic physician orders ☐ Electronic medication administration system
☐ Combination paper / electronic record ☐ Paper documentation ☐ Unknown

15. Communication Factors ***Check all that apply***

☐ Communication systems equipment failure
☐ Shift change (patient hand-offs)
☐ No adequate channels for resolving disagreements
☐ Medical record not accessible
☐ Patient identification failure
☐ Lack of or inadequate orientation / training
☐ None (*If you select this option, do not select any other choices.*)
☐ Other - please specify _____
☐ Interdepartmental communication breakdown / conflict
☐ Patient transfer (hand-offs)
☐ Preprinted orders inappropriately used (other than medications)
☐ Patient name similar / same
☐ Computer system failure
☐ Lack of ongoing education / training
☐ Unknown (*If you select this option, do not select any other choices.*)

16. Leadership / Management Factors ***Check all that apply***

☐ Poor supervision / support by others
☐ Inadequate / outdated policies / procedures
☐ Nurse shortage, sustained, at institution level
☐ Inadequate patient classification (acuity) system to support appropriate staff assignments
☐ None (*If you select this option, do not select any other choices.*)
☐ Other - please specify _____
☐ Unclear scope and limits of authority / responsibility
☐ Assignment or placement of inexperienced personnel
☐ Unknown (*If you select this option, do not select any other choices.*)

17. Backup and Support Factors ***Check all that apply***

☐ Ineffective system for provider coverage
☐ Lack of nursing expertise system for support
☐ Lack of adequate response by lab / x-ray / pharmacy or other department
☐ None (*If you select this option, do not select any other choices.*)
☐ Other - please specify _____
☐ Lack of adequate provider response
☐ Forced choice in critical circumstances
☐ Unknown (*If you select this option, do not select any other choices.*)

18. Environmental Factors ***Check all that apply***

☐ Poor lighting
☐ Frequent interruptions / distractions
☐ Equipment failure
☐ Multiple emergency situations
☐ Code situation
☐ None (*If you select this option, do not select any other choices.*)
☐ Other - please specify _____
☐ Increased noise level
☐ Lack of adequate supplies / equipment
☐ Physical hazards
☐ Similar / misleading labels (other than medications)
☐ Unknown (*If you select this option, do not select any other choices.*)

19. Health team members involved in the practice breakdown ***Check all that apply***

☐ Supervisory nurse / personnel
☐ Other prescribing provider
☐ Staff nurse
☐ Other Health professional (e.g., PT, OT, RT)
☐ Medication assistant
☐ Patient
☐ Unlicensed Assistive Personnel (nurse aide, certified nursing assistant, CNA or other titles of non-nurses who assist in performing nursing tasks)
☐ None (*If you select this option, do not select any other choices.*)
☐ Other - please specify _____
☐ Physician (may be attending, resident or other)
☐ Pharmacist
☐ Floating / temporary staff
☐ Health profession student
☐ Other support staff
☐ Patient's Family / friends
☐ Unknown (*If you select this option, do not select any other choices.*)

20. Staffing issues contributed to the practice breakdown ***Check all that apply***

☐ Lack of supervisory / management support
☐ Lack of nursing support staff
☐ Lack of other health care team support
☐ None (*If you select this option, do not select any other choices.*)
☐ Other - please specify _____
☐ Lack of experienced nurses
☐ Lack of clerical support
☐ Unknown (*If you select this option, do not select any other choices.*)

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21. Health Care Team ***Check all that apply***

- □ Intradepartmental conflict / non-supportive environment
- □ Lack of multidisciplinary care planning
- □ Lack of patient involvement in plan of care
- □ Majority of staff had not worked together previously
- □ Lack of patient education
- □ None (*If you select this option, do not select any other choices.*)
- □ Other - please specify _____
- □ Breakdown of health care team communication
- □ Intimidating / threatening behavior
- □ Care impeded by policies or unwritten norms that restrict communication
- □ Illegible handwriting
- □ Lack of family / caregiver education
- □ Unknown (*If you select this option, do not select any other choices.*)

22. Nurse's year of birth _____ □ Unknown

23. Nurse's gender □ Male □ Female □ Unknown

24. Where nurse received nursing education

□ US □ Unknown □ Non-US, please list country _____

25. Indicate all degrees the nurse holds and list the year of graduation and year of initial licensure

Degree	Year of graduation	Year of initial licensure	Year of graduation	Year of initial licensure
_____	_____	_____	□ Unknown	□ Unknown
_____	_____	_____	□ Unknown	□ Unknown
_____	_____	_____	□ Unknown	□ Unknown

26. Current Licensure Status ***Check ALL license(s) active at the time of the reported practice breakdown***

□ LPN/VN □ RN □ APRN

27. Is English the nurse's primary language?

□ Yes □ No □ Unknown

28. Did the nurse report completion of any continued competence activities or professional development activities in the last five years?

□ Yes □ No □ Unknown

29. Indicate the category of Advanced Practice Registered Nurse (APRN)

- □ Not applicable since not an APRN
- □ Nurse Practitioner
- □ Nurse Anesthetist
- □ Nurse Midwife
- □ Clinical Nurse Specialist
- □ APRN Category unknown
- □ Other - please specify _____

30. Work start and end times (*based on a 24 hour clock*) when the practice breakdown occurred ***24 hours, or circle am or pm***

Start time _____ am/pm End time _____ am/pm Time of incident _____ am/pm □ Unknown

31. Length of time the nurse had worked for the organization / agency where the practice breakdown occurred

- □ Less than one month
- □ One month - Twelve months
- □ One - Two years
- □ Two - Three years
- □ Three - Five years
- □ More than five years
- □ Unknown

32. Length of time the nurse had worked in patient care location / department where the practice breakdown occurred

- □ Less than one month
- □ One month - Twelve months
- □ One - Two years
- □ Two - Three years
- □ Three - Five years
- □ More than five years
- □ Unknown

33. Length of time the nurse had been in the specific nursing role at the time of the practice breakdown

- □ Less than one month
- □ One month - Twelve months
- □ One - Two years
- □ Two - Three years
- □ Three - Five years
- □ More than five years
- □ Unknown

34. Type of shift

□ 8 hour □ 10 hour □ 12 hour □ On call □ Unknown □ Other - please specify _____

35. Days worked in a row at the time of the practice breakdown (include all positions / employment)

□ First day back after time off □ Two - Three days □ Four - Five days □ Six or more days □ Unknown

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36. Was the nurse working in a Temporary capacity (e.g., traveler, float pool, covering a patient for another nurse)
□ Yes □ No □ Unknown

37. Assignment of the nurse at time of the practice breakdown
□ Direct patient care □ Team leader □ Charge nurse
□ Nurse manager / supervisor □ Combination patient care / leadership role □ Unknown

38. How many direct care patients were assigned to the nurse at the time of the practice breakdown?
Number of Patients _____ □ Unknown

39. How many staff members was the nurse responsible for supervising at the time of the practice breakdown?
Number of Staff _____ □ Unknown

40. How many patients was the nurse responsible for overall (counting direct care patients and the patients of the staff the nurse was supervising at the time of the practice breakdown)?
Number of Patients _____ □ Unknown

41. Nurse's reported perception of factors that contributed to the practice breakdown ***Check all that apply***
□ Nurse's language barriers
□ Nurse's high work volume / stress
□ Nurse's drug / alcohol impairment / substance abuse
□ Nurse's inexperience (with clinical event, procedure, treatment or patient condition)
□ No rest breaks / meal breaks
□ Nurse's overwhelming assignment(s)
□ Nurse's mental health issues
□ Nurse's personal pain management
□ None (*If you select this option, do not select any other choices.*)
□ Other - please specify _____
□ Nurse's cognitive impairment
□ Nurse's fatigue / lack of sleep
□ Nurse's functional ability deficit
□ Nurse's lack of orientation / training
□ Nurse's lack of team support
□ Nurse's conflict with team members
□ Lack of adequate staff
□ Unknown (*If you select this option, do not select any other choices.*)

42. Supervisor or employer's perception of factors that contributed to the practice breakdown ***Check all that apply***
□ Nurse's language barriers
□ Nurse's high work volume / stress
□ Nurse's drug / alcohol impairment / substance abuse
□ Nurse's inexperience (with clinical event, procedure, treatment or patient condition)
□ No rest breaks / meal breaks
□ Nurse's overwhelming assignment(s)
□ Nurse's mental health issues
□ Nurse's personal pain management
□ None (*If you select this option, do not select any other choices.*)
□ Other - please specify _____
□ Nurse's cognitive impairment
□ Nurse's fatigue / lack of sleep
□ Nurse's functional ability deficit
□ Nurse's lack of orientation / training
□ Nurse's lack of team support
□ Nurse's conflict with team members
□ Lack of adequate staff
□ Unknown (*If you select this option, do not select any other choices.*)

43. Previous discipline history by employer(s), including current employer, for practice issues
□ Yes □ No □ Unknown

44. Terminated or resigned in lieu of termination from previous employment
□ Yes □ No □ Unknown

45. Previous discipline by a board of nursing
□ Yes □ No □ Unknown

If Yes, please provide the previous Case Identifier(s), if available, or any other information describing the type of practice breakdown that resulted in previous discipline.

Our goal is to be able to analyze cases in which a nurse had repeat / multiple practice breakdown issues.

_____

_____

_____

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46. Previous criminal convictions
☐ Yes ☐ No ☐ Unknown

47. Employment Outcome ***Select ONLY one***
☐ Employer retained nurse
☐ Nurse resigned
☐ Nurse resigned in lieu of termination
☐ Employer terminated / dismissed nurse
☐ Unknown (*If you select this option, do not select any other choices.)*
☐ Other - please specify _____

48. Did the reported incident involve intentional misconduct or criminal behavior? ***Check all that apply***
☐ No, it did not involve intentional misconduct or criminal behavior. (*If you select this option, do not select any other choices.*)
☐ Yes: Changed or falsified charting
☐ Yes: Deliberately covering up error
☐ Yes: Theft (including drug diversion)
☐ Yes: Fraud (including misrepresentation)
☐ Yes: Patient abuse (verbal, physical, emotional or sexual)
☐ Yes: Criminal conviction
☐ Unknown (*If you select this option, do not select any other choices.)*
☐ Other - please specify _____

49. Did the practice breakdown involve a medication error?
☐ Yes ☐ No *If No, skip to question 53* ☐ Unknown

50. Name of drug involved in the practice breakdown (*Include <u>complete</u> medication order)*
Drug ordered _____ Drug actually given _____ ☐ Unknown

51. The type of medication error identifies the form or mode of the error, or how the error was manifested.
Select the type of medication error: ***Check all that apply***
☐ Drug prepared incorrectly ☐ Extra dose ☐ Improper dose / quantity ☐ Mislabeling
☐ Omission ☐ Prescribing ☐ Unauthorized drug ☐ Wrong administration technique
☐ Wrong dosage form ☐ Wrong drug ☐ Wrong patient ☐ Wrong route
☐ Wrong time ☐ Wrong reason ☐ Abbreviations
☐ Unknown (*If you select this option, do not select any other choices.*) ☐ Other - please specify _____

52. Select which factors contributed to the medication error ***Check all that apply***
☐ Blanket orders ☐ Performance deficit ☐ Brand names look alike
☐ Brand names sound alike ☐ Brand / generic drugs look alike ☐ Calculation error
☐ Communication ☐ Computer entry ☐ Computerized prescriber order entry
☐ Computer software ☐ Contra-indicated, drug allergy ☐ Contra-indicated, drug / drug
☐ Contra-indicated in disease ☐ Contra-indicated in pregnancy / breastfeeding
☐ Decimal point ☐ Dilutant wrong ☐ Dispensing device involved
☐ Documentation inaccurate / lacking ☐ Dosage form confusion ☐ Drug devices
☐ Drug distribution system ☐ Drug shortage ☐ Equipment design confusing / inadequate
☐ Equipment (not pumps) failure / malfunction ☐ Fax / Scanner involved ☐ Generic names look alike
☐ Generic names sound alike ☐ Handwriting illegible / unclear ☐ Incorrect medication activation
☐ Information management system ☐ Knowledge deficit ☐ Label - Manufacturer design
☐ Label - Your facility's design ☐ Leading / Missing zero ☐ Measuring device inaccurate / inappropriate
☐ Medication available as floor stock ☐ Monitoring inadequate / inappropriate ☐ Non-formulary drug
☐ Non-metric units used ☐ Packaging / container design ☐ Patient identification failure
☐ Performance (human) deficit ☐ Prefix / Suffix misinterpreted ☐ Preprinted medication order form
☐ Procedure / Protocol not followed ☐ Pump: failure / malfunction ☐ Pump: improper use
☐ Reconciliation - Admission ☐ Reconciliation - Discharge ☐ Reconciliation material confusing / inaccurate
☐ Repackaging by your facility ☐ Repackaging by other facility ☐ Similar packaging / labeling
☐ Similar products ☐ Storage proximity ☐ System safeguard(s) inadequate
☐ Trailing / terminal zero ☐ Transcription inaccurate / omitted ☐ Verbal order
☐ Written order ☐ Workflow disruption
☐ Unknown (*If you select this option, do not select any other choices.*) ☐ Other - please specify _____

53. Did the practice breakdown involve a documentation error? ***Check all that apply***
☐ Yes ☐ No ☐ Unknown
If Yes, the practice breakdown documentation error involved:
☐ Pre-charting / untimely charting
☐ Incomplete or lack of charting
☐ Charting incorrect information
☐ Charting on wrong patient record
☐ Other - please specify _____

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TERCAP™ ROOT CAUSE ANALYSIS of the PRACTICE BREAKDOWN

54. If Attentiveness / Surveillance was a factor in the Practice Breakdown ***Check all that apply***

☐ Patient not observed for an unsafe period of time ☐ Staff performance not observed for an unsafe period of time
☐ Other - please specify _____

55. If Clinical Reasoning was a factor in the Practice Breakdown ***Check all that apply***

☐ Clinical implications of patient signs, symptoms and/or responses to interventions not recognized
☐ Clinical implications of patient signs, symptoms and/or interventions misinterpreted
☐ Following orders, routine (rote system) without considering specific patient condition
☐ Poor judgment in delegation and the supervision of other staff members
☐ Inappropriate acceptance of assignment or accepting a delegated action beyond the nurse's knowledge and skills
☐ Lack of knowledge ☐ Other - please specify _____

56. If Prevention was a factor in the Practice Breakdown ***Check all that apply***

☐ Preventive measure for patient well-being not taken ☐ Breach of infection precautions
☐ Did not conduct safety checks prior to use of equipment ☐ Other - please specify _____

57. If Intervention was a factor in the Practice Breakdown ***Check all that apply***

☐ Did not intervene for patient ☐ Did not provide timely intervention ☐ Did not provide skillful intervention
☐ Intervened on wrong patient ☐ Other - please specify _____

58. If Interpretation of Authorized Provider's Orders was a factor in the Practice Breakdown ***Check all that apply***

☐ Did not follow standard protocol / order ☐ Missed authorized provider's order
☐ Unauthorized intervention (not ordered by an authorized provider)
☐ Misinterpreted telephone or verbal order ☐ Misinterpreted authorized provider handwriting
☐ Undetected authorized provider error resulting in execution of an inappropriate order
☐ Other - please specify _____

59. If Professional Responsibility / Patient Advocacy was a factor in the Practice Breakdown ***Check all that apply***

☐ Nurse fails to advocate for patient safety and clinical stability
☐ Nurse did not recognize limits of own knowledge and experience
☐ Nurse does not refer patient to additional services as needed ☐ Specific patient requests or concerns unattended
☐ Lack of respect for patient / family concerns and dignity ☐ Patient abandonment
☐ Boundary crossings / violations ☐ Breach of confidentiality ☐ Nurse attributes responsibility to others
☐ Other - please specify _____

Select which Practice Breakdown categories you selected above is most significant (*Primary*)

☐ Attentiveness/Surveillance
☐ Clinical Reasoning
☐ Prevention
☐ Intervention
☐ Interpretation of provider's orders
☐ Professional responsibility / patient advocacy

Select which of the Practice Breakdown categories you selected above is the second most significant (*Secondary*)

☐ Attentiveness/Surveillance
☐ Clinical Reasoning
☐ Prevention
☐ Intervention
☐ Interpretation of provider's orders
☐ Professional responsibility / patient advocacy

60. Board of Nursing Outcome

☐ Board of Nursing disciplinary action
☐ Alternative Program – The nurse was given the opportunity to participate in a non-discipline program to address practice and / or impairment concerns
☐ Non-disciplinary action (e.g., letter of concern)
☐ Referral to another oversight agency
☐ Recommendations to the health care agency involved in the practice breakdown
☐ Case dismissal (Reminder: cases dismissed do not meet the NCSBN research criteria for the aggregate data analysis.)

Optional:

Case Dates: Case Received __/__/___ Assigned to Investigator __/__/___ Investigation Complete __/__/___ Final Resolution __/__/___

•Did the instrument allow you to capture the essential elements of the practice breakdown? If not, please explain what was missing that would have helped describe the case: _____

•Provide any additional comments and feedback regarding TERCAP: _____

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Attachment B

TERCAP™ Case Selection Criteria

The case selection criteria include the following:

1. a nurse was involved in the practice breakdown;
2. patient involvement was with one or more identifiable patient(s); and
3. cases of practice breakdown involved board disciplinary action, enrollment in an alternative program, or letter of concern issued (i.e., any action other than case dismissal).

Report of Transition to Practice Committee

Background

The FY07-08 charge for the Transition to Practice Committee was to:

Recommend an evidence-based regulatory model for transition to practice.

The Transition to Practice Committee met four times and had one conference call to meet this charge. At the Dec. 11-12, 2007 meeting the committee members reviewed all the data pertaining to developing an evidence-based transition regulatory model and formally voted, unanimously, that there was enough evidence to move forward with designing the model. Subsequent meetings were spent developing the components of the model and focusing on the evidence.

Attachment A reviews the background of the model and synthesizes the data that support the model. Attachment B includes a visual and written description of the model. Important to this charge has been the ongoing development of the Transition Evidence Grid (Attachment C), which summarizes, in detail, data from 4 international, 16 national, 7 statewide, and 12 individual transition projects, research, or literature reviews that are related to a regulatory model for transitioning new nurses to practice. Also refer to Attachment D, which is a sample Transition to Practice Verification (TPV) form for boards of nursing to use when verifying that a new graduate has completed the required transition program in that jurisdiction.

Highlights of FY08 Activities

- Identified and synthesized the data from 4 international, 16 national, 7 statewide, and 12 individual transition projects, studies, or literature reviews that are related to regulation.
- Formally voted, unanimously, that there is adequate evidence to support a regulatory model for transitioning new graduates to practice.
- Summarized all the data identified into an evidence grid.
- Synthesized the data and wrote a comprehensive report.
- Decided, based on the evidence, on the modules for the transition regulatory model, which include: specialty content, communication, safety, clinical reasoning, prioritizing/organizing, utilize research, role socialization, and delegating/supervising. Feedback and reflection should be threaded throughout the transition period.
- Decided that the transition regulatory model (that is, completing the modules and working with a preceptor) should be six months in length, followed by six months of continued support.
- Decided on using the QSEN competencies for measuring outcomes of RNs; developed competency definitions for PNs, based on the QSEN model; and discussed plans for designing the KSAs for PNs.
- Developed, with the Marketing and Communications department, a visual transition to practice regulatory model.
- Developed a written, step-by-step, description of the transition regulatory model.
- Designed a Transition to Practice Verification (TPV) form for implementation of the model.
- Met with NCSBN's eLearning department to learn the feasibility of designing a national

Members

Lepaine Sharp-McHenry, MS, RN
FACDONA
Arkansas, Area III, Chair

Janine Baxter, MSN, RN
Idaho, Area I

Carol Komara, MSN, RN
Kentucky, Area III

Genell Lee, MSN, JD, RN
Alabama, Area III

Carol Silveira, MS, RN
Massachusetts, Area IV

Cynthia VanWingerden, MS, BSN, RN
Virgin Islands, Area IV

Debra A. Werner, MSN, RN
New Mexico, Area I

Pamela Zickafoose, EdD, RN, CNA-BC, CNE
Deleware, Area IV

Laura Rhodes, MSN, RN
West Virginia-RN, Area II, Board Liaison

Diane Twedell, DNP, RN, CNAA, AONE
Consultant

Staff
Nancy Spector, PhD, RN
Director, Education

Meeting Dates

- Sept. 17-18, 2007
- Dec.11-12, 2007
- Jan. 31-Feb. 1, 2008
- March 6-7, 2008
- March 24, 2008

Relationship to Strategic Plan

Strategic Initiative C
NCSBN advances evidence-based nursing regulation and regulatory solutions for public protection.

Strategic Objective 2
Provide models and resources for evidenced-based regulation to Member Boards.

Web site for connecting preceptors to new graduates, presenting the modules, and for assisting Boards with monitoring new graduates.

- Met with NCSBN's Research department to learn the feasibility of developing outcome measures for the transition regulatory model.

Future Activities

- Recommend an evidenced-based regulatory model for transition to practice.
- Collaborate with Member Boards and stakeholders regarding a future regulatory model.
- Identify strategies for implementation of the model.
- Develop model rules.

Attachments

A. Regulatory Model for Transition to Practice (Report)

B. Transition to Practice Regulatory Model (Visual)

C. Transition Evidence Grid

D. Transition to Practice Verification Form

Attachment A

Regulatory Model for Transition to Practice (Report)

BACKGROUND

Member Boards are responsible for making sure that safe and competent nurses are entering the workforce after they graduate from their nursing programs. This responsibility includes approving nursing programs in their jurisdictions and requiring graduates to pass the NCLEX®. However, is it time to take this a step further? Is it time to require new graduates, as medicine does, to complete a transition program? There are many factors inspiring this inquiry. First and foremost, medical errors have been a major concern for the health professions. The Institute of Medicine has reported that medical errors kill more people than breast cancer, AIDS or automobile accidents. (Kohn, Corrigan and Donaldson, 1999) At the same time, there has been an increased complexity of care for sicker patients with multiple conditions, a continued need for systems thinking, and technologic advances, along with a shortage of nurses and faculty that is expected to continue into the future. Another issue that prompted this transition to practice initiative was the unintended consequence of computer adapted testing, which allows new graduates to become licensed within days of passing the NCLEX. Previously new graduates waited months for their results, thus working under the supervision of licensed nurses. All of this was the impetus for NCSBN to look at transitioning new nurses to practice, through regulation.

NCSBN's work on transition to practice began in August of 2002 when the Practice, Education and Regulation in Congruence (PERC) Committee presented Delegate Assembly with the following initiatives, which the members supported, by their vote:

- Identify and promote effective models to facilitate a successful transition of new nurses from education to practice; and
- Participate in strategies for retention of the new graduate.

After these initiatives were supported by the members, the Board included transitioning of new nurses in its strategic objectives and its charges to the Practice, Regulation and Education (PR&E) Committee, and more recently the Transition to Practice Committee. Since that 2002 vote, the PR&E Committee collaborated with NCSBN's Research Department on a number of related studies, including:

- An employer's study (2003);
- A Practice and Professional Issues Study focusing on transition (2004);
- A study to look at the types of transition programs being offered across the nation and educational levels (2006); and
- A study linking transition programs to competencies, retention, and practice errors (in press).

Further, in 2005 the PR&E Committee published a literature review of transitioning new nurses to practice in the NCSBN Business Book, and this was updated in the *2007 NCSBN Business Book*.

NCSBN held a Transition Forum on Feb. 22, 2007, and nursing leaders from the National League for Nursing (NLN), American Association of Colleges of Nursing (AONE), American Nurses Association (ANA), American Organization of Nurse Executives (AONE), and the National Association for Practical Nurse Education and Service (NAPNES) took part in a panel discussion. The audience was composed of nurses from regulation, education and practice. The panel members and audience strongly supported the need for a national, standardized transition model that was implemented through regulation.

