2005 ANNUAL MEETING

BUSINESS BOOK

August 2-5, 2005 | Washington, DC

NCSBN
National Council of State Boards of Nursing

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Other Committee Reports

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 five United States territories — American Samoa, Guam, Northern Mariana Islands, Puerto Rico, 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

2005 NCSBN Annual Meeting

Business Agenda of the 2005 Delegate Assembly

TUESDAY, AUGUST 2
9:00–10:10 am

Opening Ceremonies
- Introductions
- Announcements

Opening Reports
- Credentials Committee
- Rules Committee

Adoption of Agenda

Report of the Committee on Nominations
- Presentation of the 2005 Slate of Candidates
- Nominations from Floor
- Approval of the 2005 Slate of Candidates

President's Address

Executive Director's Address

THURSDAY, AUGUST 4
3:00–4:30 pm

Board of Directors Recommendations
- Adopt Proposed Delegation Position Paper
- Adopt Proposed Model Act And Rules For Delegation And Nursing Assistant Regulatory Model
- Adopt the proposed position paper on nursing education clinical instruction in prelicensure nursing programs.
- Adopt the proposed criminal background check concept paper and model.

Results of Election of Officers, Directors and Committee on Nominations

FRIDAY, AUGUST 5
9:00 am – 12:00 pm

Board of Directors Recommendations (continued)

New Business
- Resolutions Committee

Closing Ceremony

Adjournment

Special Note

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

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. Meeting Conduct

1. Delegates must wear badges and sit in the section reserved for them.
2. All attendees shall be in their seats at least five minutes before the scheduled meeting time.
3. There shall be no smoking in the meeting room.
4. 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.
5. A delegate's conversations with non-delegates during a business meeting must take place outside the designated delegate area.
6. All attendees have a right to be treated respectfully.

3. Agenda

A. Business Agenda

1. The Business Agenda is prepared by the President in consultation with the Executive Director and approved by the Board of Directors.

B. Consent Agenda

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 nonprocedural 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, August 3, 2005, at 4:00 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, August 3, 2005, at 4:00 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 nonprocedural main motion or resolution after the deadline of 4:00 pm on Wednesday, August 3, 2005, 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. Nondelegate 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.

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, August 3, 2005.

D. Election for officers, directors, and members of the Committee on Nominations shall be held Thursday, August 4, 2005, from 7:45 to 8:45 am.

E. A majority vote is required for the election of an officer or director. 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. Run-off balloting shall proceed as follows:

- 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, on the first ballot, only 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.
- 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 only one candidate receives a majority on the third ballot, another run-off shall be limited to the remaining two candidates;
- Or, if one candidate receives a majority on the second ballot, a third run-off shall be limited to the two candidates receiving the highest numbers of votes.
- In case of a tie vote, a position shall be chosen by lot.

7. Forums

A. Scheduled Forums: 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 Forum: 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

TUESDAY, AUGUST 2, 2005

8:00–8:50 am — NCSBN Delegate Orientation
Donna Dorsey, MS, RN, FAAN, NCSBN President
Julia von Haam, Parliamentarian
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.

8:00–9:00 am — Registration and Continental Breakfast

9:00–9:40 am — Delegate Assembly: Opening Ceremony
Welcome from the District of Columbia Board of Nursing

- Opening Ceremonies
  - Introductions
  - Announcements
- Opening Reports
  - Credentials Committee
  - Rules Committee
- Adoption of Agenda
- Report of the Committee on Nominations
  - Presentation of the 2005 Slate of Candidates
  - Nominations from Floor
  - Approval of the 2005 Slate of Candidates

9:00 am – 4:30 pm — Exhibit Showcase
Stop by the Exhibit Showcase to learn about products and information pertinent to the boards of nursing!

9:40–9:55 am — President's Address
Donna Dorsey, MS, RN, FAAN, NCSBN President

9:55–10:10 am — Executive Director's Address
Kathy Apple, MS, RN, CAE, NCSBN Executive Director

10:10–10:30 am — Finance Committee Forum
Sandra Evans, MAEd, RN, NCSBN Treasurer
Robert Clayborne, MBA, CPA, NCSBN Director of Finance

10:30–11:00 am — Refreshment Break

11:00–11:30 am — Candidate Forum
Shirlie Meyer, RN, 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!