It is the belief of the Transition to Practice Committee that the need for transition programs is not because the education programs are failing to adequately prepare our nurses for practice. Nor is the need for this regulatory transition model because practice settings are failing and are expecting new nurses to hit the ground running. This need has arisen because of the tremendous changes we've seen in health care in the past 20 years. It is time for nursing education, practice and regulation to collaborate on this very important issue so that practice will be safer.

GOAL AND PREMISES OF THE MODEL

The following includes the goal, premises, and relevant definitions of the Transition to Practice Regulatory Model. A synthesis of the evidence that supports the model will be presented in the next section. Jurisdictions adopting the model will have the flexibility to adapt it to meet their particular needs.

The goal of the Transition to Practice Regulatory Model is:

To promote public safety by supporting newly licensed nurses in their critical entry and progression into practice.

The premises of the model are:

- The mission of the boards of nursing is the protection of public health, safety, and welfare.
- Nursing regulators recognize the value of evidence-based models in their responsibility of public protection.
- Transitioning new nurses to practice is best accomplished when practice, education, and regulation collaborate.
- Transition to practice programs should occur across all settings and all education levels.
- Regulation criteria for transition programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection.
- Transition program outcomes are consistent with the knowledge, skills and attitudes required for safe and effective provision of nursing care.

Relevant definitions, for this particular model include:

Competent – The ability to demonstrate an integration of the knowledge, attitudes, and skills necessary to function in a specific role and work setting. (Modified from American Association of Critical-Care Nurses, Preceptor Handbook)

Orientation – The process of introducing staff to the philosophy, goals, policies, procedures, role expectations, and other factors needed to function in a specific work setting. Orientation takes place both for new employees and when changes in nurses' roles, responsibilities, and practice settings occur. (ANA's Scope and Standards of Practice for Nursing Professional Development)

Preceptor – A competent nurse who has received formal training for the preceptorship role.

Preceptorship – A formal, one-on-one teaching-learning relationship of predetermined length between a competent preceptor and a new nurse graduate that facilitates transition to practice. (Modified from the Canadian Nurses Association)

Transition to Practice – A formal program of active learning for all newly licensed nurses (registered nurses and licensed practical/vocational nurses) designed to support their progression from education to practice across all settings.

THE EVIDENCE

While evidence-based health care is an essential foundation of any nursing model, evidence is limited at the beginning of any new initiative. Requiring substantial evidence before implementing new models can be a barrier to innovation. The committee reviewed the literature, particularly searching for evidence related to international, national, or statewide nursing models, as well as transition models from other disciplines. Individual projects, expert opinions/consensus statements, and research relevant to regulation were also reviewed. Whenever possible, the Transition to Practice Committee chair and staff interviewed individuals implementing transition programs. This added depth to the inquiry. The evidence is further explicated in Attachment C, the Evidence Grid, and numbers in this report refer to the numbers on the Evidence Grid.

The committee members reviewed the regulatory implications of transition models, as well as elements of successful models. After much review, the committee unanimously voted that there was enough evidence to support a regulatory transition model.

When reviewing the evidence for this regulatory transition model, the Transition to Practice Committee members used Sackett's widely-accepted definition for evidence-based practice to guide their inquiry. Sackett describes evidence-based practice as the integration of the best research evidence with clinical expertise and patient values. (Sackett, Straus, Richardson, Rosenberg and Haynes, 2000) The Transition to Practice Committee identified the available evidence by searching the literature systematically. They also considered the levels of research, which they defined consistent with other NCSBN work (8):

- Level I: A properly conducted randomized controlled trial, systematic review or meta-analysis.
- Level II: Other studies, such as quasi-experimental, correlation, descriptive, survey, evaluation, and qualitative.
- Level III: Expert opinions or consensus statements

Of the available evidence, there were several Level II and Level III studies or projects, but none were Level I. One study, by Hofler (10) was a synthesis of national reports on transition to practice, but the methodology was not rigorous enough to consider it a systematic or integrative review. It is common in health care, health policy, and nursing research not to find randomized controlled trials because they are not always feasible or ethically possible. Expert opinions and consensus statements (such as standards by a professional organization) can be important supportive data, especially in an area as complex as transition to practice.

TRANSITION PROGRAMS PROTECT THE PUBLIC

An important question addressed by the Transition to Practice Committee is: should transition to practice be implemented through regulation? The Transition to Practice Committee members spent much time and debate on this issue. To adequately review this question, the committee members decided to review three research topics: patient safety, competency, and job retention.

Safety and New Nurses

The committee reviewed a total of 11 reports, besides the well-known IOM To Err is Human report (Kohn et al., 1999), regarding new nurses and patient safety, near misses, adverse events and practice errors. The 1999 IOM report called attention to errors in health care. Similarly, Behrens (6) reviewed three million state and federal computer records, for safe nursing practice. Of those 11 reports (6, 12, 16, 17, 23, 28, 31, 32, 33, 34, 38), two reported disciplinary data (12, 23) and one addressed incident reports (34). It makes sense that there isn't going to be more discipline for novice nurses (0-12 months) versus those in practice for 10 years, for example, because the latter group would have a much greater opportunity to

make errors. Besides that, there is quite a leap between discipline and a near miss, which is more often is seen in new nurses (32). The NCSBN Nursys® data on discipline in the boards of nursing (12) found that 4.1 percent of the discipline was with novice nurses. For all nurses there was a trend of increased discipline from 1996-2006 (32), thus supporting IOM reports of an increase in practice errors in health care. The Massachusetts's preliminary findings on discipline data from 77 nursing homes (23) had no novice RNs in the analysis. However, of 44 LPNs disciplined, seven were novices. In the Massachusetts study, the researchers concluded that errors with new nurses were linked to inexperience, lack of familiarity, and lack of consistent preceptors. They recommended more supervision and support for new nurses. A study out of Australia (34) found that incident reporting increased during the novice nurse's first year in a supportive transition program because they were taught about the importance of reporting errors and near misses for root cause analyses.

New nurses often engage in concrete thinking and focus on technology (38), thereby missing the bigger picture, and this can be devastating during these complex times in health care (7, 31, 32). Del Bueno (31) found that when novice nurses were given patient scenarios, 50 percent of them would miss life-threatening situations. Another study (32) found that of 12 recruited new nurse participants, 7 reported at least 1 near-miss event, while 1 nurse described 2 events. Carnegie (7) recommended a yearlong transition program for new nurses, in part because students don't have the opportunity to follow-up with their patients in their nursing programs. Therefore, novice nurses are often weak in detecting subtle changes in patient conditions. A supportive transition program would assist new nurses to identify subtle changes and avoid practice errors. Orsolini (38) cites statistics showing that if new nurses fail to recognize changes in patient status, those patients can deteriorate quickly. When CPR is needed, only 27 percent of adults and 18 percent of children survive (38).

Orsolini-Hain and Malone and Ebright and colleagues (32, 38) address the impending gap in clinical nursing expertise due to retiring nurses and faculty. They point out that novices assisting novices could be a safety issue if standardized transition programs are not in place.

An NCSBN national study (17) found that when transition programs in hospitals addressed specialty care, new nurses reported making fewer practice errors. Similarly, when nurses perceived they were more competent, they reported making significantly fewer practice errors, and this was especially true when they reported more competence in clinical reasoning abilities and communication and interpersonal relationships.

Johnstone and colleagues (33, 34, 35) studied integrating new nurses into clinical risk management systems in Australia. They stress the importance of not teaching new graduates deficit education. That is, don't assume that the transition program needs to re-educate the new nurse. Instead, the nurse needs to learn, by experiential means and with support of qualified nurses, how to manage risks in practice.

Competence and New Nurses

Keller (36) provides insight as to why new nurses need continued support for the first year, even though they graduated from an approved nursing program and have passed the NCLEX. She states that nursing education cannot prepare new graduates for acculturating into their workplace and for using a recently acquired new language. Keller goes on to assert that new graduates are expected to become skilled in a wide range of absolutely necessary skills, and gain a sense of the wider world of their organization and health care. She describes some of these necessary skills as being self-aware and learning about team dynamics, leading teams, coordinating care, managing conflict, understanding the psychological effects of change and transition, communication, evidence-based practice, systems thinking, and financial pressures. Neophyte nurses become overwhelmed and stressed with all of these expectations (17, 19), and stress, in the first year of practice, has been significantly related to practice errors (16, 17).

The evidence the committee members reviewed regarding competence and transition (7, 14, 16, 17, 19, 28, 30, 31, 38) found that new nurses need a year of support to learn to work within complex systems. National reports have supported a need for novice nurses to revisit their actions and to reflect on alternate pathways for decision making (7, 8, 9, 10, 19). NCSBN has a similar study analyzing this need, as well (14). While some institutions have formal transition programs (20, 26, 30) that are less than a year long, they often continue to provide ongoing support to new nurses for 12 months.

NCSBN's unpublished transition studies (16, 17) reported that new graduates were significantly more likely to report practice errors when they also reported decreased competence and increased stress. In this study and the UHC/AACN national study (19), three to six months after hire was the vulnerable period where nurses reported more stress and less competence and therefore were at risk for practice breakdown.

In a longitudinal study from Norway, Bjørk and Kirkevold (28) analyzed the consequences of not having an extended transition program by videotaping nursing practice and conducting interviews with nurses and patients. Four nurses were followed for eight to 14 months as they performed dressing changes and ambulated new surgical patients. The nurses only had a short orientation to their units. While the nurses reported that they had become efficient and rated themselves as better nurses over time, the analysis of their practice revealed that they made the same practice errors (such as contaminating wounds) at the end of the study as they did at the beginning. According to Bjørk and Kirkvold, the nurses were considered regular nurses, and it was assumed they knew what they were doing. There were no opportunities for feedback or reflective practice, which likely would have improved the competence of these nurses. This is excellent empirical data about what can happen when new nurses don't have supportive transition programs.

In the Dartmouth-Hitchcock transition program (30), investigators measured confidence, competence and readiness to practice, all of which significantly increased after their transition program. This program uses simulation vignettes that highlight high-risk and low-frequency events, as well as commonly occurring clinical situations. According to this study, this is a highly effective way of developing competency and confidence in new graduates.

Job Retention

Some might argue whether job retention is a fair measure of patient safety because while nurses may leave one job during the first year, they generally move to another position. The first workplace, however, which may already be affected by the nursing shortage, is challenged with recruiting and orienting a new nurse. Further, there is data showing a trend of nurses leaving nursing altogether, which affects patient safety. In the late 1980s only 4.5 percent of nurses were employed outside of nursing, while in 2004, 16.8 percent were (38). It is unknown as to how many nurses who leave the profession are new graduates. Workforce studies should focus attention in this area.

Statistics indicate that temporary nurses, who are often hired when a new nurse resigns, have an increased number of disciplinary complaints filed at boards of nursing (6) compared to nurses hired on a permanent basis. These data were reported by a newspaper investigative reporter, so the results should be validated by a researcher. However, the Massachusetts preliminary data on nursing error also found that errors were often linked to lack of familiarity with the practice setting (23). Ebright and colleagues (32), in their investigation to identify factors leading to near-misses/adverse events in novice nurses, found that unfamiliarity with the unit and workflow patterns was one of the themes linked to error.

Every study examined by the Transition to Practice Committee found increased retention resulted from a transition program. Of the studies and projects cited in the Evidence Grid, eight found decreased turnover rates associated with their structured and organized transition programs (17, 19, 20, 24, 26, 29, 36, 37), and these turnover rates, for the first year

in practice, varied from 6 percent to 19 percent. Williams and colleagues (19) report, from a review of the literature, that first-year turnover rates of new nurses average from 36 percent to 55 percent. The data clearly support that a well-planned transition program will improve the retention of new nurses in their first year of practice.

SUPPORT OF THE ELEMENTS OF THE MODEL

Across All Settings and All Education Levels

There is no doubt that the literature and research on long-term settings and licensed/vocational nurses is not as strong as with acute care settings and registered nurses. One NCSBN report on practical nurses (16) found that PN transition programs averaged 4.7 weeks in length, which is so short that it most likely wouldn't provide any insight as to what the effect of transition on LPNs would be. Other NCSBN research (15) again found that PNs had limited and variable transition programs.

While there are many descriptions in the literature of transition programs in acute care, exemplars of transition programs in long-term care are limited (26, 27). Two statewide transition programs were implemented across settings. Personal communication with the project managers of each program has revealed that employers in the long-term care and rural settings have responded very positively to these programs. Similarly reports of nurses in these programs have been positive, though there is no formal data on these outcomes.

One national study (5) showed high annual turnover of PNs and RNs in long-term care (50 percent), though this was for all nurses in long-term care, and not just new nurses. A national survey on the nursing home workforce (18) calculated priority ratings on areas for needed improvement: 1) lower job stress; 2) management that listens; 3) management that cares; 4) training to deal with difficult residents; and 5) training to deal with difficult family members. If new nurses in long-term care were to receive more support through a standardized transition program, impact on these areas of priority could be made.

There is not much data on PNs in long-term care settings; however there is reason to focus attention on this area. In 25 years, it is expected that one in every four, instead of one in every six, Americans will be 60 years of age or older (38). Long-term care settings will become even more important. Relying on the limited number of studies and applying results from the acute care settings and registered nurses, the Transition to Practice Committee believes that there is sufficient evidence to support the inclusion of long-term as well as acute care settings and PNs as well as RNs in this model.

Modules

The committee identified eight modules that should be included in the transition model: specialty content, communication, safety, clinical reasoning, prioritizing and organizing, utilizing research, role socialization, and delegation and supervising. As Johnstone points out (33), these should not be presented as deficit education, meaning that those modules are being presented because students didn't learn it in the first place, or didn't learn it well. Instead, these concepts should be incorporated into the new nurses' experiences so they continue to learn, from preceptor role modeling, how to think like a nurse. While these are presented separately as modules, they should be integrated into the transition program.

Specialty content is an extremely important module because having specialty content in a transition program has been linked significantly to lower practice errors (17). Past work at NCSBN has found similar results. (NCSBN, 2004) Many of the reports we reviewed recommended integrating specialty practice into transition programs (2, 7, 9, 19, 20, 24, 26, 29, 30, 36, 37). A related element is **prioritizing and organizing** one's work. Prioritizing and organizing is a part of clinical practice that is often missing in novice nurses (8, 13, 28), most likely because of lack of experience. Specifically the UHC/AACN residency program measured ability to organize and prioritize before and after their program and found

significant increases at the end of the program. Prioritizing and organizing was integrated throughout most of the transition programs that focused on specialty content.

Communication, and particularly interprofessional communication, has been in the health education literature frequently and is essential in any regulatory model. The 2003 IOM report on Health Professions Education (Greiner and Knebel, 2003) stressed the importance of teaching health care students to collaborate across professions. McKay and Crippen (2008) report that in hospitals where collaboration occurs there is a 41 percent lower mortality rate than predicted deaths. In other hospitals, McKay and Crippen (2008) report, where collaborative communication doesn't take place, mortality rates were 58 percent higher than would be predicted. Similarly, enhanced communication in hospitals has been linked to nurse satisfaction, lower costs, and greater responsiveness of health care providers. (McKay and Crippen, 2008). Carnegie (7) and NCSBN (8) report that many nursing programs provide their students with few opportunities for interprofessional communication. Supporting McKay and Crippens (2008) NCSBN's unpublished transition study (17) found that new nurses perceived that they made significantly fewer practice errors when they reported being more competent in communication and interpersonal relationships. Most of the reports reviewed recommended a purposeful integration of communication, including interprofessional relationships, into transition programs (2, 9, 19, 20, 27, 29, 30, 36, 37).

Teaching **safety** is an essential part of a transition to practice regulatory model. Johnstone and colleagues in Australia have reported (33, 34) on the importance of experientially teaching risk management to new nurses, rather than providing deficit education. Cronenwett et al., (2007) using the expertise of national health care leaders across disciplines, have described in detail a module on safety that could be used in transition programs. This consensus opinion document, Quality and Safety Education for Nurses (QSEN), can be considered excellent evidence for this transition model. The Massachusetts Board of Nursing preliminary findings on nursing home errors (23) called attention to addressing safety issues in transition programs, based on their review of discipline of new PN graduates. Likewise, the NCSBN unpublished transition study (17) found that, according to self-reports, practice errors made by new graduates were prevalent. Many of the transition programs, reviewed by the Transition to Practice Committee, focus on safety (2, 19, 20, 27, 29, 30, 36, 37).

Clinical reasoning, also called critical thinking, is another essential part of a transition to practice regulatory model. Like most of these elements, it must be integrated through the program. As the Carnegie study (7) points out, this is where nurses learn to think like a nurse. The Dartmouth program (30) is exemplary as it uses simulation to assist novice nurses in making decisions during common clinical events or events that are uncommon, but life threatening. Transition programs that specifically report integration of clinical reasoning/critical thinking include: 19, 20, 24, 26, 27, 29, 36, 37. However, interviews with project managers of transition programs indicated that all programs examined attempt to integrate clinical reasoning.

Similarly, evidence-based practice, or the **utilization of research** findings needs to be addressed in transition programs as new nurses are expected to base their practice on the evidence. (Cronenwett et al., 2007; Greiner and Knebel, 2003) Yet, NCSBN research (8, 16, 17) has shown that new nurses are weak in this area. Evidence-based practice was integral to most of the programs that we had reviewed. In the Launch into Nursing program in Texas, for example, new nurses participate in an evidence-based project and present the results to the hospital unit they work on. The international and national programs support incorporating the utilization of research into transition programs (2, 19, 20), as do many of the individual programs (2, 19, 27, 36, 37).

Role socialization is a very important part of this model, particularly for regulation. New nurses must have a good understanding of their scope of practice, as well as that of others in the health care team. Role socialization has been studied by O'Rourke (2006) for a number of years, and she has developed a program and some metrics for measuring outcomes.

Role socialization was an integral element of many of the transition programs we reviewed (2, 19, 22, 26, 36, 37). Closely related to this is the need for new nurses to develop a better understanding of **delegating and supervising**. NCSBN studies of new nurses, since 2002, consistently found that new nurses report a lack of understanding of delegation (8, 14, 16, 17). NCSBN's position paper on delegation and supervising would be helpful for this module. (NCSBN, 2005) Transition programs may be incorporating delegation/supervising into their curricula, though not many specifically indicate that. Only the Wisconsin Nurse Internship Program identified delegating and supervising as elements of their model.

Preceptor-Nurse Relationship

The evidence was overwhelming that transition to practice programs are most successful when they incorporate the use of preceptors, in a one-to-one relationship. All the programs detailed on our Evidence Grid used the preceptor model. Past research at NCSBN (NCSBN, 2004) has shown that transition programs are more effective when the new nurse works with one preceptor with the same working hours. In the Massachusetts study (23) of nursing errors one PN commented that during her orientation to the unit, she "worked with three different nurses on three different days" after which she worked alone and was encouraged to ask questions of other nurses as needed.

The transition model developed by the Transition to Practice Committee also recommends that the preceptors be skilled in the role. In many transition programs, orienting preceptors to the role is important, however, the Vermont Nurse Intern Program (26) is an exemplary model of preceptor education. They have developed this model since the beginning of their initiative in 1999 and they now credential all their preceptors. There are also other models available in the literature. (Nicol and Young, 2007) Often, preceptors feel unprepared and unsupported for the preceptorship role. For example, in one study of 86 preceptors, researchers found that preceptors reported they were unprepared to precept new graduates and that they needed more support and recognition. (Yonge, Hagler, Cox and Drefs, 2008) As has been stated previously, the Transition to Practice Committee recommends to the Board of Directors that NCSBN develop a Web site for this standardized, regulatory, transition model. An online preceptor course, with credentialing, could be included. This has been successfully accomplished in other venues. (Phillips, 2006)

In areas where preceptors are not available (very small workplaces, remote geographic areas, or organizations with preceptor burn-out) the Transition to Practice Committee members recommends to the Board of Directors that NCSBN's E-Learning Productions department design a Web site where connections to preceptors, through a remote interface, will be possible. This approach has been successfully implemented in Scotland's program (2) and will provide new nurses with opportunities for feedback, reflection, and support even when preceptors are not geographically available.

Feedback and Reflection

Feedback and reflection are important threads in this model and should be formally maintained during the six-month transition program, as well as during the six months that follow. In the section of competence, Bjørk and Kirkvold's (28) longitudinal study, showed the importance of feedback and reflection. If new nurses cannot get feedback on their practice, along with an opportunity to reflect, their practice will not improve, and, as in Bjørk and Kirkvold's study, they are at risk of making the same mistakes time and time again. It's very important for preceptors to be taught how to provide constructive feedback and how to foster reflective practice. Many of the transition programs included in this review did provide opportunities for feedback and reflection (2, 8, 27, 29, 30, 35, 36). For fostering reflection, journaling and personal inventories were described as successful strategies (36).

Length of Program – Six Months with Continued Support for One Year

Two comprehensive national studies of transitioning new nurses to practice (17, 19), using different populations, different methodologies, and different tools, both came to the same conclusion: the three to six month period, after hire, was the most vulnerable time for new graduates. In the NCSBN study, it was most likely because this is when the new nurses began to practice independently. In this study new graduates reported more stress in the 3 to 6 month period of practice, and, interestingly, they perceived less competence at 3 to 6 months than in the 0 to 3 month period. In the UHC/AACN study the authors believe this is because during the first six months in practice, many residents have specialty classes and might be feeling overwhelmed by the amount they must learn. This would be similar to the phenomenon of reality shock that Marlene Kramer (1974) described. Because of this strong evidence, it was clear to the committee that the transition program should last at least six months (similar to the Mississippi state transition program), and there was significant discussion about whether it should be one year in length because of the evidence (2, 7, 11, 19, 21, 27, 29, 32, 36, 37, 38, 39). In the end, the decision was to keep it at six months because of the premise that "regulation criteria for transition programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection." However, the committee did note that even in some programs that were less than one year in length (20, 26, 30), project directors indicated (via personal communication) that often there was continued support after the program ended, and in some cases the preceptorships continued. In one instance, this was not the case. The Kentucky regulation (22) is for 120 hours of practice. Continued support is not included in the law.

Dr. Megan-Jane Johnstone, and colleagues, from Australia (35) have written extensively on providing support to new graduates. They define support as "a process that aids, encourages, and strengthens and thereby gives courage and confidence to a new graduate nurse or a group of new graduates to practice competently, safely, and effectively in the levels and areas they have been educationally prepared to work." Some of the components of support, according to Johnstone and colleagues, (35) include being available and approachable being able to ask questions, without being ridiculed; being prompted to engage in best practices; providing benevolent surveillance, which is keeping an eye on the new graduate; providing constructive feedback and reflection; and having backup when there are problems. Formalized support systems should be built into the last six months of the new nurse's transition program.

THE ISSUE OF COST

Cost of transition programs is an area of concern and warranted consideration. Several of the reports on the Evidence Grid have discussed cost factors, and, when the organizations consider the cost of turnover in the first year of practice, return on investment reports have all been positive. Return on investment (ROI) is a comparison of net financial improvements to the cost of the program. The formula for this calculation equals net program benefits (i.e., consider turnover costs) divided by program costs. The Joint Commission (9) reports that it costs $46,000 to replace a medical/surgical nurse and $64,000 to replace a critical care nurse. Program costs (36) include staff, office supplies, speakers, photocopying, journal subscriptions, refreshments, texts, etc. One study looking at the ROI found an 884.75 percent ROI (37), while another found an ROI of 67.3 percent (20). Keller and colleagues (36) estimated that it cost them $1,000 per resident in the internship program, while replacing one nurse was $60,000. The Mississippi Nurse Residency Program (24) reported a savings of over $4 million with their six-month residency program through the elimination of agency/travel nurses. Further, they saved $1.1 million through decreased turnover. Similarly, the Children's Memorial Hospital (Chicago) yearlong residency (29) saved that hospital $707,608 per year. The Transition to Practice Committee found no studies of transition programs that found a negative ROI. While there have been no studies on transition programs in long-term care, their turnover rates are as high as those in acute care, and it makes financial sense that they would also benefit by transition programs.

If this initiative is supported by our members, the Transition to Practice Committee recommends to our Board of Directors that we work with the Center for Medicare and Medicaid Services (CMS) to identify ways to fund transition programs for nursing, as is done with medical residencies and pharmacy residencies.

IMPLICATIONS FOR BOARDS FOR NURSING

One question for boards of nursing will be, how much will implementing, and maintaining this model cost them? This will have to be studied more comprehensively during the implementation phase, if the Board of Directors and the Member Boards adopt this model. Cost issues will include the initial time for the executive director and its board to implement the legislation to adopt the transition model. There will be the need for staff to process the first license and document and file applications. When new graduates do not comply with the regulation, there will be costs incurred for disciplining them.

Kentucky has implemented a transition to practice model, and they estimate it takes 15 percent of staff time annually to implement their transition legislation. However, in their state, new graduates must complete the transition program before they take the NCLEX, so most of that activity is during those months when large numbers of graduates are completing internships and applying for NCLEX. For this proposed national model, staff time would most likely be less than 15 percent since the paperwork involving NCLEX will have been completed. The Transition to Practice Committee recommends that NCSBN develop a national Web site for this transition model and this should decrease the cost to boards by having forms, etc., readily available online.

Another implication for the boards will be bringing legislators, practice, and other key stakeholders, on board. If adopted, the Transition to Practice Committee members will develop one-page fact sheets for those boards implementing the model that will provide talking points for legislators and others. Further, the Transition to Practice Committee members, if the model is adopted, plan to work next year to build consensus and develop partnerships with stakeholders, including the American Hospital Association (AHA), AACN, NLN, AONE, NAPNES, ANA, CMS, the Joint Commission, and others.

CONCLUSION

Currently there is no national standard for transitioning new nurses from education to practice, and few states have regulations for the process of developing novice nurses as they enter the practice arena. Medicine has standardized accredited residency programs that are required of all new medical school graduates before they can be licensed. Physical therapy and pharmacy have national, standardized residency programs that are accredited, although voluntary.

Internationally, Portugal and Ireland (3, 4) are in the process of developing a national transition program to be implemented through regulation. Dr. Johnstone from Australia has been in communication with us and has indicated they are developing a national, standardized transition program. Canada (1) has developed an excellent guide to preceptorships and mentoring, though they don't have a national model. Scotland (2) has been a leader in designing a national, standardized transition program, and their Web-based model has inspired our committee members to propose designing a Web site for NCSBN's transition regulatory model. Scotland is still in the process of collecting outcome data.

Through collaboration with nursing education, practice and regulation NCSBN and boards of nursing can make this happen. After all, regulation, practice, and education have the same goal of safe and effective patient care.

If this transition regulatory model is adopted by our board of directors and Delegate Assembly, the following are the Transition to Practice Committee members' recommendations for their work in 2008-09:

- Collaborate and develop partnerships with key stakeholders;
- Identify and develop tools for measuring the outcomes;
- Develop a national Transition to Practice Web site;
- Develop model rules for Transition to Practice; and
- Identify funding sources.

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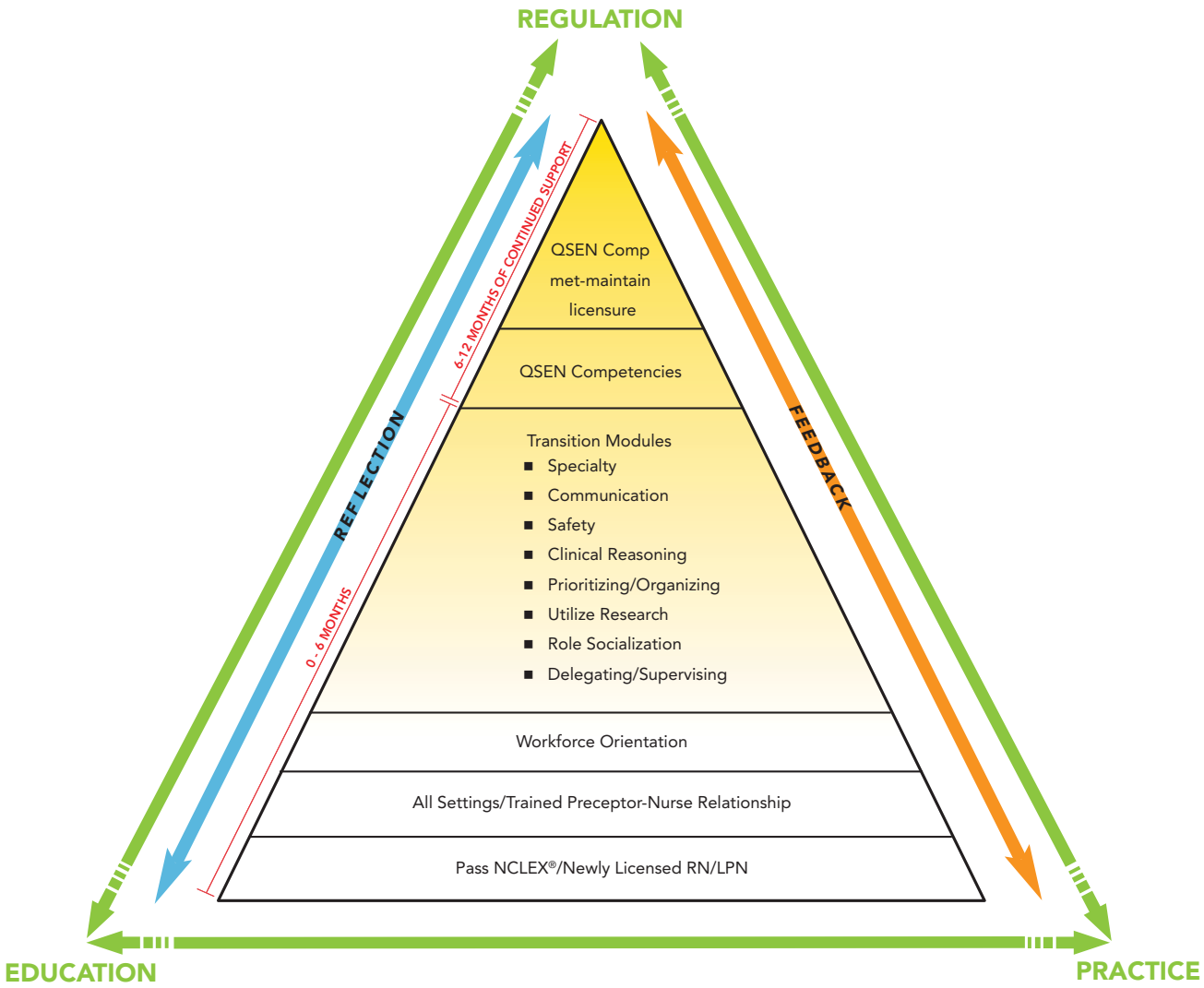
Attachment B

Transition to Practice Regulatory Model (Visual)



Attachment C

Transition Evidence Grid

This Evidence Grid represents 4 international, 16 national, 7 statewide, and 12 individual (relevant to regulation) transition projects/research/literature review findings related to transitioning new nurses to practice. The Transition to Practice Committee members reviewed all of this data, making the decision that post-graduate nurse transition programs protect the public.

Project	Description	Elements	Measurement	Length	Status/Results
1 Canadian Nurses Association's Guide to Preceptorship and Mentoring Report Online: http://www.cna.aiic.ca/CNA/nursing/education/mentorship/default_e.aspx Entitled, "Achieving Excellence in Professional Practice" **International**	General guide for setting up a mentoring and preceptorship for novice nurses.	▪ Relevant terms defined ▪ Benefits cited ▪ Costs explored ▪ Steps for developing a successful program identified ▪ Preceptor/mentoring competencies identified	Reviewed literature	N/A	From literature identified increased satisfaction, increased confidence, increased retention, and improved patient care.
2 Flying Start in Scotland Information available: http://www.flyingstart.scot.nhs.uk/ **International**	Web-based transition program launched in January 2006. Over 1,200 new nurses have taken part in the program. Approximately 200 hours of didactic content, taking about 2-5 hours per week. Uniqueness in being a Web-based program.	▪ Mentors are assigned ▪ Connections with peers/mentors can be accomplished online ▪ Online modules include: ▪ Communication ▪ Clinical skills ▪ Teamwork ▪ Safe practice ▪ Research for practice ▪ Equality and diversity ▪ Policy ▪ Reflective practice ▪ Professional development ▪ Career pathways	Currently they are interviewing with an independent research team to evaluate the program.	1 year	Have agreed to send us the research tender specification so that we can see what they're intending to evaluate; along with that they'll send us their literature review. The full evaluation won't be completed for 24 months.

Project	Description	Elements	Measurement	Length	Status/Results
3 Ireland Background available online with document entitled: "Report of the Commission of Nursing," 1998. For regulation, this document, also available online, would be helpful: "Requirements and Standards for the Midwife Registration Education Programme," 2000. **International**	In Ireland they transferred from an apprenticeship 3-year program to a 4-year program in 2002. Their implementation committee recommended a 36-week rostered year in the final year of the program.	Students are paid on the first point of their scale for staff nurses during the transition program. During this period the students are still in their education program. This is accomplished through regulatory mandate.		36 weeks	There is no data available at this point, though we are in touch with them, and they will provide data when they have it.
4 Portugal "Nursing Internate" Report not available yet. **International**	Through regulation, the country of Portugal is beginning to develop a regulatory transition model.	This program is being designed from a regulatory mandate.			As soon as their report is approved they have promised to send it to us, and they'd like to see a copy of NCSBN's Transition Model.

Project	Description	Elements	Measurement	Length	Status/Results
5 2002 American Health Care Association Survey Reported available at: http://www.ahcancal.org/Pages/Default.aspx, under Research and Data. Updated information expected in spring of 2008. **National**	Survey completed by 6,155 U.S. nursing homes.	N/A	Collected information from 6 nursing staff positions on: ▪ The number of vacant positions as of June 30, 2002 ▪ The number of employees who have left these facilities from Jan. 1 through June 30, 2002 ▪ Relative difficulty in recruiting key nursing staff	N/A	▪ Annual turnover of RNs, LPNs, and DONs is 50% ▪ 2/3 of facilities reported it was harder to recruit RNs and LPNs in 2002, compared to previous year.
6 Behrens, Michael J. September 10, 2000, investigative report, *Chicago Tribune* **National**	Analyzed 3 million state and federal computer records to create a database that quantifies the role nurses play in medical errors.	N/A	Federal and state computer records reviewed, though author acknowledges that they are incomplete.	N/A	▪ From 1995-2000 at least 1,720 hospital patients have been accidentally killed and 9,584 others injured by nurses across the country. For example: ▪ 418 killed, and 1,356 injured, by RNs operating infusion pumps incorrectly. ▪ 216 patients were killed, and 429 injured, by RNs who failed to hear alarms of lifesaving equipment. ▪ 119 patients killed, and 564 injured, by unlicensed, unregulated nurse aides, not adequately supervised by RNs. ▪ Author concludes that these deaths and injuries are due to cuts in staff and other resources. ▪ Illinois state disciplinary records show an increasing focus of investigations on temporary (agency, traveling) nurses, and most were linked to lack of knowledge or unfamiliarity with patients.

Project	Description	Elements	Measurement	Length	Status/Results
7 Carnegie study Some information about the study on their Web site: http://www.carnegiefoundation.org/ Final report will be out July, 2008; draft report available from NCSBN upon request. **National**	Part of larger, national study. Research design was qualitative ethnography, utilizing interviews (total of 588 individual interviews), focus groups, review of curricula, and observations in the classroom and clinical facilities, in excellent nursing programs. Furthermore 3 national surveys were conducted with members of the American Association of Colleges of Nursing, the National League of Nursing, and the National Student Nurse Association.	Recommendation 9.b. states: We recommend residency training programs lasting at least one year focused on one area of nursing care to be offered in all health care delivery institutions. ▪ Residency should focus on at least one area of specialty so the nurse has the opportunity to develop in-depth clinical patient population knowledge in that area. ▪ Improved follow-through evaluation of nursing graduates that identify practice-educational gaps. ▪ Evaluation of the residency program should include patient outcomes. ▪ To offset the costs of these programs, they recommend lower entry-level salaries for the residency year (similar to physical therapy residencies).	1. Ethnographic qualitative study 2. Survey of the AACN members 3. Survey of NSNA members	1 year	Conclusions related to this initiative: ▪ 3 apprenticeships were studied, including cognitive, clinical judgment and know-how, and ethical comportment. It was found that these apprenticeships must be integrated. ▪ Students and faculty alike pointed to need for yearlong residency programs. ▪ Nearly no planned interdisciplinary experiences took place in prelicensure programs. ▪ Few students reported confidence in detecting subtle clinical changes in their patient's condition and little follow-through was possible in prelicensure programs. ▪ Recommend students continue to care for 1-2 patients in their prelicensure program; researchers think larger patient care assignments will create a gap in the student's understanding of the nurse patient relationship due to insufficient time for learning and reflection.

Project	Description	Elements	Measurement	Length	Status/Results
8 "Evidence-Based Nursing Education for Regulation (EBNER)," 2006, and related Systematic Review of Studies on Nursing Education Outcomes: An Evolving Review," 2006, are available here: https://www.ncsbn.org/208.htm Related research, NCSBN Research Brief Vol. 24, "A National Survey on Elements of Nursing Education" is available here: https://www.ncsbn.org/360.htm **National**	Report of the 2006 Practice, Regulation and Education (PR&E) Committee, after being charged by the Board of Directors to identify evidence for the rules and regulations at boards of nursing. It was developed following a rigorous systematic review of related nursing education research outcomes and NCSBN research on nursing education.	Identified these education broad areas that are supported by the evidence: ▪ Adjunctive teaching methods; ▪ Assimilation to the role of nursing; ▪ Deliberate practice with actual practice; ▪ Faculty-student relationships; and ▪ Teaching methodologies (specified in the report).	Methodology available in the final report. Utilized the following levels of evidence: I. RCT, meta-analyses, systematic or integrative review – strongest level of evidence. II. Quasi-experimental, correlational, descriptive, survey, evaluation and qualitative designs – next strongest level. III. Expert opinion and consensus statements – weakest level, but adds value to professional research, especially when there isn't available evidence.	N/A	Systematic review identified: ▪ Assimilation to the role of nursing was identified as a major element, and this includes transition to practice programs. ▪ The systematic review identified feedback and reflection as integral threads in pre-and postlicensure learning.

Project	Description	Elements	Measurement	Length	Status/Results
9 Joint Commission White Paper (2002), entitled: "Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis" Report available: http://www.jointcommission.org/Nurses/ **National**	23 esteemed healthcare professionals, from nursing and other disciplines, representing education, practice and regulation, developed a white paper that calls for a "standardized, post-graduate nursing residency program," similar to that from ACGME, with funding to support the training.	Suggested areas of emphasis include: ▪ Team training ▪ Support of nursing orientation ▪ Support of in-service and continuing education ▪ Creation of career ladders ▪ Seek federal support for the transition programs			Reported on the high cost of nurse turnover; assuming a turnover rate of 20 percent, with a hospital employing 600 nurses, it will cost about $5,520,000 to replace them (research shows it costs $46,000 to replace a medical/surgical nurse and $64,000 to replace a critical care nurse). Cites evidence from the Illinois state disciplinary records that cite temporary nurses having increasingly more medical error investigations (relates patient safety to retention rates). Provides data to support new nurses receiving little orientation/transition. Flexner Report of 1910 made medical residencies obligatory, no such requirement exists for nursing. Medical residencies are partly paid for by medicare monies and are standardized through ACGME.

Project	Description	Elements	Measurement	Length	Status/Results
10 Hofler, L. D. 2008. Nursing education and transition to the work environment: A synthesis of national reports. *Journal of Nursing Education*, 47(1), 5-12. **National**	2-part process to identify reports and to analyze their content. First organizations were identified (using experts), and then each site was used to retrieve and analyze their work. They purposely did not include regulatory agencies and NCSBN because "their mission is to protect the public." They identified 15 organizations and 35 reports.	Reports identified were between 1995-2005. For inclusion, each report: ▪ Was published by a nursing professional organization. ▪ Included recommendations about nursing education and the transition of nurses to the work environment. ▪ Did not focus primarily on regulatory issues.	The data were reviewed for themes, which were then cross-compared from each report to develop an understanding of the recommendations. Five thematic categories were identified.	N/A	Themes identified were: ▪ Standards, credentialing, regulation and accreditation, including recommendations on regulation, accreditation, standardization via licensure, and standardization of professional credentialing. This theme was most closely related to our work, and synthesis of the recommendations included differentiation of practice through accreditation and licensure; articulation of competence for differentiated roles; development of political activism; and funding at the national, state and local levels. Other themes included: ▪ Capacity and infrastructure of the educational system. ▪ Collaboration and integration with others, including those outside of nursing. ▪ Incentives in the health care delivery system for the development of a highly educated workforce. ▪ Transition to work environment includes recommendations that describe the transition of new nurses from an academic to a practice setting. That is, they are recommending more collaboration between education and practice.

Project	Description	Elements	Measurement	Length	Status/Results
11 Lynn, M. R. (2007). "Initial Evaluation HRSA-Funded Residency and Internship Programs." Funded by HRSA Contract: HH-SH2302 00632050C This preliminary report is available from HRSA or NCSBN. **National**	Evaluative study of the aggregate of transition programs they fund, though participation is voluntary. 12 of the HRSA-funded sites agreed to take part. Questions: Are there differences between ▪ Hospital vs. home health ▪ Length (less than 6 mos. vs. more than 6 mos.) ▪ Classification of residents (new graduates vs. reentry) ▪ Degree ▪ Magnet status ▪ Unit of employment ▪ HRSA vs. UHC/AACN	N/A This wasn't one planned residency, but instead it consisted of many different types.	▪ Gerber's Control Over Nursing Practice Scale ▪ McCloskey/Mueller Satisfaction Scale ▪ Casey-Fink Graduate Nurse Experience Survey ▪ These tools were also used in the UHC/AACN study	10 weeks - 3 years	Many of the groups did not have large numbers. They found significant differences between: ▪ Program start and finish, which supports these programs. ▪ No differences between hospital and home health residents; this provides some support for including all settings. ▪ No differences between less that 6-month-long programs and over 6-months (except shorter programs felt they were better paid), though numbers were small. ▪ There were differences between new graduates and nurses who change specialties. ▪ No differences between educational groups. ▪ Residents in magnet hospitals were more satisfied. ▪ There were differences across specialties. ▪ There were differences between the HRSA and UHC/AACN residents.
12 NCSBN's Analysis of Nursys® Disciplinary Data from 1996 – 2006 (December 2007) Unpublished report available from NCSBN **National**	Report of 59,695 nurses reported by 44 boards of nursing for disciplinary action between January, 1996, and the end of December, 2006.	N/A	Nursys® electronic information system	10 years of disciplinary data	Trend of increasing discipline over the 10 year period.

Project	Description	Elements	Measurement	Length	Status/Results
13 NCSBN Employer Survey (2004) Research Brief is available: https://www.ncsbn.org/360.htm Vol. 14, "Report of Findings from the 2003 Employers Survey" **National**	Surveys completed by 1,230 employers from all settings.	N/A	Survey was investigator constructed.	N/A	Employers answered "Yes definitely" to overall preparation to provide safe, effective care: ▪ ADN – 41.9% (n=321) ▪ BSN – 41.9% (n=239) ▪ Diploma – 48.8% (n=106) ▪ LPN – 32.9% (n=237)
14 NCSBN Interim Results of Post-Entry Study: Preliminary report available from NCSBN. Full report is due in September 2008. **National**	Longitudinal, qualitative study of new nurses with 1,111 e-mail responses to date. LPN responses not coded yet.	N/A	Email responses with qualitative analysis about how competence develops	N/A	Implications for transition to practice: ▪ The diversity of practice settings and extreme acuity of hospital settings suggest a site-specific transition program with a preceptor for the first year. ▪ The narratives demonstrated a real need for novice nurses to revisit action and decisions and reflect on alternate pathways (i.e., need to debrief and reflect). ▪ Need for role clarification relative to LPNs and PCAs. Supervision of LPNs or PCAs was either minimal or totally absent.

Project	Description	Elements	Measurement	Length	Status/Results
15 NCSBN's Transition Study (2006) Research Brief available at: https://www.ncsbn.org/360.htm Vol. 22 – "Report of Findings from the Practice and Professional Issues Survey; Transition to Practice: Newly Licensed RN and LPN/VN Activities." April 2006 **National**	NCSBN conducted a survey on 628 new nurses and 519 new LPNs related to transition to practice issues. Survey was investigator constructed.	N/A	Survey was investigator constructed.	N/A	▪ LPNs assigned to care for patients earlier and caseload heavier ▪ 38.9% of RNs participated in "ships" + orientation ▪ 16.2% of LPNs participated in "ships" + orientation ▪ Graduates of ADN programs were more likely than BSN graduates not to have a "ship" ▪ Across nation, transition programs were quite variable ▪ Research Brief is available online
16 NCSBN's Transition Study (unpublished) Report available from NCSBN. **National** – PNs	400 new LPNs/VNs; 231 preceptors; non-experimental, comparative, nurse-preceptor dyad design. Aims: ▪ To describe the transition experience of newly licensed LPNs/VNs ▪ To identify factors that influence transition to practice of LPNs/VNs ▪ To examine the impact of the transition experience on clinical competence and safe practice issues of newly licensed LPNs/VNs	N/A	Design: non-experimental, comparative, nurse-preceptor dyad. ▪ Clinical competence defined by 35 questions on core set of functions, with validation by preceptors. ▪ Cronbach's alpha=.93 ▪ Content validity and construct validity established. ▪ Tool for practice errors contained 21 items.	N/A	▪ Transition experiences vary, with those in hospitals more likely to have internship experiences and longer programs. ▪ More likely to make practice errors when they reported they were less competent and/or more stressed. ▪ Average length of a transition program was 4.7 weeks. Because effect size (mean length of transition programs) was so small, there was not much evidence to be gleaned from those in transition programs vs. those without programs.

Project	Description	Elements	Measurement	Length	Status/Results
17 NCSBN's Transition Study (unpublished). Report available from NCSBN. **National**- RNs	▪ N=560 new nurses; N=231 preceptors ▪ Non-experimental, comparative, nurse-preceptor dyad design. ▪ To describe the transition experience of newly licensed nurses ▪ To identify factors that influence transition to practice ▪ To examine the impact of the transition experience on clinical competence and safe practice issues of newly licensed RNs	N/A	▪ NCSBN's Clinical Competency Assessment Scale – 35 items assessing 4 dimensions of clinical competence ▪ NCSBN's Practice Errors Survey – 21 items measuring practice errors. ▪ Survey was investigator constructed and validation and reliability established	N/A	▪ Preceptors and new graduate ratings were similar with competence ratings (no significant differences); conversely, new RNs reported significantly more practice errors than their paired preceptor did. ▪ Areas new nurses acknowledge weaknesses: utilize research; recognize when demands exceed capability; delegating and supervising. ▪ Vulnerable period (less competent; more stress) was 3-6 months when new graduates were less supervised ▪ During first 3 months, those with a primary preceptor rated themselves as performing at significantly higher levels than those without the primary preceptor. ▪ When more competent in clinical reasoning ability – significantly fewer errors ▪ When more competent in communication and interpersonal relationships – significantly fewer errors ▪ When transition programs (in hospital setting) addressed specialty, significantly fewer errors. ▪ Stress was positively related to practice errors. ▪ Highest stress levels occurred in 3-6 months of practice. ▪ 19% who had an internship program reported they were likely to leave their position within 6 months; 33% without an internship program reported they were likely to leave their position within 6 months.