11:30 am – 12:00 pm — Examination Committee Forum
Anita Ristau, MS, RN, Chair, NCSBN Examination Committee
Casey Marks, PhD, NCSBN Associate Executive Director – Business Operations
The Examination Committee will provide an update on testing and exam related activities and initiatives.

12:00–1:30 pm — Lunch
Provided by NCSBN.

1:30–2:30 pm — Board of Directors Forum

2:30–2:45 pm — Refreshment Break

2:45–3:45 pm — Breakout Session: Advanced Practice
Kathy Thomas, MS, RN, Chair, NCSBN APRN Advisory Panel
Nancy Chornick, PhD, RN, CAE, NCSBN Director of Practice and Credentialing
An update on APRN issues will be presented.

2:45–3:45 pm — Breakout Session: American Organization of Nurse Executives (AONE)
Marilyn Bowcutt, RN, MSN, President
Marilyn Bowcutt will present AONE's Guiding Principles for Future Care Delivery. The principles were developed to promote discussion regarding the future design of patient care delivery systems.

2:45–3:45 pm — Breakout Session: Nur*sys*®
Angela Diaz-Kay, MBA, NCSBN Director of Information Technology
An update on Nur*sys*® will be presented along with an opportunity for members to ask questions.

2:45–3:45 pm — Breakout: National League for Nursing (NLN)
Elaine Tagliareni, EdD, RN
Elaine Tagliareni, a member of the National League for Nursing's (NLN) Board of Governors, will present NLN's Innovations in Education Initiative. This multidimensional approach to encouraging excellence, innovation and evidence-based teaching practices in all types of nursing education programs is designed to enhance student learning, strengthen student/faculty relationships, promote education/service collaboratives and, ultimately, transform nursing education so that our programs are most effective and efficient in preparing graduates for practice in today's chaotic, ambiguous health care arena.

4:30–6:30 pm — Candidate Reception with performance by The Capitol Steps
Delight in the satirical and topical political humor of the Capital Steps — former congressional staffers turned comedians. Known for digging into the headlines and giving audiences an insider's view of the nation's political arena, The Capital Steps take on both sides of the aisle making them fodder for quick witted barbs, parodies and satire.

WEDNESDAY, AUGUST 3, 2005

8:00–9:00 am — Registration & Continental Breakfast

9:00–10:00 am — Keynote Presentation: Rosemary Gibson, Author of "Walls of Silence"
Rosemary Gibson, MSc
Rosemary Gibson is team leader of the End-of-Life Care Team, dedicated to grant making to improve care for people at the end of life, with a special interest in reform of health professions education, building capacity in health care systems to provide palliative care, and state and federal policy change. She also is a member of the Human Capital and Nursing teams, and serves as program officer for the Faith in Action program. Her responsibilities have included overseeing and developing new funding initiatives to improve care for persons with chronic disabling conditions, and encouraging more minorities to enter the health professions. Before joining the Foundation in 1993, Gibson served as a consultant to the Medical College of Virginia and the Joint Commission on Health Care of the Virginia State Legislature. She began her career as a research associate at the American Enterprise Institute in Washington, D.C. Gibson received a master's degree in public finance from the London School of Economics and a bachelor's degree from Georgetown University.

9:00 am – 5:00 pm — Exhibit Showcase
Stop by the Exhibit Showcase to learn about products and information pertinent to the boards of nursing!

10:00–10:30 am — Refreshment Break

10:30 am – 12:00 pm — Practice, Regulation, and Education (PR&E) Forum

NCSBN Proposed Delegation Position Paper

Cheryl Koski, MN, RN, CS, Chair, NCSBN PR&E Subcommittee on Delegation and Assistive Personnel
Vickie Sheets, JD, RN, CAE, NCSBN Director of Practice and Regulation
"Working with Others: Delegation and Other Health Care Interfaces: A Position Paper" is intended as a resource for boards of nursing in the regulation of nursing and provides an analysis of the critical and complex concepts related to delegation and working with nursing assistive personnel.