Project	Description	Elements	Measurement	Length	Status/Results
18 National Survey of Nursing Home Workforce Satisfaction (2006) Report available online: http://www.myinnerview.com/downloadPDF.php?pdf=miv/reports/MIV_NHWS07_FA.pdf **National**	Collected satisfaction data from 106,858 staff working in 1,933 nursing homes in every state, except Alaska.	N/A	Utilized confidential surveys completed by employees and returned to MyInnerView during 2006. Psychometrics of the instrument were good. To delve more deeply into employee concerns, they identified priority items. Then they calculated a priority rating on how each item ranked, both in terms of its average score and the strength of its correlation with workplace recommendation. These top ratings (see results column) reflect areas where most nursing homes need improvement and where the greatest impact in satisfaction is likely.	N/A	▪ Generally found good satisfaction of nursing home employees. ▪ The priority listings were very relevant for our transition work: 1) help with job stress; 2) management listens; 3) management cares; 4) training to deal with difficult residents; and 5) training to deal with difficult family members.
19 University HealthSystem Consortium/American Association of Colleges of Nursing (UHC/AACN): Williams, C.A., Goode, C.J., Krsek, C., Bednash, G.D. and Lynn, M. R. (2007). Postbaccalaureate nurse residency 1-year outcomes. *JONA*. 37(7/8), 357-365. **National**	This is another national, standardized model that is being implemented in 34 sites in university healthcare settings in 24 states.	▪ Core curriculum with focus on leadership, research based practice, professional development, communication, critical thinking, patient safety, and skills. ▪ Clinical guidance with a preceptor. ▪ Access to a resident facilitator for role development and guidance. ▪ Residents also participate in usual orientation procedures for that institution. ▪ Program designed for BSN graduates, though many agencies have developed alternative programs for ADN and diploma graduates.	They collect data on skill development and support, perceptions of control over practice, job satisfaction, retention, and demographics. Tools include: ▪ Casey-Fink Graduate Nurse Experience Survey ▪ Gerber's Control Over Nursing Practice Scale ▪ McCloskey Mueller Satisfaction Scale	12 months	Ongoing ▪ Turnover of 12%, compared to literature reports from 36%-55%. ▪ Weren't able to gather reliable cost data ▪ Similar to our transition study, showed vulnerability at 4-6 months (dip in scores, with recovery after 6 months). ▪ Dynamics of what occurs during a residency program are complex. ▪ Significant increments were seen on the Casey-Fink scales for Organize and Prioritize and Communication-Leadership. One of the two cohorts showed significant increases in the Support Scale.

Project	Description	Elements	Measurement	Length	Status/Results
20 Versant: Beecroft, P.C., Kunzman, L. and Krozek, C. (2001). RN internship: Outcomes of a one-year pilot program. *JONA*. 31(12), 575-582. www.versant.org **National**	Implemented in over 30 organizations nationwide, and they have over 5 years of data (over 3,000 residents). Unique in that it supports a cultural change by incorporating committees within the agency to oversee and plan activities; by including preceptors, mentors, and trained facilitators; being based on a business model; and being a national, standardized model.	Developed using Ohio State University's DACUM method; includes some specialty curriculum. ▪ Protected time. ▪ Looping where residents go to other units. ▪ Use a portal Web where competencies are validated. ▪ One-to-one preceptors. ▪ Mentor who is non-evaluative. ▪ Support groups with trained facilitators for a safe, confidential environment. ▪ Classroom and skills lab education.	Some of the tools used include: ▪ Professional Subscale from Corwin's Nursing Role Conception Scale ▪ Schutzenhofer Professional Nursing Autonomy Scale ▪ Skills Competency Self-Confidence Survey (investigator designed) ▪ The Slater Nursing Competencies Rating Scale ▪ The Organizational Commitment Questionnaire (OCQ) ▪ The Anticipated Turnover Scale (ATS)	18-22 weeks (while the program lasts only 18-22 weeks, from personal-communication we found that the preceptorship and/or mentoring often continue)	▪ Cost benefit positive ▪ ROI (%) of 67.3 ▪ Increases retention (6% turnover) ▪ Increase competency While the 2001 publication is fairly true to the program, there have been changes (such as from 6 months to 18-22 weeks). Other publications are in process, from personal communication.
21 California Institute for Nursing and Health Care Information available here: http://www.cinhc.org/ **Statewide**	A collaborative project in California where they are working to redesign nursing education. Their work groups include: ▪ Academic/Service Partnerships; ▪ Professional and Clinical Role Development; ▪ Economical Models for Funding Education; ▪ Collaborative Education; ▪ Faculty Recruitment and Development; ▪ Simulation; ▪ New Graduate Transition: Residencies; ▪ Out of the Box – Big Bold Steps for Innovation and Evaluation; and ▪ Synthesis Advisory Team.	Regarding the transition programs only: ▪ Using medical terminology of "attending" nurse who will be with new nurses for 3 years. ▪ Developing collaborative partnerships. ▪ Goal is to go across all settings. ▪ Using the Oregon Model for inspiration, would like a seamless movement from ADN to BSN degrees in nurses. ▪ Are exploring long-term funding. ▪ Study demonstration models. ▪ Compile standards for new graduates based on evidence.	N/A	Recommend 1 year of transition, and 3 years to move to proficiency	Are in the process of writing a white paper and making recommendations formal. Further, there is a partnership of service in California looking into residency programs. It is being led by nurse leaders from the Association of California Nurse Leaders, with participation from nurse leaders at Tenet Healthcare and Scripps. There is interest in the dedicated nursing education unit that's being used at the University of Portland, Oregon.

Project	Description	Elements	Measurement	Length	Status/Results
22 Kentucky's legislation Information available here: http://www.kbn.ky.gov/education/pon/entry/ **Statewide**	Legislation for 120 hours of precepted experience within nursing program (directly before graduation) and 120 hours after graduation with the employer, but before fully licensed.	▪ Education and practice are both responsible. ▪ Monitored through regulation. ▪ Must pass NCLEX within 6 months. ▪ Integrated practicum in education and clinical internship following graduation. ▪ Across settings and education levels.	NCSBN and a Kentucky University measured outcomes.	120 hours of precepted experiences before and after graduation.	Outcomes being measured, and NCSBN will review the results.
23 Massachusetts Department of Public Health Board of Registration in Nursing: "A Study to Identify Evidence-Based Strategies for the Prevention of Nursing Errors" – Preliminary Data Report available from NCSBN. **Statewide**	Descriptive study of nursing errors found in 78 complaint cases involving 34 RNs and 44 LPNs who practiced in nursing homes in Massachusetts; sampling technique was presented.	N/A	Used a case analysis format, with data being collected using a modified Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP™) audit instrument.		▪ Seven of the 44 LPNs were licensed for 12 months or less; there were no novice RNs in the analysis. ▪ Applicable to the Transition to Practice initiative, errors were linked to inexperience to particular clinical events; lack of familiarity with the practice setting; lack of consistently assigned preceptors and the adequacy of the novice nurse's transition program. ▪ Interruptions challenged the novice LPNs who made errors, thus effecting their organizational, prioritizing, communication, delegation, and task completion skills. ▪ Study calls attention to the potential patient safety benefit of a novice nurse transition program that provides sufficient time, supervision, and support to new nurses.

Project	Description	Elements	Measurement	Length	Status/Results
24 Mississippi Office of Nursing Workforce Nurse Residency Program Information available: www.monw.org **Statewide**	6-month residency/ internship program, which is implemented through the Mississippi Office of Nursing Workforce.	▪ Coordinator ▪ Weekly meetings/ seminars ▪ 2 weeks of a general orientation ▪ Includes NCLEX reviews ▪ Unit orientation (or specialty content) included ▪ Work up to a full patient load ▪ Preceptors will mentor 1-2 residents/interns	Factor Analysis of Tool (Halfer-Graf Job/Work Environment Nursing Satisfaction Survey): ▪ Resourcefulness – 4 items ▪ Mutual respect – 3 items ▪ Empowerment – 4 items ▪ Nonjudgmental work environment – 2 items ▪ Becoming part of a team – 3 items ▪ Lifelong learner – 3 items ▪ Degree of job fit – 2 items	3-6 months	▪ Savings of over $4 million through elimination of agency/travel nurses ▪ Savings of $1.1 million through decreased turnover ▪ Reduction of vacancy by 47% ▪ Reduction of turnover by 10% ▪ Patient satisfaction increased 10% ▪ 80% of residents completed program
25 North Carolina's Transition program Information is available here: http://www.ffne.org/transition.cfm **Statewide**	Long-range goal is to create a regulatory model for transitioning new nurses in NC by 2015. Our Research Department is using our transition tools, so these results should enrich our 2006 study results.	Phase I – studying the current transition practices and their impact on newly licensed nurses. Phase II – will focus on developing evidence-based, population-specific transition programs for NC.	Phase I ▪ NCSBN's Clinical Competency Assessment Scale – 35 items assessing 4 dimensions of clinical competence. ▪ NCSBN's Practice Errors Survey – 21 items measuring practice errors. ▪ NCSBN's Risk for Practice Breakdown tool – Error index will be generated based on above tool.	N/A	Data collection taking place now, and study will be completed by summer of 2008.

Project	Description	Elements	Measurement	Length	Status/Results
26 Vermont Nurse Internship Program (VNIP) Information available: http://www.vnip.org/ **Statewide**	A standardized, statewide internship program that incorporates all levels of education (from LPN through BSN) and takes place in all settings. The model has been used in over 20 agencies across the state, in both acute and long-term care. To date over 500 interns have been enrolled in the program. Unique aspects of this program include that it has been used across all settings; that they have a standard program whereby they train their preceptors; and this is a collaborative project between regulation, practice and education.	▪ Educate their preceptors and have started a statewide cred (approximately 200 hours of educator time for each internship cohort and/or session). ▪ Program components include: managed care, standards of care, cultural competence, quality improvement, IVs, medications, pain management.	COPA model for competencies Retention rates Recruitment Satisfaction	Minimum 10 weeks; specialty care internships sometimes require up to 12 months	▪ Pre-internship retention was 75%, after program is 93%. ▪ 48% of interns were recruited from out of state. ▪ Increased satisfaction. ▪ Informal survey of longterm settings showed positive response to the transition program.

27
Wisconsin Nurse Residency Program (WNRP)
 	
Information available here: http://wnrp.org/
 	
Statewide
	Statewide with 40 plus hospitals, including a large rural group, which is a unique aspect of this program. They have enrolled over 300 new graduates in this program.	▪ Clinical coach
		▪ Learn to think like a professional
		▪ Meet once a month
		▪ Reflection and feedback
		▪ Focus on:
		  ▪ Critical thinking
		  ▪ Systems
		  ▪ Failure to rescue
		  ▪ Best practice
		  ▪ EBP
		  ▪ Delegation
		  ▪ Communication
			They look at job stress, organization commitment, clinical decision-making, and behavior in the professional role. Tools include:
			▪ Porter and Steers Organizational Commitment
			▪ Jenkins's clinical decision-making
			▪ Professional Nursing Behavior
				12 months	Just finished 3 year HRSA report and have a grant for another 3 years. Are looking to possibly collaborate with NCSBN on use of our transition tool. Will focus on preceptors this time. Increase of retention; rural settings found it highly beneficial.

Project	Description	Elements	Measurement	Length	Status/Results
28 Bjørk, I.T. and Kirkevold, M. (1999). Issues in nurses' practical skill development in the clinical setting. Journal of Nursing Care Quality. 14(1), 72-84. **Individual**	▪ Longitudinal, videotaped interviews of 4 nurses from 8-14 months after licensure ▪ Interviews with patients and nurses ▪ Practicing skills of dressing changes and ambulation	N/A	▪ Videotapes ▪ Interviews with patients and nurses	Had short orientation of 3 weeks	While the nurses became more efficient, they made the same omissions after 14 months: ▪ Contaminated wounds ▪ Misuse of gloves ▪ Failed to wash hands ▪ Dangerous tube removal ▪ Interviews with patients showed caring over the year ▪ Inadequate physical support during ambulation ▪ Privacy not maintained Conclusion: Limited orientation/ transition program did not allow for reflection and/or feedback so that the same errors were made. Results are relevant for regulation and public protection.

29
Children's Memorial Hospital, Chicago:
 	
Halfer, D. (2007). A magnetic strategy for new graduate nurses. Nursing Economics. 25(1), 6-11.
 	
Individual
	Designed an internship program to bridge the gap between the academic and service settings. Based on Benner's and Kramer's classic research. Program includes 80 hours of classroom content. Unique aspects include: Web-based delivery of content; professional transitioning that allows for a safe environment for sharing mistakes they made or almost made; opportunities to rotate throughout clinical areas; phased preceptor model; preceptors receive 5% hourly pay differential; code debriefing for support.	▪ Classroom learning:
		  ▪ Family
		  ▪ Assessment
		  ▪ Safety
		  ▪ Pain
		  ▪ Abuse
		  ▪ Diversity
		▪ Skills labs
		▪ Precepted orientation
		▪ Professional transitioning sessions
		▪ Clinical learning exchanges
		▪ Clinical mentors
		▪ Code debriefing
			Recruitment and retention	1-year program	▪ Recruitment increased by 28%.
					▪ 7% reduction in nurse vacancy rate.
					▪ Decrease in turnover from 29.5% to 12.3%.
					▪ Cost savings of $707,608 per year.
					▪ Steadily improved nurse satisfaction.

Project	Description	Elements	Measurement	Length	Status/Results

30
Dartmouth-Hitchcock Transition program:
 	
Beyea, S.C., von Reyn, L., and Slattery, M.J. (2007). A nurse residency program for competency development using human patient simulation. *Journal for Nurses in Staff Development*. 23(2), 77-82.
 	
Individual
	To date, 375 residents have been through this residency program. There is a didactic portion of the program and various tracks of the program. Classes include about 40 hours of didactic content and 40 hours of simulated learning. The uniqueness of this program is the focus on simulation, and especially for low frequency, but high risk events.	▪ Preceptor assigned in first week.
		▪ Ongoing support of preceptor, clinical education, clinical specialist after program ends.
		▪ Didactic includes: health systems, information management, safety, and clinical/functional.
		▪ Focus on improving novice response to "failure to rescue."
		▪ Reflection/debriefing focus.
		▪ Focus on high-risk, low frequency situations, as well as high frequency, commonly occurring clinical events.
		▪ Didactic concepts include:
		  ▪ Systems
		  ▪ Information management
		  ▪ Safety
		  ▪ Functional
			▪ Weekly self-rating of confidence, competence, readiness for independent practice.
			▪ Nurse Resident's Readiness for Entry into Practice Competence Questionnaire, adapted from Babenko-Mould's Self-Efficacy for Professional Nursing Competencies Instrument.
			▪ Weekly simulator evaluation.
				12 weeks, though institution provides ongoing support	▪ Personal communication: Hospital mortality and cardiac arrests fell after program instituted…however these data should be cautiously considered because at the same time the organization started an early response team.
					▪ All three measures of confidence, competence, and readiness to practice increased significantly after the program.
					▪ Great improvement in IV medications, use of equipment and response to physiologic emergencies after program (attributed to simulations).

31 del Bueno, 2005. A crisis in critical thinking. Nursing Education Perspectives. 26(5), 278-282. **Individual**	Description of ongoing work with the Performance Based Development System (PBDS), used in 350 health care agencies and 46 states.	▪ Clinical reasoning/ critical thinking. ▪ Clinical coaching. ▪ Nontraditional strategies (not spelled out). ▪ Patient situations that require application, analyzing, and synthesis.	Analysis of PBDS tools	10-12 weeks find positive results	▪ 35% of graduates met employer expectations for clinical judgment. ▪ Examples given where 50% of the new nurses would miss recognizing life-threatening situations.

Project	Description	Elements	Measurement	Length	Status/Results
32 Ebright, Urden, Patterson and Chalko (2004). "Themes Surrounding Novice Nurse Near-Miss and Adverse-Event Situations" **Individual**	Purpose of the study was to identify the human performance factors that characterized novice nurse near-miss/adverse-event situations in acute care. Experience since completion of a nursing program ranged from 6 months to 12 months.	N/A	8 Retrospective interviews of novice nurses about details of near-miss or adverse-event situations. Interview team consisted of: ▪ Faculty member with expertise in complexity ▪ Faculty member with expertise in critical care and the human performance framework ▪ PhD prepared engineer with expertise in human performance	Findings suggest support up to 1 year following graduation.	Themes surrounding near-miss/adverse-event cases: ▪ Clinically focused critical thinking ▪ Seeking assistance from experienced nurses ▪ Knowledge of unit and workflow patterns ▪ First-time experiences ▪ Time constraints ▪ Hand-offs ▪ Influence of peer pressure and social norms ▪ Losing the big picture ▪ Novice assisting novice Of the 12 recruited participants, 7 had at least 1 near-miss event, and 1 provided 2 events. Most, but not all, errors were related to medication administration. Study pointed out the importance of novice nurses being able to reflect about their own patient situations and those of others.

33
Johnstone, M. J. and Kanitsaki, O. (2006). Processes influencing the development of graduate nurse capabilities in clinical risk management: An Australian study.
 	
Individual
	Exploratory-descriptive case study approach, with qualitative and quantitative data collection and analysis.	Elements (from literature) of opportunities putting graduate nurses at risk for error:
		▪ Inadequate education
		▪ Inadequate supervision
		▪ Workplace bullying
		▪ Hierarchical structures inhibiting performance
		▪ Poor planning and scheduling of work
		▪ Poor skill mix
		▪ Heavy workload
		▪ Time pressure
			Over a 12-month period and in 5 phases, 6 questionnaires, focus groups, and interviews. The 4 sampling units included: graduate nurses, key stakeholders, patient outcome data, and literature. Data were analyzed using content and thematic analysis strategies. A total of 63 questionnaires were completed. Additionally, 35 focus group and individual interviews were completed with new graduates and key stakeholders. Patient outcome data included: variance analysis of planned care against outcome; number of incident reports, patient complaints and patient feedback.	N/A	▪ "Deficit education" is not appropriate for teaching new graduates to avoid errors. That is, don't provide education with the idea that there is a knowledge deficit. Instead, the experiential aspects must be stressed.
					▪ None of the graduates, having been introduced to clinical risk management, was directly involved in a preventable adverse event resulting in patient harm.
					▪ New graduates personal characteristics for managing risks include:
					  ▪ Being (hyper)vigilant of limitations as a beginner.
					  ▪ Asking for assistance without fearing they'd be perceived as "not coping."
					  ▪ Actively seeking supportive supervision.
					  ▪ Actively seeking to decrease their workload.

Project	Description	Elements	Measurement	Length	Status/Results
34 Johnstone, M. J. and Kanistsaki, O. Johnstone, M. and Kanitsaki, O. In press. Patient safety and the integration of graduate nurses into effective organisational clinical risk management systems and processes: an Australian study. Quality Management in Health Care [Accepted 21 May, 2007] **Individual**	Exploratory descriptive case study: ▪ 2 cohorts of graduate nurses undertaking a 12-month graduate nurse transition program ▪ Key stakeholders ▪ Outcomes data ▪ Literature review	N/A	Quantitative and qualitative data collection and analysis strategies were used. 12-month period in 5 phases. 6 survey questionnaires and 35 in-depth individual and focus group interviews.	Sample took part in a 12-month transition program. Clinical risk management was integrated by students within 3-4 months.	▪ Novice nurses were able to integrate patient safety with the system, during this 12-month program, within 3-4 months. ▪ Incident reporting increased from 2.6% at first to 9.8% over the 12 months because at first the novice nurses were reluctant to report incidents, but with support in learning about risk management they learned to complete incident reports. ▪ Key indicators validating that novice nurses developed this integration included familiarity with: ▪ Geographical layout of hospital ▪ Hospitals' policies regarding patient risk assessment tools ▪ Processes of evidence-based practice ▪ Incident reporting
35 Johnstone, M. J., Kanitsaki, O. and Currie, T. (2008). The nature and implications of support in graduate nurse transition programs: An Australian study. Journal of Professional Nursing, 24(1), 46-53. **Individual**	Exploratory-descriptive case study approach, incorporating both qualitatitve and quantitative analysis. The study was conducted over 12 months.	N/A	Used 6 survey questionnaires to neophyte nurses. Descriptive data was sought on: graduate nurse self reported confidence and competence, particularly with safety, evidence-based practice, managing risk in patients, seeking advice, recognizing limitations, making decisions, reporting incidents, and understanding risk management. Additionally, 35 individual and focus group interviews were conducted.	The period of support was largely dependent on the graduate, though they recommended at least 4 months duration.	Definition of support (p. 52): A process that aids, encourages, and strengthens and thereby gives courage and confidence to a new graduate nurse or a group of new graduates to practice competently, safely, and effectively in the levels and areas they have been educationally prepared to work." Support themes: ▪ Availability ▪ Approachability ▪ Being able to ask questions ▪ Prompted to engage in best practices ▪ Benevolent surveillance ▪ Feedback ▪ Given reassurance ▪ Backup ▪ Reflection (they call it "debriefing")

Project	Description	Elements	Measurement	Length	Status/Results
36 Launch into Nursing: a collaboration between the University of Texas M.D. Anderson Cancer Center and The University of Texas Health Science Center at Houston, School of Nursing. Keller, J. L., Meekins, K. and Summers, B.L. (2006). Pearls and pitfalls of a new graduate academic residency program. *JONA*. 36(12), 589-598. **Individual**	Describe the design of a collaborative academic residency program for graduate nurses.	▪ Academic leadership course has become cornerstone. Also included simulations, including "Friday Night in the ER." ▪ Introduction to workplace resources, which included projects, small group discussions, introductions to a variety of roles, etc. ▪ Socialization was very important, as it has been cited as linked to retention and safety. ▪ Each was matched to a trained "clinical coach." Describes their curriculum map in detail. Will be helpful with module design. Areas from curriculum map include: ▪ Communication ▪ Systems thinking ▪ Safety ▪ EBP ▪ Socialization ▪ QI	Outcomes measured, with various tools: ▪ Progress to competent nurse (Benner) ▪ Knowledge ▪ Retention ▪ Intent to leave ▪ Job satisfaction ▪ Employee engagement ▪ Competence in clinical leadership ▪ Comprehension of Magnet essentials ▪ Evidence-based practice techniques ▪ Commitment to lifelong learning ▪ Culture of support ▪ Cultural competency ▪ Role as patient advocate ▪ Successful acculturation ▪ Accountability	12 months	▪ Education, at its best, cannot prepare for acculturation into a work group, using a newly learned language in practice, becoming proficient in a wide range of absolutely necessary skills, and gaining a sense of the wider world of health care. ▪ Incorporates reflection and feedback ▪ Turnover at 1 year was 10.8% ▪ Cost was $1,000 per resident ▪ Estimated that cost of replacing 1 nurse was $60,000
37 Methodist Hospital of Houston and the University of Texas, Houston, Health Science Center: Pine, R. and Tart, K. (2007). Return on investment: Benefits and challenges of a baccalaureate nurse residency program. Nursing Economics. 25(1), 13-18, 39. **Individual**	▪ Has joined the UHC/AACN Consortium, so participants are BSN educated. A unique aspect of this UHC/AACN program is that ADN/diploma educated nurses have also had a precepted program for up to 6 months.	See UHC/AACN for elements.	See UHC/AACN	1-year program	Besides aggregate results as reported by UHC/AACN, for this particular organization: ▪ Turnover The return of investment was $823,680 (benefit) ÷ $93,100 (cost) =8.847 or ROI (%) of 884.7

Project	Description	Elements	Measurement	Length	Status/Results
38 Orsolini-Hain, L. and Malone, R. E. (2007). Examining the impending gap in clinical nursing expertise. Policy, Politics & Nursing Practice. 8(3), 158-169. **Individual**	Literature review describing the impending expertise gap in clinical nursing, as a result of the nursing shortage, the aging and retiring workforce, nursing's desirability as a profession, the aging faculty, and the faculty shortage.	N/A	Excellent review of the literature, with citing of evidence and figures to make their point.	Recommend a state-mandated yearlong mentorship or residency program for new graduate nurses.	▪ From literature review concluded that graduates need "several months" (p.162) to become minimally proficient and to feel confident about decision making. ▪ When new graduates miss life-threatening events (as cited above from del Bueno research), they can put patients at risk. Cite statistics where once CPR is needed, 27% of adults and 18% of children survive. ▪ In the late 1980s 4.5% of nurses were employed outside of nursing; by 2004 that has risen to 16.8%.
39 Sir Charles Gairdner Hospital Centre for Nursing Education, Australia **Individual**	Designed to guide the newly graduated registered nurse through the first year of practice. It provides a supportive and structured learning environment, allowing nurses to develop. This program is unique in that nurses must meet their outcomes and then receive a certificate for satisfactory performance.	▪ Specific program and participant outcomes ▪ Specific prerequisites ▪ 6 months of surgery and 6 months of medical ▪ Study days and graduate seminars ▪ Assigned preceptor	Professional development journal contains: ▪ Checklists ▪ Self-evaluation ▪ Preceptor feedback ▪ Skills acquisition sheet ▪ Self-directed learning package record ▪ Specialty achievement record	12-18 months of practice	No results yet, but will forward them to NCSBN.