NCSBN Proposed Act and Rules For Delegation And Nursing Assistant Regulatory Model

Cheryl Koski, MN, RN, CS, Chair, NCSBN PR&E Subcommittee on Delegation and Assistive Personnel
Vickie Sheets, JD, RN, CAE, NCSBN Director of Practice and Regulation
NCSBN Regulatory Model for Nursing Assistive Personnel presented as a new article and chapter for the *NCSBN Model Nursing Practice Act and Administrative Rules*. Draft of the Model Language Assistive Personnel addresses how licensed nurses work with, and delegate nursing care tasks/functions/activities to assistive personnel.

NCSBN Proposed Position Paper On Nursing Education Clinical Experience

Gino Chisari, MSN, RN, Chair, NCSBN PR&E Committee
Nancy Spector, RN, BSN, MSN, DNSc, NCSBN Director of Education
The NCSBN PR&E committee presents "Clinical Experiences in Prelicensure Nursing Programs" a position paper designed to provide guidance to the boards of nursing for evaluating the clinical experience component of prelicensure programs.

NCSBN Proposed Criminal Background Check Concept Paper and Model

Valerie Smith, MS, RN, Chair, NCSBN Disciplinary Resources Advisory Panel
Vickie Sheets, JD, RN, CAE NCSBN Director of Practice and Regulation
The proposed model process for criminal background checks and supporting paper will be presented. Included is background on the topic, the necessary legislative authority, identified activities that need to be undertaken to implement criminal background checks and discussion of how boards can use the information obtained to inform licensure decision making.

12:00–2:00 pm — Area Lunch and Meeting

NCSBN AREA LUNCHEONS ARE OPEN TO NCSBN MEMBERS AND STAFF ONLY.

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

- Area I Luncheon Meeting
- Area II Luncheon Meeting
- Area III Luncheon Meeting
- Area IV Luncheon Meeting

12:00–2:00 pm — External Organizations Lunch & Meeting

NCSBN guests are invited to attend this lunch meeting to discuss issues of mutual concern with NCSBN policy staff.

2:00–2:30 pm — Refreshment Break

2:30–4:00 pm — 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:

- PN/VN Issues
- Practice/Discipline
- NCSBN Presidents
- NCSBN Executive Officers
- NCSBN Board Members
- Education

4:00–6:00 pm — Resolutions Committee Meeting
Charlene Kelly, PhD, RN, NCSBN Resolutions Committee

6:00–8:00 pm — Nurse Licensure Compact Administrators (NLCA) Dinner
This is a business meeting of the Nurse Licensure Compact Administrators (NLCA).

THURSDAY, AUGUST 4, 2005

7:45–8:45 am — Election of Candidates

8:00–9:00 am — Pearson VUE Breakfast

9:00–10:00 am — Practice Breakdown: TERCAP Forum
Kathy Malloch, PhD, RN, Chair, NCSBN Practice Breakdown Advisory Panel
Vickie Sheets, JD, RN, CAE, Director of Practice and Regulation
Presentation of the results of the analysis done on the discipline cases resolved from January 1, 2004 to April 30, 2005 that NCSBN Member Boards submitted via the electronic TERCAP.

10:00–10:30 am — Refreshment Break

10:30 am – 12:00 pm — Open Forum
This is the opportunity for delegates and members to ask questions and discuss any items pertinent to the business agenda.

12:00–2:30 pm — NCSBN Awards Luncheon
Please join us to celebrate the individual and organizational achievements of the NCSBN membership.

2:30–3:00 pm — Refreshment Break

3:00–4:30 pm — Delegate Assembly: Second Meeting

- Adopt Proposed Delegation Position Paper.
- Adopt Proposed Model Act And Rules For Delegation And Nursing Assistant Regulatory Model.
- Adopt Proposed Position Paper on Nursing Education Clinical Instruction in Prelicensure Nursing Programs.
- Adopt the Proposed Criminal Background Check Concept Paper and Model.

Friday, August 5, 2005

8:00–9:00 am — Registration & Continental Breakfast

8:00–10:00 am — NCSBN Institute of Regulatory Excellence Poster Session
Please support members participating in the NCSBN Institute fellowship program. Engage participants in discussion regarding their projects on nursing regulation topics and issues.