Attachment D

Transition to Practice Verification Form

Transition to Practice Verification Form	
NAME: _____	License #: _____
ADDRESS: _____	
CITY/STATE/ZIP: _____	PHONE DAY: _____
SSN: _____ DOB: _____	PHONE EVE: _____
SCHOOL OF NURSING: _____	
OCCUPATION/EMPLOYER: _____	
PRECEPTOR NAME: _____	TITLE: _____
PHONE: _____	
TRANSITION PROGRAM SUCCESSFULLY COMPLETED & FULL REQUIREMENTS OF TRANSITION TO PRACTICE WERE MET.	
EMPLOYER: _____	DATE: _____
NURSE: _____	DATE: _____

Section III

2008 NCSBN Annual Meeting

SECTION III: RESOURCES AND GENERAL INFORMATION

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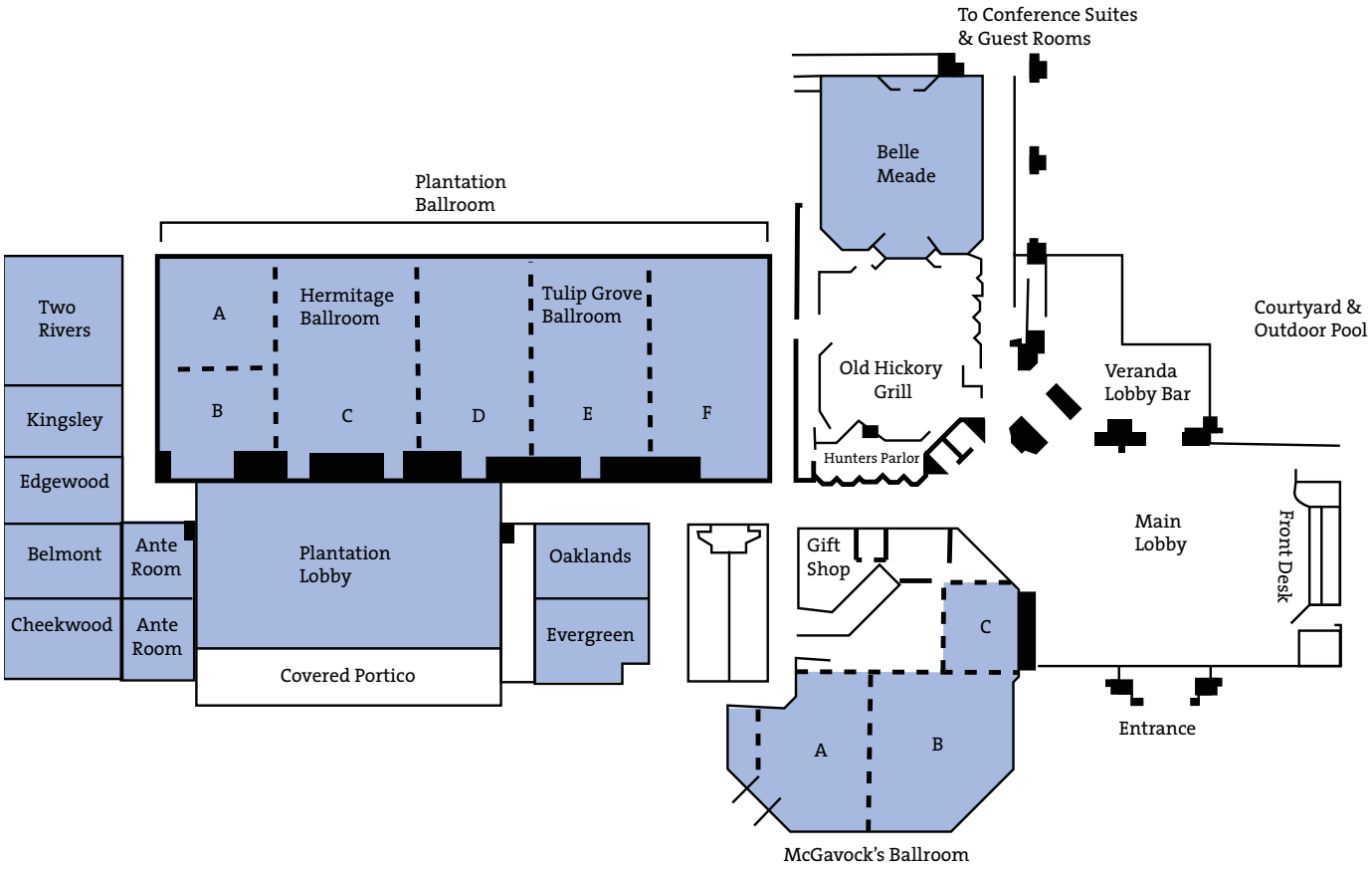
Sheraton Music City Hotel Map



Orientation Manual for Delegate Assembly Participants

The purpose of the Orientation Manual is to provide information about the mission, governance, and operations of NCSBN. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants as well as the Board of Directors and committee members.

Following a brief discussion of NCSBN's history, this manual will describe the organization's structure, functions, policies and procedures.

History

The concept of an organization such as NCSBN had its roots as far back as August 1912 when a special conference on state registration laws was held during the American Nurses Association (ANA) convention. At that time, participants voted to create a committee that would arrange an annual conference for people involved with state boards of nursing to meet during the ANA convention. It soon became evident that the committee required a stronger structure to deal with the scope of its concerns. However, for various reasons, the committee decided to remain within the ANA.

Boards of nursing also worked with the National League for Nursing Education (NLNE), which, in 1932, became the ANA's Department of Education. In 1933, by agreement with ANA, NLNE accepted responsibility for advisory services to the State Boards of Nurse Examiners (SBNE) in all education and examination-related matters. Through its Committee on Education, NLNE set up a subcommittee that would address, over the following decade, state board examination issues and problems. In 1937, NLNE published *A Curriculum Guide for Schools of Nursing*. Two years later, NLNE initiated the first testing service through its Committee on Nursing Tests.

Soon after the beginning of World War II, nurse examiners began to face mounting pressures to hasten licensing and to schedule examinations more frequently. In response, participants at a 1942 NLNE conference suggested a "pooling of tests" whereby each state would prepare and contribute examinations in one or more subjects that could provide a reservoir of test items. They recommended that the Committee on Nursing Tests, in consultation with representative nurse examiners, compile the tests in machine-scorable form. In 1943, the NLNE board endorsed the action and authorized its Committee on Nursing Tests to operate a pooling of licensing tests for interested states (the State Board Test Pool Examination or SBTPE). This effort soon demonstrated the need for a clearinghouse whereby state boards could obtain information needed to produce their test items. Shortly thereafter, a Bureau of State Boards of Nursing began operating out of ANA headquarters.

The bureau was incorporated into the ANA Bylaws and became an official body within that organization in 1945. Two years later, the ANA Board appointed the Committee for the Bureau of State Boards of Nurse Examiners, which was comprised of full-time professional employees of state boards.

In 1961, after reviewing the structure and function of the ANA and its relation to state boards of nursing, the committee recommended that a council replace it. Although council status was achieved, many people continued to be concerned about potential conflicts of interest and recognized the often-heard criticism that professional boards serve primarily the interests of the profession they purport to regulate.

In 1970, following a period of financial crisis for the ANA, a council member recommended that a free-standing federation of state boards be established. After a year of study by the state boards, this proposal was overwhelmingly defeated when the council adopted a resolution to remain with the ANA. However, an ad hoc committee was appointed later to examine the feasibility of the council becoming a self-governing incorporated body. At the council's

1977 meeting, a task force was elected and charged with the responsibility of proposing a specific plan for the formation of a new independent organization. On June 5, 1978, the Delegate Assembly of ANA's Council of State Boards of Nursing voted 83 to 8 to withdraw from ANA to form the National Council of State Boards of Nursing.

Organizational Mission, Strategic Initiatives and Outcomes

The National Council of State Boards of Nursing (NCSBN®), composed of Member Boards, provides leadership to advance regulatory excellence for public protection.

NCSBN currently has six strategic initiatives, one of which is to assist Member Boards in their role in the evaluation of initial and continued nurse and nurse aide competence. Another is to assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role. NCSBN also seeks to analyze the changing health care environment to develop state, national, and international strategies to impact public policy and regulation effecting public protection. NCSBN will develop information technology solutions valued and utilized by Member Boards to enhance regulatory sufficiency. Lastly, NCSBN seeks to support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

To achieve its strategic initiatives, NCSBN identifies expected outcomes, under which performance measures for achieving these outcomes are developed, assessed and refined each fiscal year and provide the organization with a flexible plan within a disciplined focus. Annually, the Board of Directors evaluates the accomplishment of strategic initiatives and objectives, and the directives of the Delegate Assembly.

Organizational Structure and Function

MEMBERSHIP

Membership in NCSBN is extended to those boards of nursing that agree to use, under specified terms and conditions, one or more types of licensing examinations developed by NCSBN. At the present time, there are 59 Member Boards, including those from the District of Columbia, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Boards of nursing may become Member Boards upon approval of the Delegate Assembly, payment of the required fees, and execution of a contract for using the NCLEX-RN® examination and/or the NCLEX-PN® examination. Revisions to the bylaws by the membership in 2007 also allow for advanced practice nurse boards to become full members.

Member Boards maintain their good standing through remittance of fees and compliance with all contract provisions and bylaws. In return, they receive the privilege of participating in the development and use of NCSBN's licensure examinations. Member Boards also receive information services, public policy analyses and research services. Member Boards that fail to adhere to the conditions of membership may have delinquent fees assessed or their membership terminated by the Board of Directors. They may then choose to appeal the Board's decision to the Delegate Assembly.

Additional changes to the bylaws adopted by the 2007 Delegate Assembly created the first ever Associate Member category. Associate Members are authorized nurse regulatory bodies from other countries, must pay an annual membership fee, and be approved for membership by the Delegate Assembly.

AREAS

NCSBN's membership is divided into four geographic areas. The purpose of this division is to facilitate communication, encourage regional dialogue on relevant issues, and provide diversity of board and committee representation. Delegates elect area directors from their respective areas through a majority vote of the Delegate Assembly. In addition, there are two

directors-at-large who are elected by all delegates voting at the Annual Meeting. In FY09, there will be four elected directors-at-large (see Glossary for list of jurisdictions by area).

DELEGATE ASSEMBLY

The Delegate Assembly is the membership body of NCSBN and comprises delegates who are designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates. The Delegate Assembly meets at NCSBN's Annual Meeting, traditionally held in early August. Special sessions can be called under certain circumstances. Regularly scheduled sessions are held on a rotation basis among areas.

At the Annual Meeting, delegates elect officers and directors and members of the Leadership Succession Committee by majority and plurality vote respectively. They also receive and respond to reports from officers and committees They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly adopts the mission statement, strategic initiatives of NCSBN, and approves the substance of all NCLEX® examination contracts between NCSBN and Member Boards, adopts test plans to be used for the development of the NCLEX® examination, and establishes the fee for the NCLEX® examination.

OFFICERS AND DIRECTORS

NCSBN officers include the president, vice president, and treasurer. Directors consist of four area directors and two directors-at-large. Beginning in FY09, there will be four directors-at-large. Only members or staff of Member Boards may hold office, subject to exclusion from holding office if other professional obligations result in an actual or perceived conflict of interest.

No person may hold more than one elected office at the same time. The president shall have served as a delegate, a committee member or an officer prior to being elected to office. An officer shall serve no more than four consecutive years in the same officer position.

The president, vice president, and treasurer are elected for terms of two years or until their successors are elected. The president, vice president, and treasurer are elected in even-numbered years.

The four area directors are elected for terms of two years or until their successors are elected. Area directors are elected in odd-numbered years. The two directors-at-large are elected each year for a one-year term. Beginning in FY09, there will be four directors-at-large. Two directors-at-large will be elected each year for a one-year term and two will be elected for terms of two years in even-numbered years or until their successors are elected.

Officers and directors are elected by ballot during the annual session of the Delegate Assembly. Delegates elect area directors from their respective areas.

Election is by a majority vote. Write-in votes are prohibited. In the event a majority is not established, the bylaws dictate the reballoting process.

Officers and directors assume their duties at the close of the session at which they were elected. The vice president fills a vacancy in the office of president. Board appointees fill other officer vacancies until the term expires.

BOARD OF DIRECTORS

The Board of Directors, the administrative body of NCSBN, beginning in FY09 will consist of the 11 elected officers. The Board is responsible for the general supervision of the affairs of NCSBN between sessions of the Delegate Assembly. The Board authorizes the signing of contracts, including those between NCSBN and its Member Boards. It also engages the services of legal counsel, approves and adopts an annual budget, reviews membership status of noncompliant Member Boards, and renders opinions, when needed, about actual or perceived conflicts of interest.

Additional duties include approval of the NCLEX® examination test service, appointment of committees, monitoring of committee progress, approval of studies and research pertinent to NCSBN's purpose, and provision for the establishment and maintenance of the administrative offices.

MEETINGS OF THE BOARD OF DIRECTORS

All Board meetings are typically held in Chicago, with the exception of the pre- and post-Annual Meeting Board meetings that are held at the location of the Annual Meeting. The call to meeting, agenda and related materials are mailed to Board officers and directors two weeks before the meeting. The agenda is prepared by staff, in consultation with the president, and provided to the membership via the NCSBN Web site (www.ncsbn.org).

A memo or report that describes the item's background and indicates the Board action needed accompanies items for Board discussion and action. Motion papers are available during the meeting and are used so that an accurate record will result. Staff takes minutes of the meeting.

Resource materials are available to each Board officer and director for use during Board meetings. These materials, which are updated periodically throughout the year, are kept at the NCSBN office and include copies of the articles of incorporation and bylaws, strategic plan, policies and procedures, contracts, budget, test plan, committee rosters, minutes and personnel manual.

COMMUNICATIONS WITH THE BOARD OF DIRECTORS

Communication between Board meetings takes place in several different ways. The chief executive officer communicates weekly with the president regarding major activities and confers as needed with the treasurer about financial matters. Monthly updates are provided to the full board by the chief executive officer.

LEADERSHIP SUCCESSION COMMITTEE

Beginning in FY09, the Leadership Succession Committee will replace the Committee on Nominations. The Leadership Succession Committee will consist of one member from each area, elected for two-year terms in even-numbered years, and two designated members. Designated members will be elected for one-year terms every year and will be a current or former chair; or a board member of a Member Board. Members will be elected by ballot with a plurality vote. The member receiving the highest number of votes shall serve as vice chair in the first year of the member's term and as chair in the second year of the term. The first meeting of the committee is held concurrent with the first meeting of the Board of Directors in the subsequent fiscal year.

The Leadership Succession Committee's function will be to recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

COMMITTEES

Many of NCSBN's objectives are accomplished through the committee process. Every year, the committees report on their activities and make recommendations to the Board of Directors. At the present time, NCSBN has two standing committees: NCLEX® Examinations and Finance. Subcommittees, such as the Item Review Subcommittee (Exam), may assist standing committees.

In addition to standing committees, special committees are appointed by the Board of Directors for a defined term to address special issues and concerns. NCSBN conducts an annual call for committee member nominations prior to the beginning of each fiscal year. Committees are governed by their specific charge and NCSBN policies and procedures. The appointment of committee chairs and committee members is a responsibility of the Board of Directors. Committee membership is extended to all current members and staff of Member Boards, consultants, and external stakeholders.

In the appointment process, every effort is made to match the expertise of each individual with the needs of NCSBN. Also considered is balanced representation whenever possible, among areas, board members and staff, registered and licensed practical/vocational nurses (LPN/VN), and consumers. Nonmembers may be appointed to special committees as consultants to provide specialized expertise to committees or as external stakeholders to promote collaboration. A Board of Director liaison and an NCSBN staff member are assigned to assist each committee. The respective roles of board liaison, committee chairperson and committee staff are provided in NCSBN policy. Each work collaboratively to facilitate committee work and provide support and expertise to committee members to complete the charge. Neither the board liaison nor the NCSBN staff are entitled to a vote, but respectively can advise the committee regarding the strategic or operational impact of decisions and recommendation.

Description of Standing Committees

NCLEX® EXAMINATIONS COMMITTEE

The Examination Committee comprises at least nine members. One of the committee members shall be an LPN/VN or a board or staff member of an LPN/VN board of nursing. The committee chair shall have served as a member of the committee prior to being appointed as chair. The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce and deliver the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests enhancements, based on research that is important to the development of licensure examinations.

The NCLEX® Examination Committee advises the Board of Directors on matters related to the NCLEX® examination process, including psychometrics, item development, test security, and administration and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation, oversight of test service transitions, and preparation of written information about the examinations for Member Boards and other interested parties. The committee also regularly evaluates the licensure examinations by means of item analysis and test, and candidate statistics.

One of NCSBN's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is a key component of this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: 1) whether or not the examination actually measures competencies required for safe and effective job performance; and 2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation.

There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts, and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe and effective practice. The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually

specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills and abilities (KSA) statements or competency statements which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a passing standard to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected to recommend a series of passing standards for this process. Judges are trained in conceptualizing the minimally competent candidate (performing at the lowest acceptable level), and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in identification of a series of recommended passing standards. Taking these recommendations along with other data relevant to identification of the level of competence, the Board of Directors sets a passing standard that distinguishes between candidates who do and do not possess the essential competencies, thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes and utilizing item construction and test delivery processes based on sound psychometric principles constitute the best legal defense available for licensing examinations. For most of the possible challenges that a candidate might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

FINANCE COMMITTEE

The Finance Committee comprises at least four members and the treasurer, who serves as the chair. The committee's primary purpose is to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. It also reviews financial status on a quarterly basis and provides the Board of Directors with a proposed annual budget prior to each new fiscal year.

NCSBN STAFF

NCSBN staff members are hired by the chief executive officer. Their primary role is to implement the Delegate Assembly and Board of Directors policy directives and provide assistance to committees.

GENERAL DELEGATE ASSEMBLY INFORMATION

Agendas for each session of the Delegate Assembly are prepared by the president in consultation with the Board of Directors and chief executive officer and approved by the Board of Directors. At least 45 days prior to the Annual Meeting, Member Boards are sent the recommendations to be considered by the Delegate Assembly. A Business Book is provided to all Annual Meeting registrants which contains the agenda, reports requiring Delegate Assembly action, reports of the Board of Directors, reports of special and standing committees, and strategic initiatives and objectives.

Prior to the annual session of the Delegate Assembly, the president appoints the credentials, resolutions, and elections committees, as well as the Committee to Approve Minutes. The president must also appoint a timekeeper, a parliamentarian, and pages.

The function of the Credentials Committee is to provide delegates with identification bearing the number of votes to which the delegate is entitled. It also presents oral and written reports

at the opening session of the Delegate Assembly and immediately preceding the election of officers and the Leadership Succession Committee. The Elections Committee conducts all elections that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits, and evaluates all others in terms of their relationship to NCSBN's mission and fiscal impact to the organization. At a time designated by the president, it reports to the Delegate Assembly.

The parliamentarian keeps minutes of the Delegate Assembly. These minutes are then reviewed, corrected as necessary and approved by the Committee to Approve Minutes, which includes the chief executive officer who serves as corporate secretary

Assembly on all resolutions and motions submitted by Member Boards. The committee is governed by the operational policies and procedures, the standing rules and the bylaws.

BYLAWS COMMITTEE

The Bylaws Committee is comprised of at least four members. The committee reviews and makes recommendations on proposed bylaw amendments as directed by the Board of Directors or the Delegate Assembly. The bylaws may be amended at any annual meeting or special session of the Delegate Assembly upon written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting or written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present, and in no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.

NCSBN STAFF

NCSBN staff members are hired by the executive director. Their primary role is to implement the Delegate Assembly and Board of Directors policy directives and provide assistance to committees.

GENERAL DELEGATE ASSEMBLY INFORMATION

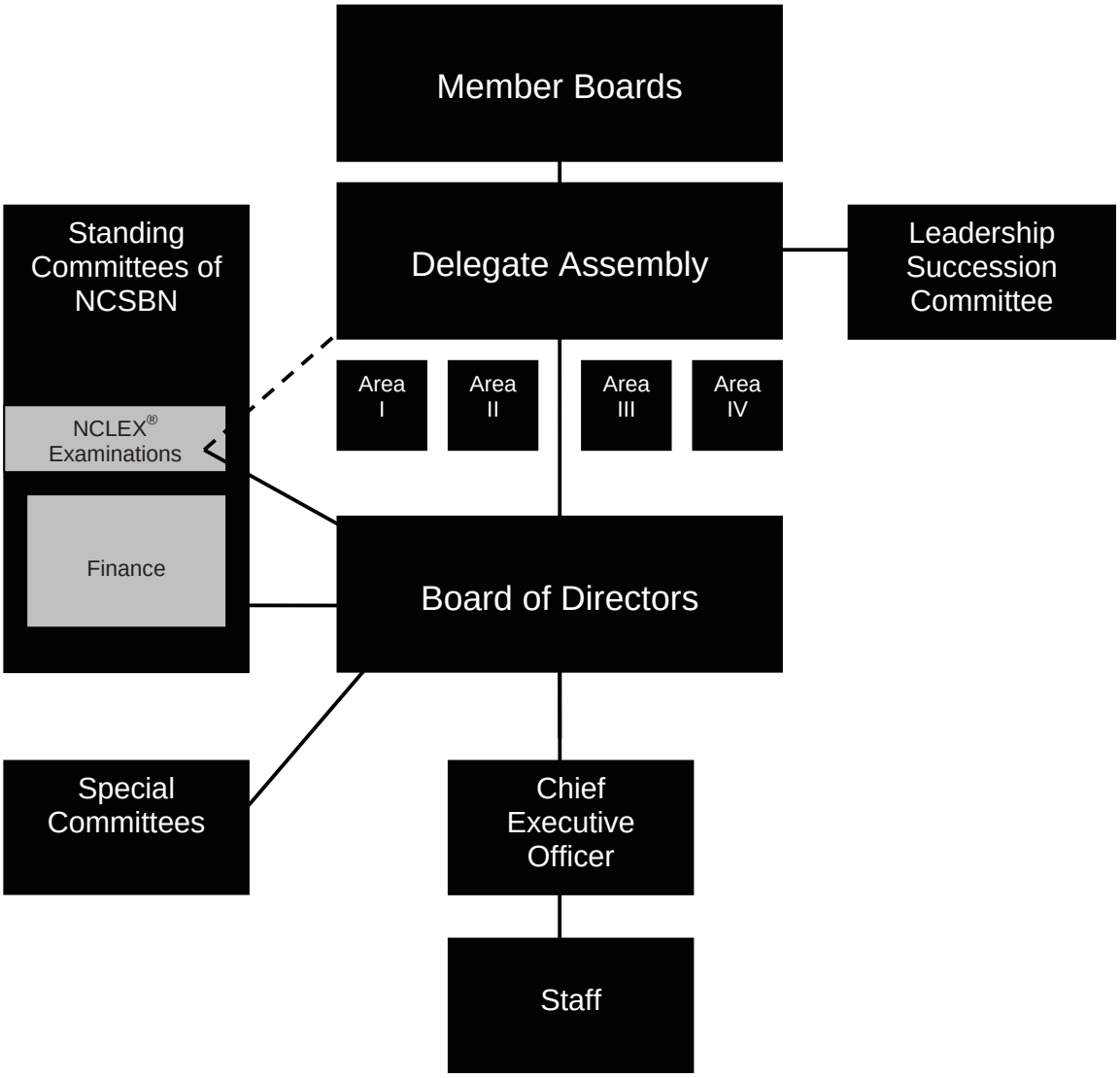
Agendas for each session of the Delegate Assembly are prepared by the president in consultation with the Board of Directors and executive director and approved by the Board of Directors. At least 45 days prior to the Annual Meeting, Member Boards are sent the recommendations to be considered by the Delegate Assembly. A Business Book is provided to all Annual Meeting registrants, which contains the agenda, reports requiring Delegate Assembly action, reports of the Board of Directors, reports of special and standing committees, and strategic initiatives and outcomes.

Prior to the annual session of the Delegate Assembly, the president appoints the credentials and elections committees as well as the committee to approve minutes. The president must also appoint a timekeeper, a parliamentarian, and pages.

The function of the Credentials Committee is to provide delegates with identification bearing the number of votes that the delegate is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and Committee on Nominations. The Elections Committee conducts all elections that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits, and evaluates all others in terms of their relationship to NCSBN's mission and fiscal impact to the organization. At a time designated by the president, it reports to the Delegate Assembly.

The parliamentarian keeps minutes of the Delegate Assembly. These minutes are then reviewed, corrected as necessary and approved by the Committee to Approve Minutes, which includes the executive director who serves as corporate secretary.

NCSBN Organizational Chart



NCSBN Bylaws

Revisions adopted – 8/29/87
Amended – 8/19/88
Amended – 8/30/90
Amended – 8/01/91
Revisions adopted – 8/05/94
Amended – 8/20/97
Amended – 8/8/98
Revisions adopted – 8/11/01
Amended – 08/07/03
Revisions adopted – 08/08/07

Article I

NAME

The name of this organization shall be the National Council of State Boards of Nursing, Inc. (NCSBN®).

Article II

PURPOSE AND FUNCTIONS

Section 1. Purpose. The purpose of the NCSBN is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

Section 2. Functions. The NCSBN's functions shall include but not be limited to providing services and guidance to its members in performing their regulatory functions regarding entry into nursing practice, continued safe nursing practice and nursing education programs. The NCSBN provides Member Boards with examinations and standards for licensure and credentialing; promotes uniformity in standards and expected outcomes in nursing practice and education as they relate to the protection of the public health, safety and welfare; provides information, analyses and standards regarding the regulation of nursing practice and nursing education; promotes the exchange of information and serves as a clearinghouse for matters related to nursing regulation.

Article III

MEMBERS

Section 1. Definition.

(a) *State Board of Nursing*. A state board of nursing is the governmental agency empowered to license and regulate nursing practice in any state, territory or political subdivision of the United States of America.

(b) *Member Board*. A Member Board is a state board of nursing, which is approved by the Delegate Assembly as a member of NCSBN.

(c) *Associate Member.* An Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory, which is approved by the Delegate Assembly.

Section 2. Qualifications. To qualify for approval, as a Member Board, a state board of nursing that regulates registered nurses and/or practical/vocational nurses must use one

or more NCSBN Licensing Examinations (the "NCLEX® examination") for licensure of registered nurses and/or practical/vocational nurses, and execute a membership agreement with NCSBN specifying the terms and conditions for the use of the NCLEX® examination(s) where applicable.

Section 3. Admission. A state board of nursing shall become a member of the NCSBN and be known as a Member Board upon approval by the Delegate Assembly, as described in Article IV, payment of the required fees and execution of a contract for using the NCLEX® examination where applicable.

Section 4. Areas. The Delegate Assembly shall divide the membership into numbered geographical areas. At no time shall the number of areas be less than three nor more than six. New members shall be assigned to existing areas by the Board of Directors. The purpose of this division is to facilitate communication, encourage regional dialogue on NCSBN issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. Fees. The annual membership fees, for a Member Board and an Associate Member shall be set by the Delegate Assembly and shall be payable each October 1.

Section 6. Privileges. Member Board privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. Noncompliance. Any member whose fees remain unpaid after January 15 is not in good standing. Any member who does not comply with the provisions of the bylaws, and where applicable, the membership agreement, shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. Appeal. Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. Reinstatement. A member in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

Article IV

DELEGATE ASSEMBLY

Section 1. Composition.

(a) *Designation of Delegates.* The Delegate Assembly shall be comprised of no more than two (2) delegates designated by each Member Board as provided in the Standing Rules of the Delegate Assembly ("Standing Rules"). An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges.

(b) *Qualification of Delegates.* Members and employees of Member Boards shall be eligible to serve as delegates until their term or their employment with a Member Board ends. A NCSBN officer or director may not represent a Member Board as a delegate.

(c) *Term.* Delegates and alternates serve from the time of appointment until replaced.

Section 2. Voting.

(a) *Annual Meetings.* Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting.

(b) *Special Meetings*. A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the corporate secretary of the NCSBN or a delegate of another Member Board to cast its votes.

Section 3. Authority. The Delegate Assembly, the membership body of the NCSBN, shall provide direction for the NCSBN through resolutions and enactments, including adoption of the mission and strategic initiatives, at any Annual Meeting or special session. The Delegate Assembly shall approve all new NCSBN memberships; approve the substance of all NCLEX® examination contracts between the NCSBN and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; and establish the fee for the NCLEX® examination.

Section 4. Annual Meeting. The NCSBN Annual Meeting shall be held at a time and place as determined by the Board of Directors. The Delegate Assembly shall meet each year during the Annual Meeting. The official call to that meeting, giving the time and place, shall be conveyed to each Member Board at least 90 days before the Annual Meeting. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the NCSBN.

Section 5. Special Session. The Board of Directors may call, and upon written petition of at least ten Member Boards made to the Board of Directors, shall call a special session of the Delegate Assembly. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least ten days before the date for which such special session is called.

Section 6. Quorum. The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Section 7. Standing Rules. The Board of Directors shall present and the Delegate Assembly shall adopt Standing Rules for each Delegate Assembly meeting.

Article V

OFFICERS AND DIRECTORS

Section 1. Officers. The elected officers of the NCSBN shall be a president, a vice president and a treasurer.

Section 2. Directors. The directors of the NCSBN shall consist of four directors-at-large and a director from each area.

Section 3. Qualifications. Board Members of Member Boards and employees of Member Boards shall be eligible to serve as NCSBN officers and directors until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 4. Qualifications for President. The president shall have served NCSBN as either a delegate, a committee member, a director or an officer before being elected to the office of President.

Section 5. Election of Officers and Directors.

(a) *Time and Place*. Election of officers and directors shall be by ballot of the Delegate Assembly during the Annual Meeting.

(b) *Officers and Directors-at-Large*. Officers and directors-at-large shall be elected by majority vote of the Delegate Assembly.

(c) *Area Directors.* Each area shall elect its area director by majority vote of the delegates from each such area.

(d) *Run-Off Balloting.* If a candidate for officer or director does not receive a majority vote on the first ballot, reballoting shall be limited to the two candidates receiving the highest numbers of votes for each position. In the case of a tie on the reballoting, the final selection shall be determined by lot.

(e) *Voting.* Voting for officers and directors shall be conducted in accordance with these bylaws and the Standing Rules. Write in votes shall be prohibited.

Section 6. Terms of Office. The president, vice president, treasurer, area directors, and directors-at-large shall be elected for a term of two years or until their successors are elected. The president, vice president treasurer, and two directors-at-large shall be elected in even numbered years. The area directors and two directors-at-large shall be elected in odd numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.

Section 7. Limitations. No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the NCSBN, as determined by the Leadership Succession Committee before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors win an election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.

Section 8. Vacancies. A vacancy in the office of president shall be filled by the vice president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting and a successor is elected. The Delegate Assembly shall elect a person to fill any remainder of the term.

Section 9. Responsibilities of the President. The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and speak on behalf of and communicate the policies of the NCSBN.

Section 10. Responsibilities of the Vice President. The vice president shall assist the president, perform the duties of the president in the president's absence, and fill any vacancy in the office of the president until the next Annual Meeting.

Section 11. Responsibilities of the Treasurer. The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors, and that annual financial reports are provided to the Delegate Assembly.

Article VI

BOARD OF DIRECTORS

Section 1. Composition. The Board of Directors shall consist of the elected officers and directors of the NCSBN.

Section 2. Authority. The Board of Directors shall transact the business and affairs and act on behalf of the NCSBN except to the extent such powers are reserved to the Delegate Assembly as set forth in these bylaws and provided that none of the Board's acts shall conflict with resolutions or enactments of the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly and approve the NCLEX® examination test service.

Section 3. Meetings of the Board of Directors. The Board of Directors shall hold its annual meeting in association with the Annual Meeting. The Board may schedule other regular meetings of the Board at other times as necessary to accomplish the work of the Board. Publication of the dates for such regular meetings in the minutes of the Board meeting at which the dates are selected shall constitute notice of the scheduled regular meetings. Special meetings of the Board of Directors may be called by the president or shall be called upon written request of at least three members of the Board of Directors. At least twenty-four hours notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Section 4. Removal from Office. A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly or the Board of Directors. The individual shall be given 30 days written notice of the proposed removal.

Section 5. Appeal. A member of the Board of Directors removed by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two thirds-vote of the Delegate Assembly.

Article VII

LEADERSHIP SUCCESSION COMMITTEE

Section 1. Committee on Nominations.

(a) *Composition.* The Leadership Succession Committee shall be comprised of eight members elected by the Delegate Assembly. Four of the eight elected positions shall be designated members to include a past Board of Directors member, a current or former NCSBN committee chair, a board member of a Member Board and an employee of a Member Board. The remaining four members shall be elected from each of the four areas.

(b) *Term.* The term of office shall be two years. One-half of the Committee members shall be elected in even-numbered years and one-half in odd-number years. A committee member shall serve no more than two consecutive terms. Members shall assume duties at the close of the Annual Meeting at which they are elected.

(c) *Election.* The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. The chair shall be selected by the Board of Directors.

(d) *Limitation.* A member elected or appointed to the Leadership Succession Committee may not be nominated for an officer or director position during the term for which that member was elected or appointed.

(e) *Vacancy.* A vacancy occurring in the committee shall be filled from the remaining candidates from the previous election, in order of votes received. If no remaining candidates can serve, the Board of Directors shall fill the vacancy with an individual who meets the qualifications of Section 1a. of this Article. The person filling the vacancy shall serve the remainder of the term.

(f) *Duties.* The Leadership Succession Committee shall recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

(g) *Eligibility.* Any board member of a Member Board or employee of a Member Board is eligible to serve as a member of the Leadership Succession Committee.

Article VIII

MEETINGS

Section 1. Participation.

(a) *Delegate Assembly Session.*

(i) *Member Boards.* Members and employees of Member Boards shall have the right, subject to the Standing Rules of the Delegate Assembly, to speak at all open sessions and forums of the Delegate Assembly, provided that only delegates shall be entitled to vote and only delegates and members of the Board of Directors may make motions at the Delegate Assembly, except the Examination Committee may bring motions to approve test plans pursuant to Article X, Section 1(a).

(ii) *Public.* All sessions of the Delegate Assembly held in accordance with Sections 4 and 5 of Article IV of these bylaws shall be open to the public, except executive sessions, provided that the minutes reflect the purpose of, and any action taken in, executive session.

(b) *Delegate Assembly Forums.* Participation in forums conducted in association with the Annual Meeting shall be governed by the Standing Rules of the Delegate Assembly.

(c) *Meetings.* NCSBN, including all committees thereof, may establish methods of conducting its business at all other meetings provided that the meetings of the Board of Directors and committees are open to members and employees of Member Boards.

(d) *Interactive Communications.* Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the NCSBN office.

(e) *Manner of Transacting Business.* To the extent permitted by law and these bylaws, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

Article IX

CHIEF EXECUTIVE OFFICER

Section 1. Appointment. The chief executive officer shall be appointed by the Board of Directors. The selection or termination of the chief executive officer shall be by a majority vote of the Board of Directors.

Section 2. Authority. The chief executive officer shall serve as the agent and chief administrative officer of the NCSBN and shall possess the authority and shall perform all duties incident to the office of chief executive officer, including the management and supervision of the office, programs and services of NCSBN, the disbursement of funds and execution of contracts (subject to such limitations as may be established by the Board of Directors). The chief executive officer shall serve as corporate secretary and oversee maintenance of all documents and records of the NCSBN and shall perform such additional duties as may be defined and directed by the Board.

Section 3. Evaluation. The Board of Directors shall conduct an annual written performance appraisal of the chief executive officer, and shall set the chief executive officer's annual salary.

Article X

COMMITTEES

Section 1. Standing Committees. NCSBN shall maintain the following standing committees:

(a) *NCLEX® Examination Committee.* The NCLEX® Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The committee chair shall have served as a member of the committee prior to being appointed as chair. The NCLEX® Examination Committee shall advise the Board of Directors on matters related to the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.

(b) *Finance Committee.* The Finance Committee shall be comprised of at least four members and the treasurer, who shall serve as chair. The Finance Committee shall review the annual budget, the NCSBN's investments and the audit. The Finance Committee shall recommend a budget to the Board of Directors and advise the Board of Directors on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

Section 2. Special Committees. The Board of Directors may appoint special committees as needed to accomplish the mission of the NCSBN and to assist any standing committee in the fulfillment of its responsibilities. Special committees may include subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. Delegate Assembly Committees. The president shall appoint such Delegate Assembly Committees as provided in the Standing Rules and as necessary to conduct the business of the Delegate Assembly.

Section 4. Committee Membership.

(a) *Composition.* Members of standing and special committees shall be appointed by the Board of Directors from the membership, provided, however, that Associate Members may not serve on the NCLEX® Examination, Bylaws, or Finance Committees. Committees may also include other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, one representative from each area shall be selected unless a qualified member from each area is not available considering the expertise needed for the committee work. The president, or president's designee, shall be an ex-officio member of all committees except the Leadership Succession Committee. Associate Members shall have full voting rights as committee members.

(b) *Term.* The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for re-appointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

(c) *Vacancy*. A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

Article XI

FINANCE

Section 1. Audit. The financial records of the NCSBN shall be audited annually by a certified public accountant appointed by the Board of Directors. The annual audit report shall be provided to the Delegate Assembly.

Section 2. Fiscal Year. The fiscal year shall be from October 1 to September 30.

Article XII

INDEMNIFICATION

Section 1. Direct Indemnification. To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney's fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.

Section 2. Insurance. To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. Additional Rights. Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

(a) not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and

b) continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIII

PARLIAMENTARY AUTHORITY

The rules contained in the current edition of "Robert's Rules of Order Newly Revised" shall govern the NCSBN in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the NCSBN.

Article XIV

AMENDMENT OF BYLAWS

Section 1. Amendment and Notice. These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly upon:

(a) written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting; or

(b) written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present and voting.

In no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.

Section 2. Bylaws Committee. A bylaws committee composed of board members from Member Boards and/or employees of Member Boards may be appointed by the Board of Directors to review and make recommendations on proposed bylaw amendments as directed by the Board of Directors or the Delegate Assembly.

Article XV

DISSOLUTION

Section 1. Plan. The Board of Directors at an annual, regular or special meeting may formulate and adopt a plan for the dissolution of the NCSBN. The plan shall provide, among other things, that the assets of the NCSBN be applied as follows:

Firstly, all liabilities and obligations of the NCSBN shall be paid or provided for.

Secondly, any assets held by the NCSBN which require return, transfer or conveyances, as a result of the dissolution, shall be returned, transferred or conveyed in accordance with such requirement.

Thirdly, all other assets, including historical records, shall be distributed in considered response to written requests of historical, educational, research, scientific or institutional health tax exempt organizations or associations, to be expended toward the advancement of nursing practice, regulation and the preservation of nursing history.

Section 2. Acceptance of Plan. Such plan shall be acted upon by the Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. A majority of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.

Section 3. Conformity to Law. Such plan to dissolve must conform to the law under which NCSBN is organized and to the Internal Revenue Code concerning dissolution of exempt corporations. This requirement shall override the provisions of Sections 1 and 2 herein.

NCSBN Glossary

A

Acclimation of International Nurses into U.S. Nursing Practice
Online course offered through NCSBN Learning Extension. Learners earn 6.6 contact hours for completing the course.

Accredit
To recognize (an educational institution) as maintaining standards that qualify the graduates for admission to higher or more specialized institutions or for professional practice.[1]

Accrediting Agency
See also *Nursing School Accrediting Agency* entry.

ACNM Certification Council Inc. (ACC)
National certifying body for certified-nurse midwives (CNMs) and certified midwives (CMs). ACC's mission is to protect and serve the public by providing the certification standard for individuals educated in the profession of midwifery.[2]

Administrative Rules
Used by boards of nursing to promulgate rules/regulations to further interpret and implement the Nursing Practice Act, as authorized in most jurisdictions. Rules/regulations cannot conflict with law and once adopted, have the force and effect of law.

Advanced Practice Registered Nurse (APRN)
A master's prepared nurse holding a graduate degree in nursing, who has completed a program of study in a specialty area in an accredited nursing program, has taken a licensing examination in the same area and has been granted a license to practice as an APRN. The hallmark of APRN practice is the assumption by the APRN of primary responsibility for the direct care of patients/clients in relation to their human needs, disease states, and therapeutic and technologic interventions. Subcategories of APRN licensure include: nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM) and clinical nurse specialist (CNS). A nurse seeking recognition as an APRN must be academically prepared for the expanded scope of practice described as APRN nursing.

Agent Role
NCSBN once served as an agent for 41 boards of nursing for reporting past, or legacy data (1996–1999). NCSBN continues to serve as an agent (for ongoing discipline reporting) for 32 boards as of Jan. 24, 2007, with five contracts still out and expected to be signed. NCSBN Member Boards continue to share discipline data through Nursys®. NCSBN is also working to obtain discipline information from states that either directly report to the HIPDB or use another agent, so that the discipline data NCSBN has is complete. Although all boards of nursing are authorized to query the HIPDB, there is also a fee; NCSBN continues to provide discipline data for use by member boards at no charge.

Alternative Dispute Resolution (ADR)
A forum or means for resolving disputes (as arbitration or private judging) that exists outside the state or federal judicial system.[3]

Alternative Item Format
Previously known as an innovative item format; an NCLEX® examination item (question) that takes advantage of technology and uses a format other than standard, four-option, multiple-choice items to assess candidate ability. Alternative item formats may include multiple-response items (requiring a candidate to select one or more than one response), fill-in-the-blank items (requiring a candidate to type in number(s) within a calculation item), hot spot items (asking a candidate to identify an area on a picture or graphic), a chart/exhibit format (where candidates are presented with a problem and use the information in the chart/exhibit to answer the problem), and a drag-and-drop item type (requiring a candidate to rank or move options to provide the correct answer). Any item format, including standard multiple-choice items, may include charts, tables or graphic images.

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5. American Association of Colleges of Nursing Web site. (n.d.) *About AACN*. Retrieved 4 April 2005, from http://www.aacn.nche.edu/ContactUs/index.htm
6. American Association of Critical Care Nurses Web site. (n.d.) *About critical care nursing*. Retrieved 4 April 2005, from http://www.aacn.org/AACN/mrkt.nsf/vwdoc/AboutCriticalCareNursing?opendocument
7. American Association of Nurse Anesthetists Web site. (n.d.) *About the American association of nurse anesthetists – who we are*. Retrieved 4 April 2005, from http://www.aana.com/Default.asp
8. *American College of Nurse-Midwives Web site*. Retrieved 4 April 2005, from http://www.midwife.org/about/
9. *American Dental Association Home Page*. Retrieved 4 April 2005, from http://www.ada.org/
10. American Dietetic Association Web site. (n.d.) *What is ADA*? Retrieved 4 April 2005, from http://www.eatright.org/Public/index_adafaq.cfm
11. AILA.org Web site. (n.d.) *About AILA*. Retrieved 4 April 2005, from http://www.aila.org/contentViewer.aspx?bc=39
12. American Medical Association Web site. (n.d.) *About AMA*. Retrieved 4 April 2005, from http://www.ama-assn.org/ama/pub/category/1815.html

Alternative Program
A voluntary, private opportunity for chemically dependent nurses who meet specified criteria to have their recovery closely monitored by program staff in lieu of disciplinary action.

American Academy of Nurse Practitioners (AANP)
The largest and only full-service professional membership organization in the U.S. for nurse practitioners of all specialties.[4]

American Association of Colleges of Nursing (AACN)
A national voice for America's baccalaureate and higher degree nursing education programs. AACN's educational, research, governmental advocacy, data collection, publications and other programs work to establish quality standards for bachelor- and graduate-degree nursing education, assist deans and directors to implement those standards, influence the nursing profession to improve health care, and promote public support of baccalaureate and graduate education, research and practice in nursing—the nation's largest health care profession.[5]

American Association of Critical Care Nurses (AACN)
Provides and inspires leadership to establish work and care environments that are respectful, healing and humane. AACN is committed to providing the highest quality resources to maximize nurses' contribution to caring and improving the health care of critically ill patients and their families.[6]

American Association of Nurse Anesthetists (AANA)
A professional association representing more than 30,000 certified registered nurse anesthetists (CRNAs) nationwide. The AANA promulgates education, practice standards and guidelines, and affords consultation to both private and governmental entities regarding nurse anesthetists and their practice.[7]

American College of Nurse Midwives (ACNM)
Provides research, accredits midwifery education programs, administers and promotes continuing education programs, establishes clinical practice standards, and creates liaisons with state and federal agencies and members of Congress. The mission of ACNM is to promote the health and well being of women and infants within their families and communities through the development and support of the profession of midwifery as practiced by certified nurse-midwives (CNMs), and certified midwives (CMs). The philosophy inherent in the profession states that nurse-midwives believe every individual has the right to safe, satisfying health care with respect for human dignity and cultural variations.[8]

American Dental Association (ADA)
A professional association of dentists committed to the public's oral health, ethics, science and professional advancement; leading a unified profession through initiatives in advocacy, education, research and the development of standards.[9]

American Dietetic Association (ADA)
The nation's largest organization of food and nutrition professionals.[10]

American Immigration Lawyers Association (AILA)
A national association of more than 8,000 attorneys and law professors who practice and teach immigration law. AILA member attorneys represent tens of thousands of U.S. families who have applied for permanent residence for their spouses, children, and other close relatives to lawfully enter and reside in the U.S. AILA members also represent thousands of U.S. businesses and industries that sponsor highly skilled foreign workers seeking to enter the U.S. on a temporary or—having proven the unavailability of U.S. workers—permanent basis. AILA members also represent foreign students, entertainers, athletes, and asylum seekers, often on a pro bono basis.[11]

American Medical Association (AMA)
The national professional organization for all physicians. The AMA serves as the steward of medicine and leader of the medical profession. The AMA speaks out on issues important to patients and the nation's health.[12]

American Nurses Association (ANA)
The only full-service professional organization representing the nation's 2.7 million RNs through its 54 constituent member associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic

and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying Congress and regulatory agencies on health care issues affecting nurses and the public.[13]

American Nurses Credentialing Center (ANCC)
A subsidiary of the American Nurses Association that provides tangible recognition of professional achievement in a defined functional or clinical area of nursing. More than 150,000 nurses throughout the U.S. and its territories in 40 specialty and advanced practice areas of nursing carry ANCC certification. While the role for nurses continues to evolve, ANCC has responded positively to the reconceptualization of certification with Open Door 2000, a program that enables all qualified RNs, regardless of their educational preparation, to become certified in any of five specialty areas: Gerontology, Medical-Surgical, Pediatrics, Perinatal and Psychiatric and Mental Health Nursing.[14]

American Organization of Nurse Executives (AONE)
A subsidiary of the American Hospital Association, and national organization of nearly 4,000 nurses who design, facilitate and manage care. Its mission is to represent nurse leaders who improve health care. AONE members are leaders in collaboration and catalysts for innovation.[15]

Americans for Nursing Shortage Relief (ANSR)
An alliance of 49 national nursing organizations and five friends of nursing organizations and companies. ANSR is committed to promoting legislative and regulatory solutions to the current and impending nursing shortage.[16]

Americans with Disabilities Act (ADA)
Effective July 26, 1992, this federal law prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions and privileges of employment. An individual with a disability is a person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such an impairment.[17]

APRN Certification Programs
In January 2002, the Board of Directors approved criteria for both the certification programs and the accrediting agencies that were developed by the Advanced Practice Task Force. The Requirements for Accrediting Agencies and the Criteria for Certification Programs (available for download at www.ncsbn.org) represent required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses.