9:00–10:15 am — Delegate Assembly: Third Meeting

New Business

- Resolutions Committee

10:15–10:35 am — Refreshment Break

10:35 am – 12:00 pm — Delegate Assembly Closing Ceremony & Adjournment

Summary of Recommendations to the 2005 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 2005 Delegate Assembly. Additional recommendations may be brought forward during the 2005 Annual Meeting.

BOARD OF DIRECTORS

1. **Adopt the proposed Delegation Position Paper *Working with Others: Delegation and Other Health Care Interfaces*.**

   Rationale
   Nurses work with and through others, resulting in multiple interactions and relationships with a variety of health team members, clients and families. The subcommittee has described the means by which such an interaction and communication is achieved as an interface (Webster). One important type of nursing interface with others is delegation. This paper discusses the elements that need to be in place for delegation to be used, including the authority. Many of the interfaces in traditional practice settings, such as hospitals and nursing homes, involve delegation. In other settings, there may not be clear lines of authority. It is important that the nurse understand the type of interface that is expected in a role and setting, because this has significant consequences for how he or she may approach the role as well as the accountability of the nurse. This paper identifies the elements a nurse should consider in using delegation and other types of interfaces.

   Fiscal Impact
   Incorporated into FY05 budget.

2. **Adopt the proposed *Model Act and Rules For Delegation and Nursing Assistant Regulatory Model*.**

   Rationale
   Providers of health care must maximize the use of every health care worker to meet the public's increasing need for accessible, affordable and quality health care. There is a place for appropriately trained and supervised assistive personnel. Nurses coordinate and supervise the delivery of nursing care in many settings. Nurses typically have the broadest interface with patients in acute care, long-term care and many community settings, and work with a variety of assistive personnel who may be delegated nursing tasks. The regulation of assistive personnel to promote uniform training and oversight is a logical activity of boards of nursing. The regulation of nursing should include nursing practice by licensed nurses and the selected nursing functions performed by nursing assistive personnel.

   Fiscal Impact
   Incorporated into FY05 budget.

3. **Adopt the proposed position paper on *Nursing Education Clinical Instruction In Prelicensure Nursing Programs*.**

   Rationale
   This position paper was written in response to the 2004 Delegate Assembly resolution where NCSBN members asked for guidance with evaluating clinical experiences in prelicensure programs. The committee members reviewed the literature, consulted with experts, surveyed the membership and nursing education organizations, sought stakeholder input, and participated in simulation experiences in order to comprehensively study this question.

   Fiscal Impact
   Incorporated into FY05 budget.

4. **Adopt the proposed criminal background concept paper and model.**

   Rationale
   Boards of Nursing have the responsibility of regulating nursing, and have a duty to exclude individuals who pose a risk to the public health and safety. One means of predicting future behavior is to look at past behavior. Checking whether applicants for the privilege of nursing licensure have a criminal history and examining the nature of that history can provide significant information for boards to use in making decisions about who should be granted the privilege to practice nursing. The proposed model process provides background on the topic, the necessary legislative authority, identifies activities that need to be undertaken to implement criminal background checks, and discusses how boards can use he information obtained to inform licensure decision making.

   Fiscal Impact
   Incorporated into FY05 budget.

COMMITTEE ON NOMINATIONS

1. **Adopt the 2005 Slate of Candidates.**

   Rationale
   The Committee on Nominations has prepared the 2005 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, August 2, 2005.

   Fiscal Impact
   Incorporated into FY05 budget.

Report of the Committee on Nominations

Recommendations to the Delegate Assembly

Adopt the 2005 Slate of Candidates.

Rationale

The Committee on Nominations has prepared the 2005 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, August 2, 2005.

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.

Highlights of FY05 Activities

- The committee reviewed their role, the bylaws, policies, mission, vision, values and strategic initiatives for 2005-2007. The committee also discussed the importance of teams.
- The committee reviewed Nominations survey evaluation results from the 2004 Annual Meeting attendees. Suggestions included slating only two candidates per position. The committee reviewed the feedback and decided that any qualified candidate should be slated.
- The committee discussed the Nominations Chair selection outlined in the bylaws and revised their operational policies.
- Strategies for recruitment were identified including selection of the date for Call to Nominations and deadline for nomination submissions. The committee's recruitment strategy for 2005 is focused on recruiting more board members of Member Boards.
- The committee decided to allow PowerPoint presentations during the Candidate Forum.