APRN Compact
Addresses the need to promote consistent access to quality, advanced practice nursing care within states and across state lines. The Uniform APRN Licensure/Authority to Practice Requirements, developed by NCSBN with APRN stakeholders in 2000, establishes the foundation for this APRN Compact. Similar to the existing Nurse Licensure Compact for recognition of RN and LPN licenses, the APRN Compact offers states the mechanism for mutually recognizing APRN licenses/authority to practice. This is a significant step forward for the increasing access and accessibility to qualified APRNs. A state must either be a member of the current nurse licensure compact for RN and LPN, or choose to enter into both compacts simultaneously to be eligible for the APRN Compact.

Area
One of four designated geographic regions of NCSBN Member Boards.

Area I	Area II	Area III	Area IV
Alaska	Illinois	Alabama	Connecticut
American Samoa	Indiana	Arkansas	Delaware
Arizona	Iowa	Florida	District of Columbia
California	Kansas	Georgia	Maine
Colorado	Michigan	Kentucky	Maryland
Guam	Minnesota	Louisiana	Massachusetts
Hawaii	Missouri	Mississippi	New Hampshire
Idaho	Nebraska	North Carolina	New Jersey
Montana	North Dakota	Oklahoma	New York
Nevada	Ohio	South Carolina	Pennsylvania
New Mexico	South Dakota	Tennessee	Rhode Island
N. Mariana Islands	West Virginia	Texas	Vermont
Oregon	Wisconsin	Virginia	U.S. Virgin Islands
Utah			
Washington			
Wyoming			

13. ANA Nursing World Web site. (n.d.) *About the American nurses association*. Retrieved 4 April 2005, from http://www.nursingworld.org/about/
14. ANCC: American Nurses Credentialing Center Web Site. (n.d.) *American nurses credentialing center – certified nursing excellence*. Retrieved 4 April 2005, from http://www.nursingworld.org/ancc/inside.html
15. Hospitalconnect.com: AONE Web site. (n.d.) *About AONE*. American Organization of Nurse Executives (AONE). Retrieved 4 April 2005, from http://www.aone.org/aone/about/home.html
16. Association of Women's Health, Obstetric and Neonatal Nurses Web site. (n.d.) *Americans for Nursing Shortage Relief*. Retrieved 26 May 2005, from http://www.awhonn.org/awhonn/?pg=875-12550-3260-7650
17. EEOC U.S. Equal Employment Opportunity Commission Web site. (n.d.) *Facts about the Americans with disabilities act*. Retrieved 4 April 2005, from http://www.eeoc.gov/facts/fs-ada.html

18. *All Nursing Schools Web site*. (n.d.) Retrieved 11 May 2007, from http://www.allnursingschools.com/faqs/cnm.php

Area Director
Type of NCSBN board member. A director is elected for each of NCSBN's geographic areas: I, II, III and IV. Responsibilities include attending area meetings of the Member Boards at Midyear and Annual Meetings and communicating with their respective jurisdictions pre- and post- Board of Director meetings.

Assessment of Critical Thinking
Online course offered through NCSBN Learning Extension for nursing educators to assist in writing test items in the NCLEX style at higher cognitive levels. Learners earn 15.6 contact hours for completing the course. Formerly called "Advanced Assessment Strategies: Assessing Higher Level Thinking."

Assessment Strategies
Test service for Canadian Nurses Association.

B

Blueprint
The organizing framework for an examination that includes the percentage of items allocated to various categories. Also known as a test plan.

Board of Nursing
The authorized state entity with the legal authority to regulate nursing. Legislatures enact the Nurse Practice Act for each state. Boards of nursing have the legal authority to license nurses and to discipline nurses for unsafe practice. The mission of boards of nursing is to protect the health, safety and welfare of the public.

Bylaws
The rules that govern the internal affairs of an organization.

Bylaws Committee
A standing committee of NCSBN.

C

Canadian Nurses Association
A federation of 11 provincial and territorial nursing associations representing more than 123,000 RNs.

Canadian Registered Nurse Examination (CRNE)
Canadian Nurses Association nurse licensure examinations.

Candidate Bulletin
Document that serves as a guideline for candidates preparing to take the NCLEX®. Candidate Bulletins contain information regarding registration, scheduling, information on the testing experience and other useful information for candidates.

Candidate Performance Report (CPR)
An individualized, two-page document sent to candidates who fail the NCLEX® examination. The CPR reflects candidate performance on various aspects of the NCLEX® examination by test plan content area.

Centers for Medicare & Medicaid Services (CMS)
An agency of the U.S. Department of Health and Human Services (HHS); formerly called the Health Care Financing Administration (HCFA).

Certification
A credential issued by a national certifying body that is used as a requirement for certain types of licensure, meeting specified requirements acceptable to the board of nursing.

Certification Program
An examination designed by a certifying body to evaluate candidates for advanced practice nursing.

Certified Nurse-Midwife (CNM)
Certified nurse-midwives (CNMs) are RNs who are also certified. To become certified, they must graduate from a nurse-midwifery program accredited by the American College of Nurse-Midwives, and pass a national certification exam. CNMs are educated in both nursing and midwifery and can practice anywhere in the U.S.[18]

See also *Advanced Practice Registered Nurse* entry.

Certified Registered Nurse Anesthetist (CRNA)
Nurse anesthesia is an advanced clinical nursing specialty. As anesthesia specialists, CRNAs administer approximately 65 percent of the 26 million anesthetics given to patients in the U.S. each year.[19]

See also *Advanced Practice Registered Nurse* entry.

Certifying Body for Nurses
A nongovernmental agency that validates by examination, based on predetermined standards, an individual nurse's qualifications and knowledge for practice in a defined functional or clinical area of nursing.

Citizen Advocacy Center (CAC)
A nonprofit, nonpartisan community legal organization dedicated to building democracy for the 21st century. Center community lawyers and volunteers focus on strengthening the citizenry's capacity and motivation to participate in civic affairs, building community resources and improving democratic protocols within our community institutions. Through public education, community organizing, issue advocacy, and precedent-setting litigation in state and federal courts, the Center forges ahead with programs to advance civic life. The Center is a free public resource to the community.[20]

Clinical Nurse Specialist (CNS)
A licensed RN who has graduate preparation (master's or doctorate) in nursing as a clinical nurse specialist.

See also *Advanced Practice Registered Nurse* entry.

Commission on Collegiate Nursing Education (CCNE)
An autonomous accrediting agency contributing to the improvement of the public's health. CCNE ensures the quality and integrity of baccalaureate and graduate education programs focused on preparing effective nurses. CCNE serves the public interest by assessing and identifying programs that engage in effective educational practices. As a voluntary, self-regulatory process, CCNE accreditation supports and encourages continuing self-assessment by nursing education programs and the continuing growth and improvement of collegiate professional education.[21]

Commission on Graduates of Foreign Nursing Schools (CGFNS)
Internationally recognized authority on education, registration and licensure of nurses and other health care professionals worldwide. CGFNS protects the public by ensuring that nurses and other health care professionals educated in countries other than the U.S. are eligible and qualified to meet licensure, immigration and other practice requirements in the U.S. The agency provides credentialing services for foreign-educated nurses, as well as a certification program designed to predict success on the NCLEX-RN® examination.[22]

Commitment to Ongoing Regulatory Excellence (CORE)
A system of performance measurement to determine best practices for nursing regulation, initially established to implement NCSBN's Commitment to Excellence in Nursing Regulation project.

Committee on Nominations
The elected committee of NCSBN responsible for preparing a slate of qualified candidates for each year's elections. Members serve one-year terms.

Computerized Adaptive Testing (CAT)
A testing methodology used to administer NCLEX on a computer; the computer selects the items candidates receive as they take the examination, which gives them the best opportunity to demonstrate their competence. Each examinee's test is dynamically constructed, with each item selected to provide the maximum possible information, given responses made to previous items.

Confronting Colleague Chemical Dependency
Online CE course offered through NCSBN Learning Extension, released in 2005. Based on NCSBN's Video and Facilitation Package "Breaking the Habit: When Your Colleague is Chemically Dependent." Learners earn 3.3 contact hours for completing the course.

Continued Competence Accountability Profile (CCAP)
No longer an active project of NCSBN, this project provided a framework for the licensed nurse to document learning needs, learning plans and goals/objectives, strategies for development and evaluation of the achievements of goals/objectives. It is an expected

19. American Association of Nurse Anesthetists Web site. (n.d.) *Questions and Answers: A Career in Nurse Anesthesia*. Retrieved 11 May 2007, from http://www.aana.com/becomingcrna.aspx?ucNavMenu_SMenuTargetID=103&ucNavMenu_SMenuTargetType=4&ucNavMenu_TSMenuID=6&id=110
20. Building Democracy in the 21st Century – Citizens Advocacy Center. (n.d.) *About CAC*. Retrieved 11 May 2007, from http://www.citizenadvocacycenter.org/about-cac.htm
21. American Association of Colleges of Nursing (AACN) Web site. (n.d.) *Mission Statement and Goals:Commission on Collegiate Nursing Education*. Retrieved 11 May 2007, from http://www.aacn.nche.edu/Accreditation/mission.htm
22. Commission on Graduates of Foreign Nursing Schools (CGFNS) Web site. (n.d.) *Who We Are/What We Do*. Retrieved 11 May 2007, from http://www.cgfns.org/sections/about/

23. The Council of State Governments Web site. (n.d.) *Frequently asked questions*. Retrieved 11 May 2007, from http://www.csg.org/about/faqs.aspx
24. American Council of Nurse Anesthetists Web site. (n.d.) Council on Certification. *Council on certification of nurse anesthetists (CCNA)*. Retrieved 4 April 2005, from http://www.aana.com/council/default1.asp

activity of all licensed nurses to reflect upon lifelong learning activities and their application to daily practice. The profile was, in essence, the application of the nursing process to one's own competence, professional development and accountability.

Continuing Education Unit (CEU)
Represents 10 contact hours in a formal education program.

Council Connector
One of the main sources for information on what is happening at NCSBN. The bimonthly public newsletter contains news about committee activities, updates from NCSBN departments, information about upcoming events and other information related to the work of NCSBN.

Council of State Governments (CSG)
Provides a network for identifying and sharing ideas with state leaders and is founded on the premise that the states are the best sources of insight and innovation. NCSBN is a member at the associate level.[23]

Council on Certification of Nurse Anesthetists (CCNA)
An autonomous, multidisciplinary body existing under the corporate structure of the American Association of Nurse Anesthetists (AANA). Responsible for the certification of RN anesthetists who have fulfilled educational and other criteria for the practice of nurse anesthesia. CCNA is charged with protecting and serving the public by assuring that individuals who are credentialed have met predetermined qualifications or standards for providing nurse anesthesia services.[24]

Council on Licensure, Enforcement and Regulation (CLEAR)
An organization of regulatory boards and agencies.

D

Delegate Assembly (DA)
The voting body of NCSBN that comprises 59 Member Boards. Provides direction through adoption of the mission, strategic initiatives and outcomes, and adoption of position statements and actions. Each Member Board is entitled to two votes.

Delegating Effectively
Online continuing education course offered through NCSBN Learning Extension, released in 2006. Based on NCSBN's video and facilitation package called "Delegating Effectively: Working Through and With Assistive Personnel." Learners earn 4.2 contact hours for completing the course.

Delegation
Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The licensed nurse retains accountability for the delegation.

Differential Item Functioning (DIF)
A statistical measure of potential item bias.

Direct Registration
Method(s) by which NCLEX candidates register for the NCLEX through test service. NCLEX registrations are processed one of three ways: scan form, Internet or phone. The NCLEX registration fee of $200 is due at time of processing.

Director-at-Large
NCSBN Board of Directors position. Two directors are elected and represent the perspectives of the membership at large during meetings of the board.

Disciplinary Actions: What Every Nurse Should Know
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 4.8 contact hours for completing the course.

Disciplinary Data Bank (DDB)
An NCSBN data management system used between 1981 and 2000 to provide a database of disciplinary actions reported by Member Boards. The DDB data was incorporated into Nursys®, which continues to provide tracking of disciplinary data reported by boards of nursing.

Discipline
The actions taken, as well as the process used, to investigate and resolve complaints received by boards of nursing regarding the practice and/or conduct of licensed nurses. Boards follow their jurisdiction's Administrative Procedures Act, as well as the State Nurse Practice Act and Nursing Administrative Rules/Regulations in providing due process (i.e., the procedural safeguards for the nurse of receiving notice,

having an opportunity to respond to allegations and having a fair and objective decision maker) in the enforcement of nursing laws and rules.

Diversity: Building Cultural Competence
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 6.0 contact hours for completing the course.

Documentation: A Critical Aspect of Client Care
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 6.0 contact hours for completing the course.

E

End-of-Life Care and Pain Management
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 3.0 contact hours for completing the course.

English as a Second Language (ESL)
NCSBN asks NCLEX candidates to self-identify their primary language. The possible categories are: (1) English, (2) English and another language, (3) another language and (4) missing. Candidates who report their primary language as "English and another language" or "another language" are considered for research purposes to be ESL candidates.

Ethics of Nursing Practice
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 4.8 contact hours for completing the course.

Examination Committee (EC)
A standing committee of NCSBN. The Item Review Subcommittee is a subcommittee of the EC.

F

Federation of Associations of Regulatory Boards (FARB)
An organization made up of an association of licensing boards, FARB provides a forum for individuals and organizations to share information related to professional regulation, particularly in the areas of administration, assessment and law. NCSBN holds a seat on the FARB Board of Directors.

Fiscal Year (FY)
Oct. 1 to Sept. 30 at NCSBN.

Finance Committee
A standing committee of NCSBN.

H

Health Insurance Portability and Accountability Act (HIPAA)
Passed in 1996 to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health care delivery; to promote the use of medical savings accounts, to improve access to long-term care services and coverage; and to simplify the administration of health insurance and for other purposes.

Health Resources and Services Administration (HRSA)
The agency of the federal government under the Department of Health and Human Services that includes the Practitioner Database Branch and Division of Nursing.

Healthcare Integrity and Protection Data Bank (HIPDB)
A national data collection program mandated and operated by the Health Resources and Services Administration (HRSA) for the reporting of final adverse actions against health care providers, suppliers or practitioners, as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I

Incident Reports (IRs)
Reports written by test center staff regarding irregularities that may occur during an NCLEX candidate's examination. IRs may also be generated when a candidate calls NCLEX Candidate Services or in the event that special examination accommo-

25. Institute of Medicine of the National Academies Web site. (n.d.) *About.* Retrieved 11 May 2007, from http://www.iom.edu/CMS/3239.aspx
26. International Council of Nurses Web site. (n.d.) *About ICN*. Retrieved 11 May 2007, from http://www.icn.ch/abouticn.htm

dations are requested. IRs are entered in the Pearson VUE system so NCSBN and Member Boards can view them from the NCLEX® Administration Web site.

Institute of Medicine (IOM)
A nonprofit organization specifically created for science-based advice on matters of biomedical science, medicine and health as well as an honorific membership organization. The IOM's mission is to serve as adviser to the nation to improve health. The IOM provides unbiased, evidence-based and authoritative information and advice concerning health and science policy to policymakers, professionals and leaders in every sector of society and the public at large.[25]

Institute of Regulatory Excellence (IRE)
NCSBN created this program in 2004 to assist regulators in their professional development by providing opportunities for both education and networking.

Interagency Collaborative on Nursing Statistics (ICONS)
ICONS promotes the generation and utilization of data, information and research about nurses, nursing education and the nursing workforce. ICONS is an association of individuals from a variety of organizations that are responsible for the development, compilation and analysis of data on nurses and the settings in which they practice.

International Council of Nurses (ICN)
A federation of national nurses' associations (NNAs), representing nurses in more than 120 countries. ICN is the world's first and widest-reaching international organization for health professionals. ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce.[26]

International Scheduling Fee
The charge associated with scheduling an NCLEX® examination appointment in an international testing center ($150 plus a value added tax (VAT) where applicable). These nonrefundable fees must be paid by credit card and will be charged when a candidate schedules an examination appointment.

International Testing Centers
There are Pearson Professional Center (PPC) test center locations in Australia, Canada, Germany, Hong Kong, India, Japan, Mexico, Puerto Rico, Taiwan, Philippines and United Kingdom that administer the NCLEX for the purposes of domestic licensure.

Interprofessional Workgroup on Health Professions Regulation (IWHPR)
A coalition of organizations representing millions of health care practitioners in more than 15 separate health disciplines.

Interstate Compact
An agreement (contract, usually adopted by legislation) between two or more states that has the force and effect of statutory law.

Item
A question on one of the NCLEX® examinations.

Item Development
Process by which items for examinations are created, reviewed and validated, in order to become operational.

Item Development Panels
Comprised of volunteers who meet specific criteria to participate in the item development process.

Item Response Theory (IRT)
A family of psychometric measurement models based on characteristics of examinees' item responses and item difficulty. Their use enables many measurement benefits

See also *Rasch Measurement Model* entry.

Item Reviewers
Individuals who review items developed for the NCLEX-RN® and NCLEX-PN® examinations. Item reviewers must meet specific criteria in order to participate on a panel.

Item Writers
Individuals who write items for the NCLEX-RN® and NCLEX-PN® examinations. Item writers must meet specific criteria in order to participate on a panel.

Item Writing
Process by which examination items are created.

J

Joint Commission
Formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Joint Commission evaluates and accredits more than 15,000 health care organizations and programs in the U.S. It is the nation's predominant standard-setting and accrediting body in health care. The Joint Commission's mission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.[27]

Joint Research Committee (JRC)
Committee consisting of 3 NCSBN and 3 test service staff members as well as 4 external researchers. The committee is the vehicle through which research is funded for the NCLEX® examination program. Funding is provided jointly by the NCSBN and the test service.

K

Knowledge, Skill and Ability Statements (KSA)
The attributes required to perform a job, generally demonstrated through qualifying service, education or training. Knowledge is a body of information applied directly to the performance of a function. Skill is an observable competence to perform a learned psychomotor act. Ability is competence to perform an observable behavior or a behavior that results in an observable product.[28]

L

Leader to Leader
NCSBN semiannual newsletter sent to nursing schools.

License
In nursing, current authority to practice nursing as a RN, LPN/VN or APRN.

Licensed Practical Nurse (LPN)
A graduate of a school of practical nursing who has passed the practical/vocational nursing examination and is licensed to administer care.

Licensed Vocational Nurse (LVN or VN)
A graduate of a vocational nursing program who has passed the practical/vocational nursing examination and is licensed to administer care.

Licensing Board
A state's regulatory body responsible for issuing licenses for RN and LPN/VN licensure as well as APRN licensure/authority to practice.

Licensure by Endorsement
The granting of authority to practice based on an individual's licensure in another jurisdiction.

Licensure by Examination
The granting of authority to practice based on an individual's passing of a board-required examination.

Licensure Portability Grant (LPG)
A grant NCSBN received from the Health Resources and Services Administration's (HRSA) Office for the Advancement of Telehealth to work with state boards of nursing to reduce licensure barriers impacting telehealth and interstate nursing practice.

Logit
A unit of measurement used in item response theory (IRT) models. The logarithmic transformation of an odds ratio creates an equal interval logit scale on which item difficulty and person ability may be jointly represented.

M

Master Pool Items
NCLEX operational items. The bank of test items from which examinations are developed.

Medication Errors: Detection and Prevention
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 6.9 contact hours for completing the course.

27. The Joint Commission Web site. (n.d.) *Facts about the Joint Commission*, Retrieved 11 May 2007, from http://www.jointcommission.org/AboutUs/joint_commission_facts.htm
28. U.S. Office of Personnel Management Web site. (n.d.) *Operating Manual: Qualification Standards for General Schedule Positions, General Policy and Procedures Part C and D.* Retrieved 11 May 2007, from http://www.opm.gov/qualifications/SEC-II/s2-c-d.asp

29. National Association for Practical Nurse Education & Services, Inc. (NAPNES) Web site. (n.d.) *About NAPNES*. Retrieved 11 May 2007, from http://www.napnes.org/about.htm
30. National Association of Hispanic Nurses Web site. (n.d.) *NAHN At a Glance*. Retrieved 11 May 2007, from http://www.thehispanicnurses.org/
31. National Black Nurses Association, Inc. (NBNA) Web site. (n.d.) *Who Are We?* Retrieved 11 May 2007, from http://www.nbna.org/whoare-we.htm
32. National Certification Board of Pediatric Nurse Practitioners and Nurses Web site. (n.d.) *Welcome*. Retrieved 11 May 2007, from http://www.people.virginia.edu/~sep3y/certification.htm

Member Board
A jurisdiction that is a member of NCSBN.

Member Board Editorial Advisory Pool (MBEAP)
Voluntary editorial pool consisting of boards of nursing staff for the purpose of reviewing and providing input for NCSBN Learning Extension course development.

Model Nursing Administrative Rules (MNAR)
Serve to clarify and further interpret and implement the *Model Nursing Practice Act*. Models can be used to identify essential elements needed for rules/regulations to the *Model Nurse Practice Act*. Rules must be consistent with the law, cannot go beyond the law, and once enacted have the force and effect of law. MNAR are available on NCSBN's Web site.

Model Nursing Practice Act (MNPA)
A publication of NCSBN, approved at the Delegate Assembly in Kansas City, Missouri in 2004 with additional content on assistive personnel adopted in 2005 and on criminal background checks in 2006. The Model Acts and Rules were first adopted in 1983 and were created to serve as a guide to boards who were deliberating changes to state nurse practice acts and nursing administrative rules. Some boards look to the models for new ideas and different approaches for regulation. Other boards may use them in evaluating their existing regulatory language. Some boards use the framework and/or language in developing amendments and revisions to state laws and rules. The models may assist in the development of rationale for rules as part of the rule promulgation process. Models can be used to identify essential elements for legislation. While there will always be some variation with state nursing statutes, models are a way to advance a degree of uniformity among the several states to promote a common nationwide understanding of what constitutes the practice of nursing. The MNPA are available on NCSBN's Web site.

Motion Papers
Available at Annual Meeting and used for accurate record keeping.

Mutual Recognition
A model for nurse licensure that allows a nurse licensed in his or her state of residency to practice in other compact states (both physical and electronic), subject to each state's practice law and regulation. Under mutual recognition, a nurse may practice across state lines unless otherwise restricted. In order to achieve mutual recognition, each state must enact legislation authorizing the Nurse Licensure Compact.

See also *Nurse Licensure Compact* entry.