Attachments

A. 2005 Slate of Candidates

Committee Members

Shirlie Meyer, RN, Chair
Idaho, Area I

Karla Bitz, RN, BSN, MMGT
North Dakota, Area II

Karen Taylor, LPN, Vice Chair
Arkansas, Area III

Mary Bowen, CRNP, DNS, JD, CAN
Pennsylvania, Area IV

Staff

Kathy Apple, RN, MS, CAE
Executive Director

Meeting Dates

- September 20-21, 2004
- January 18, 2005 (Conference Call)
- March 21, 2005
- April 25-26, 2005

Attachment A

2005 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 2005 Delegate Assembly on Tuesday, August 2, 2005, from 11:00–11:30 am.

Board of Directors

Area I Director

Area II Director

Area III Director

Area IV Director

Director-at-Large (two positions)

Committee on Nominations

Area I

Area II

Detailed Information on Candidates

Information is provided on each candidate in the following pages (taken directly from nomination forms) and organized as follows:

1. Name, Jurisdiction, Area
2. Present board position, board name
3. Date of term expirations and eligibility for reappointment
4. Professional/Regulatory/ Community Involvement including Service on NCSBN committee(s)
5. Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.
6. Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

Date of expiration of term:
June 30, 2007

Eligible for reappointment:
Yes

Area I Director

Judith D. Personett, EdD, RN, CNAA

Board Member, Washington Board of Nursing, Area I

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Chair, Washington State Nursing Commission
Chair, Washington State Nurse Practice Subcommittee

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

I believe that a primary role of NCSBN is to establish and support standards of nursing practice that ensure the safety and well-being of the patient/consumer.

Standards will be taught in schools of nursing who prepare their students to take the state board examination that is carefully written to incorporate the highest standards of nursing practice throughout the examination.

As economic and legal pressures confront the nursing profession in an attempt to lower standards of care and education, it is vitally important to educate the patient/consumer about the role of the nurse and the importance of the well-educated, ethical nurse. NCSBN plays a key role in the dissemination of information.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

To advance the mission, vision and strategic initiatives, I will participate in work groups to prepare materials for committees and for the body on NCSBN. I will also bring my personal expertise as a nurse executive and nurse educator to issues and goals of NCSBN.

Area II Director

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

Mary Blubaugh, MSN, RN

Executive Administrator, Kansas Board of Nursing, Area II

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

NCSBN

- NCSBN Area II Director, 2003–2005
- PR&E Committee, 2002–2003
- PERC Committee, 2000–2002

Kansas State Board of Nursing

- Executive Administrator, Kansas State Board of Nursing, 1999–Present
- Kansas ESAR/VHP Advisory/Planning Workgroup, 2005
- Kansas Strategic National Stockpile Planning Committee, 2005
- KSNA Educational Task Force, 2004–Present
- Kansas Nursing Work Force Partnership, 2002–Present
- Recruitment/Retention Strategies Workforce Council Team for HealthCare and Direct Care Classes, 2001–2003
- Kansas Small State Agency Administrators, 2000–Present
- Health Resource Partnership, 2000–2004

Professional Involvement

- Kansas Society of Public Managers, 2002–Present
- Kansas Organization of Nurse Leaders, 2002–Present
- Sigma Theta Tau International Nursing Society, 1993–Present
- Nu Zeta Chapter, Fort Hays University, 1992–Present
- Fort Hays State University Nursing Honor Society, 1991–Present

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

Issues facing nursing regulation today are no longer state issues; they are becoming international. As the issues become international, NCSBN must maintain the state's right to protect the public. NCSBN has the opportunity to promote dialogue with Member Boards and make research-based decisions regarding the nursing regulation in the national and international arena. These decisions must be made with input from Member Boards and on research-based information. NCSBN and Member Boards can be the leader for regulatory excellence nationally and internationally.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

It has been an honor and a privilege to serve as Area II Director for the last two years. It has been a positive and rewarding experience. I will continue to be committed to advancing regulatory excellence for public protection. As a board member, I participated in the development of the mission, vision, and strategic initiatives and I support them. I will be a voice for Member Boards and help foster open dialogue and healthy debate through communication between the Member Boards and the Board of Directors. During my two years on the Board of Directors, I remained true to my values of open communication, honesty, optimism, asking the tough questions, and continue to have a passion to serve as an effective voice for Member Boards.

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

Area III Director

Martha Bursinger, RN, MSN, MEd

Executive Director, South Carolina Board of Nursing, Area III

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Participant in Institute of Regulatory Excellence – NCSBN

Participant in TERCAP committee work – NCSBN

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

It is my belief that professions that assume as much autonomy for direct patient care as nursing does, should be regulated for the protection of the public. Being a part of NCSBN allows boards of nursing to maintain their oversight of protection of the public by obtaining information as to issues that are facing nursing on an ongoing basis, determining a basis for best practices for the profession, while allowing continuous communication to be disseminated to the Member Boards for future problems, challenges, and conflicts that may arise in the future that have a direct impact on the nursing profession.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

It is my belief that communication on an ongoing basis, regardless of the means, is integral to maintaining open dialogue among and between professionals. If selected for this position, I would utilize my experience and knowledge of 26 plus years in the health care profession in an attempt to add to the core of information that is needed for decision making and problem solving at the national level of regulation. In every way, I would attempt to keep my peers abreast of changes, potential challenges affecting nursing, and to be an intermediary for communication between them and NCSBN for concerns and problems, as they arise, to improve care delivery through public protection.

Area IV Director

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

Myra Broadway, JD, MS, RN

Executive Director, Maine Board of Nursing, Area IV

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Education

- Franklin Pierce Law Center, JD (law), 1990
- University of Colorado, MS (Community Health Nursing), 1973
- Hunter College, BSN, 1967

Professional/Regulatory/Community Involvement

- Executive Director, Maine State Board of Nursing

NCSBN

- Board Liaison to Examination Committee, 2004–2005
- Board Liaison to Commitment to Ongoing Regulatory Excellence, 2003–2004
- Commitment to Ongoing Regulatory Excellence, 2002–2003
- Director-at-Large, 2000–2002
- Board Liaison to Commitment to Excellence, 2001–2002
- Model Rules Subcommittee Liaison, 2001–2002
- Bylaws Committee Liaison, 2001–2002
- Awards Advisory Panel Liaison, 2000–2001
- Delegate Assembly Advisory Group Liaison, 2000–2001
- Commitment to Excellence Advisory Group, 1999–2000
- Resolutions Committee, 1999
- Mutual Recognition Member Board Operations Analysis Tool Working Group, 1998
- Nurse Licensure Compact Administrators, Executive Committee, 2002–2003

United States Air Force Reserves

- 9019th Air Reserves Squadron, 1976–1998
- Colorado Air National Guard, 1972–1975
- Active Duty, 1968–1971

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

A major challenge that currently faces nursing regulation is the impact of the nursing shortage. Consequently, there has been a proliferation of unlicensed assistive personnel categories, increased used of foreign educated nurses, new definitions and expansions of scopes of practice, proposed extraordinary creative solutions by legislator, and public uncertainty while expecting safe care. Activities of NCSBN can influence a positive outcome to this challenge through monitoring activities of national organizations as well as collaborating with them in defined efforts consistent with NCSBN's mission; establishing work groups, committees or task forces composed of Member Board representation to address these issues; monitor and share with jurisdictions proposed federal and state legislation; monitor and influence appropriately international nursing endeavors; and support research that is planned, developed and performed to enable boards to engage in evidence based decision making in nursing regulation.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

I believe that I can contribute to the advancement of the mission, vision and strategic initiatives of NCSBN through participating in decision making that is consistent with the mission, compliant with the vision and in concert with the strategic initiatives. Being on the Board of Directors requires listening well to all perspectives on an issue, deliberating and discussing openly issues that confront us all – as a national organization and as Boards of Nursing individually. I believe strongly that it is also important that we maintain flexibility in implementing the strategic initiatives so that as the environment changes, we may respond by likewise adapting strategy to meet the mission. I am committed to NCSBN and its service to Member Boards and would consider it a great privilege to serve as Area IV Director of NCSBN.