N

National Association for Practical Nurse Education and Service (NAPNES)
Advocates for the education and practice of practical/vocational nurses. It is the organization responsible for the legislation that provides for the licensure and education of practical nursing.[29]

National Association of Hispanic Nurses (NAHN)
Designed and committed to work toward improvement of the quality of health and nursing care for Hispanic consumers and toward providing equal access to educational, professional and economic opportunities for Hispanic nurses.[30]

National Black Nurses Association (NBNA)
Provides a forum for collective action by African American nurses to investigate, define and determine what the health care needs of African Americans are and to implement change to make available to African Americans and other minorities health care commensurate with that of the larger society.[31]

National Certification Board of Pediatric Nurse Practitioners and Nurses (NCBPNP/N)
Provides high-quality certification services to nurses in pediatric practice through the provision of certification exams and certification maintenance programs. The NCBPNP/N remains the largest certification organization for pediatric nursing.[32]

National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC)
A nonprofit association that provides its

buyers with national credentialing and continuing education programs in the fields of obstetrics, gynecology and neonatal care. NCC buyers are primarily inpatient obstetric nurses, women's health care nurse practitioners and neonatal intensive care nurses.[33]

National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)
Formed so that leading national health care organizations could meet, collaborate and cooperate to address the interdisciplinary causes of errors and to promote the safe use of medications.[34]

National Council Licensure Exam for Licensed Practical/Vocational Nurses (NCLEX-PN® Examination)
The NCLEX-PN® Examination is used in the U.S. and by territorial Member Boards to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.

National Council Licensure Exam for Registered Nurses (NCLEX-RN® Examination)
The NCLEX-RN® examination is used in the U.S. and by territorial Member Boards to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.

National Council of State Legislatures (NCSL)
A bipartisan organization that serves the legislators and staff of the nation's 50 states, its commonwealths and territories. NCSL provides research, technical assistance and opportunities for policy makers to exchange ideas on the most pressing state issues. NCSL is an effective and respected advocate for the interests of state governments before Congress and federal agencies.[35]

National Federation of Licensed Practical Nurses (NFLPN)
A professional organization for LPNs, LVNs and practical/vocational nursing students in the U.S.[36]

National Institute of Nursing Research (NINR)
NINR is part of the National Institute of Health and improves the health and health care of Americans through the funding of nursing research and research training. Its mission is to promote and improve the health of individuals, families, communities, and populations. This mission is accomplished through support of research in a number of scientific areas. Among those areas of research are chronic and acute diseases, health promotion and maintenance, symptom management, health disparities, caregiving, self-management, and the end-of-life. NINR also supports the training of new investigators who bring new ideas and help to further expand research programs. The ultimate goal of NINR's research is its dissemination into clinical practice and into the daily lives of individuals and families.

National League for Nursing (NLN)
A national organization created to identify the nursing needs of society and to foster programs designed to meet these needs; to develop and support services for the improvement of nursing service and nursing education through consultation, continuing education, testing, accreditation, evaluation and other activities; to work with voluntary, governmental and other agencies, groups and organizations for the advancement of nursing and toward the achievement of comprehensive health care; and to respond in appropriate ways to universal nursing needs.[37]

National League for Nursing Accrediting Commission, Inc. (NLNAC)
Responsible for the specialized accreditation of nursing education programs, both post-secondary and higher degree. NLNAC has authority and accountability for carrying out the responsibilities inherent in the application of standards and criteria, accreditation processes, and the affairs, management, policy-making, and general administration of the NLNAC. NLNAC is a nationally recognized specialized accrediting agency for all types of nursing programs.[38]

National Nurse Aide Assessment Program (NNAAP™)
The nurse aide certification examination developed by NCSBN and Promissor, Inc.

See also *Promissor* entry.

National Practitioner Data Bank (NPDB)
A federally mandated program for collecting data regarding health care practitioners. The

33. National Certification Corporation for the Obstetric, Gynecologic & Neonatal Nursing Specialties (NCC) Web Site. *What is NCC?* Retrieved 11 May 2007, from http://www.nccnet.org/public/pages/index.cfm?pageid=61
34. The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Web site. (n.d.) *About NCC MERP*. Retrieved 11 May 2007, from http://www.nccmerp.org/aboutNCCMERP.html
35. National Conference of State Legislatures (NCSL) Web site. (n.d.) *About NCSL*. Retrieved 11 Mat 2007, from http://www.ncsl.org/public/ncsl/nav_aboutNCSL.htm
36. The National Federation of Licensed Practical Nurses, Inc. Web site. (n.d.) *All About NFLPN*. Retrieved 11 May 2007, from http://www.nflpn.org/allaboutnflpn.htm
37. National League for Nursing (NLN) Web site. (n.d.) *Bylaws*. Retrieved 11 May 2007, from http://www.nln.org/aboutnln/Bylaws/index.htm
38. National League for Nursing Accrediting Commission (NLNAC) Web site. (n.d.) *About NLNAC*. Retrieved 11 May 2007, from http://www.nlnac.org/About NLNAC/whatsnew.htm

39. National Student Nurses Association (NSNA) Web site. (n.d.) *NSNA Mission Statement*. Retrieved 11 May 2007, from http://www.nsna.org/about_us.asp

NPDB has been in operation for 10 years and requires medical malpractice payment reports for all health care practitioners, and reports of discipline and clinical privilege/society actions regarding physicians and dentists. Mandatory reporting of licensure actions regarding other health care practitioners, including nurses, is required by section 1921 of the Social Security Act (originally enacted in P.L.100-93, section five). Proposed rules to implement section 1921 were published in March 2006 and final rules are expected in 2007.

National Provider Identifier (NPI)
Planned to be a new, unique eight-character alpha-numeric identifier. Created in response to the posting of rules in the Federal Register on May 7, 1998, which proposed a standard for a national health care provider identifier and requirements for its use by health plans, health care clearing houses and health care providers.

National Student Nurses' Association (NSNA)
Organizes, represents and mentors students preparing for initial licensure as RNs, as well as those enrolled in baccalaureate completion programs and conveys the standards and ethics of the nursing profession. NSNA promotes development of the skills that students will need as responsible and accountable members of the nursing profession and advocates for high-quality health care in addition to advocating for and contributing to advances in nursing education, and developing nursing students who are prepared to lead the profession in the future.[39]

NCLEX® Administration Web Site
Allows Member Boards to process and manage NCLEX candidate records. Member Boards use the site to perform tasks including: setting candidate eligibility status, entering candidate accommodations requests and viewing candidate results.

Please Note: A user name and password is needed to enter this site.

NCLEX® Invitational
An annual one-day educational conference with sessions related to the NCLEX program and NCLEX® Examinations Department products and services.

NCLEX® Program Reports
Published twice per year for subscribing schools of nursing, the NCLEX® Program Reports provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX® examination. Included in the NCLEX® Program Reports is information about a given program's performance by the *NCLEX® Test Plan* dimensions and content areas, and data regarding the program's rank at both national and state levels.

NCLEX® Quarterly Reports
Reports that summarize the performance of all first-time candidates educated in a given jurisdiction and tested in a given quarter, and the national group of candidates. They also provide a summary of the preceding three quarters' passing rates.

NCLEX® Quick Results Service
Candidates in select jurisdictions may access their "unofficial" results via the NCLEX® Candidate Web site or through the NCLEX® Quick Results Line. "Unofficial" results are available two business days after taking the test. There is a charge for the service.

NCLEX® Regional Workshop
A one-day educational conference for educators related to the NCLEX® examinations. It is produced at the request of individual Member Boards.

NCSBN Board of Directors (BOD)
Administrative body of NCSBN, consisting of nine elected officers, whose authority is to transact the business and bylaws of the affairs of NCSBN.

NCSBN Learning Extension
Brand name for the online campus located at www.learningext.com where NCSBN promotes educational products and provides online course access to learners.

NCSBN Strategic Plan
The strategic initiatives and outcomes of NCSBN spanning a three-year period.

NCSBN Vice President
NCSBN Board of Directors leader that assists the president as needed, performs the president's duties in the president's absence, fills any vacancy in the office of the president until the next annual meeting and is responsible for continuing Board development.

NCSBN 101
Online course about the history, structure and purpose of the NCSBN organization for Member Board members and staff and NCSBN staff. The course is free through Member Relations and NCSBN Learning Extension. Learners earn 4.8 contact hours upon successful course completion.

NCSBN's Review for the NCLEX-PN® Examination
Online course offered through NCSBN Learning Extension for NCLEX-PN® candidates.

NCSBN's Review for the NCLEX-RN® Examination
Online course offered through NCSBN Learning Extension for NCLEX-RN® candidates.

North American Free Trade Agreement (NAFTA)
Agreement between Canada, Mexico and the U.S. that addresses trade in services and contains requirements and encouragement related to harmonization of qualifications for professional practice in the three countries.

Nurse Aide Registry
NCSBN publication that contains a listing of all the Nurse Aide Registries by state along with contact information for those responsible for registry maintenance and complaint investigation. Updated annually.

Nursing Assistant Workshop
An annual one-day program offered to NCSBN members and other stakeholders to address the current regulation of nursing assistants.

Nurse Licensure Compact (NLC)
An agreement establishing mutual recognition and reciprocal licensing arrangements between party states for LPN/VNs and RNs. In August 2002, NCSBN delegates voted to expand the compact to include APRNs.

Nurse Licensure Compact Administrators (NLCA)
Organized body of nurse licensing boards that have implemented and administer the Nurse Licensure Compact.

Nurse Practice Acts Continuing Education Course
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 2.0 contact hours for completing the course.

Nurse Practitioner (NP)
A RN with advanced academic and clinical experience, which enables him or her to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team. A NP provides some care previously offered only by physicians and in most states has the ability to prescribe medications. NPs focus largely on health maintenance, disease prevention, counseling and patient education in a wide variety of settings. NPs are educated through programs that grant either a certificate or a master's degree. The scope of an NP's practice varies depending upon each state's regulations. Unnecessary obstacles to an NP's practice contribute to the rising costs and inaccessibility of health care for all Americans.[40]

See also *Advanced Practice Registered Nurse* entry.

Nursing Assistive Personnel (NAP)
Any unlicensed person, regardless of title, who performs tasks delegated by a nurse. Also known as unlicensed assistive personnel (UAP).

Nursing Practice Act (NPA)
Statutes governing the regulation of nursing practice in a jurisdiction, typically empowering a board of nursing to license individuals who meet specified requirements.

Nursing Practice and Education Committee (NP&E)
The former name of a standing committee of NCSBN, now called PR&E Committee.

Nursing Practice and Education Consortium (N-PEC)
A group founded in 1997 that comprised 10 nursing organizations. N-PEC member representatives held four workshops and five conference calls in 2000 to draft, review and produce a consensus report. The project resulted in a 13-page series of ideas entitled "Vision 2020 for Nursing: A Strategic Work Plan to Transform U.S. Nursing Practice and Education."[41]

Nursing Program
The authorized state entity with the legal authority to regulate nursing. Legislatures enact the Nurse Practice Act for each state.

40. American College of Nurse Practitioners Web site. (n.d.) *About NPs.* Retrieved 11 May 2007, from http://www.npcentral.net/consumer/about.nps.shtml

41. Robert Wood Johnson Foundation Web site. (n.d.) *Grant Results Report.* Retrieved 3 June 2005, from http://www.rwjf.org/portfolios/resources/grantsreport.jsp?filename=038622.htm&iaid=137#int_appendix

Boards of nursing have the legal authority to license nurses and to discipline nurses for unsafe practice.

Nursing School Accrediting Agency
An organization that establishes and maintains standards for professional nursing programs and recognizes those programs that meet these standards.

Nursing Shortage
A nursing shortage occurs when the demand for nurses exceeds the supply available.

Nur*sys*®
A database developed by NCSBN to contain demographic information on all licensed nurses (in the U.S.) and an unduplicated count of licensees. Nur*sys*® serves as a foundation for a variety of services, including the disciplinary tracking system, licensure verification, interstate compact functions and research on nurses.

Nur*sys*® Advisory Panel (NAP)
NCSBN committee charged with identifying and addressing Nur*sys* day-to-day Member Board issues and enhancing the database system. Responsible for advising NCSBN staff regarding content of Nur*sys*® Users Group and IT Summit as well as the need for its continuation.

Nur*sys*® Business Design Advisory Panel (NBDAP)
NCSBN committee charged with evaluating the Nur*sys*® business design and rules, along with associated policies and procedures.

Nur*sys*® Licensure QuickConfirm
Nur*sys*® Licensure QuickConfirm provides online detailed nurse license verification reports to employers and others.

O

Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)
Contains requirements for nurse aide training and competency evaluation.

P

Panel of Judges
A panel of experts used for the standard setting process; an NCSBN panel composed of nurses who participate in the NCLEX standard setting process.

Parliamentarian
Assists the president in presiding, ensures proper parliamentary procedure is followed and prepares a written record of the proceedings.

Passing Standard
The minimum level of knowledge, skill and ability required for safe and effective entry-level nursing practice. The NCSBN Board of Directors reevaluates the passing standard once every three years, based upon the results of a standard-setting exercise performed by a panel of experts with the assistance of professional psychometricians; the historical record of the passing standard with summaries of the candidate performance associated with those standards; the results of a standard-setting survey sent to educators and employers; and information describing the educational readiness of high school graduates who express an interest in nursing.

Once the passing standard is set, it is imposed uniformly on every test record according to the procedures laid out. To pass an NCLEX® examination, a candidate must exceed the passing standard. There is no fixed percentage of candidates that pass or fail each examination.

Patient Privacy Continuing Education Course
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 5.4 contact hours for completing the course.

Pearson Professional Testing Network
Network of Pearson Professional Centers (PPCs) where candidates take the NCLEX® examinations. There are more than 200 domestic and 18 international PPCs that administer the NCLEX.

See also *Pearson VUE* entry.

Pearson VUE
Contracted test service provider for NCSBN since 2002 to assist with the NCLEX program.

Pew Task Force on Health Care
Charged by the Task Force on Health Care Workforce Regulation to identify and explore how regulation protects the public's health and propose new approaches to health care workforce regulation to better serve the public's interest. The task force was composed of eight individuals with legal, policy and public health expertise. Its recommendations were issued in late 1995.

Plurality Vote
Voting process where each voter votes for one candidate, and the candidate with the plurality (most votes) wins, regardless of whether that candidate gets a majority or not.

Practice (Job) Analysis
Research study conducted by the NCLEX Examinations Department that examines the practice of newly licensed job incumbents (RNs, LPN/VNs) or new nursing assistants. The results are used to evaluate the validity of the test plans/blueprints that guide content distribution of the licensure examinations or the nurse aide competency evaluation.

Practice and Professional Issues Survey (PPI)
A survey conducted twice each year to collect information from entry-level nurses on practice activities.

Practice, Regulation and Education Committee (PR&E)
A standing committee of NCSBN, comprised of at least six members. The committee's purpose is to provide general oversight of nursing practice, regulation and education issues.

Practitioner Remediation and Enhancement Partnership (PreP)
A partnership of licensing boards and health care organizations whose goal is to jointly identify, remediate and monitor practitioners whose practice is not up to standard, but whose actions do not require discipline. This project is sponsored by the Citizen's Advocacy Center (CAC). NCSBN is a member of the national advisory board.

Prep-4-Patient Safety
A pilot project funded by a grant from the Health Resources and Services Administration (HRSA) that provides tools for state medical and nursing boards to work with hospitals and other health care organizations to identify, remediate and monitor health care practitioners (now limited to physicians and nurses) with deficiencies that do not rise to the level of disciplinary action. This improves patient safety by allowing organizations and licensing boards to work together to identify providers with clinical deficiencies in a nonpunitive environment.[42]

NCSBN is a member of the national advisory board. Many boards of nursing are participating or planning to join.

President
NCSBN Board of Directors leader that guides the Board in the enforcement of all policies and regulations relating to NCSBN and performs all other duties normally incumbent upon the Board President.

Pretest Items
Newly written test questions placed within the NCLEX® examinations for gathering statistics. Pretest items are not used in determining the pass/fail result.

Privilege to Practice
This refers to the multistate licensure privilege, which is the authority to practice nursing in any compact state that is not the state of residency. Additional license is not granted for this authority.

See also *Nurse Licensure Compact* entry.

Professional Accountability and Legal Liability for Nurses
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 5.4 contact hours for completing the course.

Professional Boundaries
The space between the nurse's power and the client's vulnerability—the power of the nurse comes from the professional position and access to private knowledge about the client. Establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the client's needs. Complimentary professional boundaries materials are available from NCSBN.

42. 4 Patient Safety Web site. (n.d.) *Home Page*. Retrieved 11 May 2007, from http://www.4patientsafety.net/

Profiles of Member Boards
NCSBN publication that provides an overview of the regulatory environment in which state boards of nursing function. Includes data by jurisdiction on board structure, educational programs, entry into practice, licensure requirements, continued competency mechanisms, nurse aide competency evaluations and advanced practice. Available on NCSBN's Web site.

Promissor, Inc.
Promissor is a Pearson Vue Company. It is the test service for the National Nurse Aide Assessment Program (NNAAP™). Formerly known as CAT*ASI.

Psychometrics
The scientific field concerned with all aspects of educational and psychological measurement (or testing), specifically achievement, aptitude and mastery as measured by testing instruments.

Public Policy
Policy formed by governmental bodies. These include all decisions, rules, actions and procedures established in the public interest.

R

Rasch Measurement Model
A logistic latent trait model of probabilities, which analyzes items and people independently, and then expresses both item difficulty and person ability on a single continuum. These models are derived not from data but from the structure necessary for measurement. The dichotomous Rasch model is the item response theory (IRT) model used to develop the NCLEX® examination measurement scale.

Registered Nurse (RN)
A nurse who has graduated from a state-approved school of nursing, has passed the professional nursing state board examination and has been granted a license to practice within a given state.

Reliability
A test statistic that indicates the expected consistency of test scores across different administrations or test forms. For adaptively administered examinations, such as the NCLEX® examination, the "decision consistency statistic" is the preferred statistic for assessing reliability. NCSBN uses the Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of the National Nurse Aide Assessment Program (NNAAP™).

Resolutions Committee
Comprised of at least four members generally representing each of the four NCSBN geographical areas and includes one member of the Finance Committee. Reviews, evaluates and reports to the Delegate Assembly all resolutions and motions submitted by Member Boards. The committee is governed by the operational policies and procedures, the standing rules and the bylaws.

Respecting Professional Boundaries
Online continuing education course offered through NCSBN Learning Extension, released in 2005. Based on NCSBN's video and facilitation package called "Crossing the Line: When Professional Boundaries are Violated." Learners earn 3.9 contact hours for completing the course.

S

Scope of Practice
Practicing within the limits of the issued health care provider license.

Sharpening Critical Thinking Skills for Competent Nursing Practice
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 3.6 contact hours for completing the course.

Standard Setting
The process by which the Board of Directors determines the passing standard for an examination, at or above which examinees pass the examination and below which they fail. This standard denotes the minimum level of knowledge, skill and ability required for safe and effective entry-level nursing practice. NCSBN uses multiple data sources to set the standard, including a criterion-referenced statistical procedure and a Survey of Professionals. Standard setting is con-

ducted every three years for each NCLEX® examination.

Standard Setting Panel of Judges
A group of individuals that contributes to the recommendation of potential NCLEX passing standards to the NCSBN Board of Directors.

Standing Committee
A permanent committee established by the NCSBN Bylaws.

Statistical Criteria
Guidelines that all proposed NCLEX items must meet in order to become operational.

Strategic Initiative
A goal, or generalized statement, of where an organization wants to be at some future time; the end toward which effort is directed.

Strategic Objective
Desired result; a translation of the strategic initiative into tangible results, a statement of what the strategy must achieve and the elements that are critical to its success.

T

Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP™)
An instrument developed for NCSBN's practice breakdown research.

Test Administrator (TA)
Test service staff person who is responsible for day-to-day operation of the center and for proctoring of examinations.

Test Development
Process by which items for examinations are created, reviewed and validated in order to become operational.

Test Development and Item Writing
Online course offered through NCSBN Learning Extension for nursing educators to assist in writing in the NCLEX style. Learners earn 19.5 contact hours for completing the course. Formerly called "Assessment Strategies for Nursing Educators: Test Development and Item Writing."

Test Plan
The organizing framework for the NCLEX-RN® and NCLEX-PN® examinations that includes the percentage of items allocated to various categories.

Test Service
The vendor that provides services to NCSBN, including test scoring and reporting. Pearson VUE is the contracted test service for the NCLEX® examinations, and Promissor is the contracted test service for NNAAP™.
See also *Pearson VUE* and *Promissor* entries.

Treasurer
NCSBN Board of Directors position that serves as the Chairperson of the Finance Committee and manages the Board's review of and action related to the Board's financial responsibilities.

U

U.S. Department of Education (DOE)
The agency of the federal government that establishes policy for, administers and coordinates most federal assistance to education.[43]

U.S. Department of Health and Human Services (HHS)
The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.[44]

U.S. Department of Homeland Security (DHS)
Leverages resources within federal, state and local governments, coordinating the transition of multiple agencies and programs into a single, integrated agency focused on protecting the American people and their homeland. DHS is comprised of five major divisions or directorates: Border and Transportation Security; Emergency Preparedness and Response; Science and Technology; Information Analysis and Infrastructure Protection; and Management. Besides the five directorates of DHS, several other critical agencies are folding into the new department or being newly created.[45]

U.S. Drug Enforcement Administration (DEA)
Federal agency charged to enforce the controlled substances laws and regulations of

43. U.S. Department of Education Web site. (n.d.) Overview," Retrieved 11 May 2007, from http://www.ed.gov/about/overview/focus/whattoc.html?src=ln
44. U.S. Department of Health & Human Services Web site. (n.d.) What we do," Retrieved 5 May 2007, from http://www.hhs.gov/about/whatwedo.html/
45. U.S. Department of Homeland Security Web site. (n.d.) FAQs," "DHS Organization," Retrieved 6 June 2005, from http://www.dhs.gov/dhspublic/faq.jsp, http://www.dhs.gov/dhspublic/display?theme=13

46. U.S. Drug Enforcement Administration Web site. (n.d.) DEA Mission Statement. Retrieved 6 June 2005, from http://www.usdoj.gov/dea/agency/mission

47. "Delegation Concepts and Decision-Making Process." NCSBN Position Paper, 1995.

the U.S. and bring to the criminal and civil justice system of the U.S., or any other competent jurisdiction, those organizations and principal members of organizations involved in the growing, manufacture or distribution of controlled substances appearing in or destined for illicit traffic in the U.S.; and to recommend and support nonenforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.[46]

Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements
Developed by NCSBN with APRN stakeholders in 2000; establishes the foundation for the APRN Compact.

Uniform Core Licensure Requirements for Registered Nurse/Licensed Practical/Vocational Nurse
Developed in 1999, the requirements promote consistency in licensure requirements for initial entry into the nursing profession.

Unlicensed Assistive Personnel (UAP)
Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated.[47]

V

Validity
The extent to which inferences made using test scores are appropriate and justified by evidence; an indication that the test is measuring what it purports to measure. NCSBN assures the content validity of its examinations by basing each test strictly on the appropriate test plan (NCLEX-RN® or NCLEX-PN® examination) or blueprint (NNAAP™). Each test plan or blueprint is developed from a current job analysis of entry-level practitioners.

VTN Technologies, Inc.
E-learning courseware provider for online courses offered through NCSBN Learning Extension.

VisaScreen®
A screening program that certain health care professionals must successfully complete before receiving an occupational visa, including the H-1B, H-2B, TN status, and permanent (green card) visas, as required by Section 343 of the Illegal Immigration Reform and Immigration Responsibility Act of 1996 (IIRIRA). This service is provided by The Commission on Graduates of Foreign Nursing Schools (CGFNS); however, the NCLEX® examination(s) maybe used to fulfill one component of the *VisaScreen®* process. The *VisaScreen®* itself is a trademarked product of CGFNS and currently is the only federally accepted organization to perform screening on nurses immigrating to the U.S.

See also *Commission on Graduates of Foreign Nursing Schools (CGFNS)* entry.

W

White Paper
A detailed policy document issued by NCSBN, widely disseminated to external groups, to discuss issues or to encourage dialogue about a particular regulatory subject.