Director-at-Large

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

Constance Kalanek, PhD, RN

Executive Director, North Dakota Board of Nursing, Area II

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Board of Directors, Director-at-Large, 2004–2005
Board Liaison, Commitment to Ongoing Regulatory Excellence Research Project, 2004–2005
Fellow, NCSBN's Institute of Regulatory Excellence, second year
Member, Executive Officers Network
Planning Committee, Executive Officer Network Group Leadership Development Seminar, April 28-29, 2003 and April 22-23, 2004
Commitment to Ongoing Regulatory Excellence (CORE) Research Project, 2002–2004
Resolutions Committee, 2003–2005
Member, Nurse Licensure Compact Administrators, July 1, 2002
Chair; Practice, Education, and Regulation Task Force; Work completed August 12, 2002

State Committees

Established in 2004 — North Dakota Nurse Leadership Council — The Nurse Leadership Council (NLC) is a coalition of the North Dakota Board of Nursing, North Dakota Nurses Association and six other organizations. The goal of the organization is to create a futuristic, unified, goal directed, state level agenda for nursing. The council members have come together in a spirit of cooperation and plan to create a consensus model of decision making among state nursing organizations.

Professional memberships and offices held:

American Nurses' Association, 1981–2002
Certification, Maternal-Child Nurse, 1987–1998
American Nurses Credentialing Center-Commission on Accreditation, Category Alternate, 1997
ANCC Item Writer for Prenatal Certification Examination
ANA Institute of Constituent Members on Nursing Practice, Representative for North Dakota, 1992–1994
American Society of Psychoprophylaxis in Obstetrics, 1975–1990
Certified Childbirth Educator, 1975–1990
Badlands Childbirth Educators, (treasurer/member) 1975–1990

North Dakota Nurses Association, District #10, 1980–1990
Continuing Education Committee
Professional Affairs Committee
Government Relations Committee (chairperson)
Nominating Committee
NDNA Delegate, 1987, 1989
NDNA Alternate Delegate, 1984, 1986

North Dakota Nurses' Association District # 6, 1990–2002
Continuing Education Committee, (Nursing Education Rep.) 1996–1998
NDNA Research/Education Council, 1996–1998
NDNA Women, Infants, and Children Interest Group, 1996–1998

Refresher Course Task Force, 1988–1998
IV Therapy Committee, 1987–1998
NDNA District #6 Delegate, 1991, 1992, 1994, 1996
Statewide Task Force on Impact of Entry into Practice, (chairperson), 1991–1994
Congress on Education and Practice, (chairperson), 1987–1993
Government Relations Committee, 1984–1992
Membership Committee, 1984–1990

Delta Kappa Gamma International Society, 1986–1990

Northern Rocky Mountain Educational Research Association, 1996–present

Sigma Theta Tau International Honor Society of Nursing, 1988–present
Kappa Upsilon Chapter
STT Workshop Planning Committee, 1996–1997

North Dakota Board of Nursing, Ad hoc Committee on Revision for Rules for IV Therapy for LPNs, 1997

NCSBN, Appointed alternate for the Case Development Committee, 1996–1997

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

The nursing profession and more specifically nursing regulation are facing many challenges nationally and internationally. We have three examples of scenarios that call for nursing leadership. The first is the nursing shortage of critical proportions; the second is nursing education and the graying of the faculty; and third is an economic imperative that is calling for cuts in reimbursement as well as education funding. The leadership of NCSBN will be expected to initiate at all levels significant policy development to fill the need for practicing RNs and LPNs for our health care delivery system. The leaders in nursing must have courage to formulate policy to include model rules for innovative nursing education curricula, develop licensure requirements and scopes of practice for emerging practitioners, position papers on management of delegation as the significant role of ancillary personnel and competency issues relevant to the globally educated nurse. NCSBN has become a leader in conducting research on practice. As we all know, research can influence the face of practice and education. This past year on the Board has provided me with the opportunity to understand at a greater level the involvement of NCSBN in numerous research projects and how these data have been used for policy development and action of NCSBN.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

To advance the mission of NCSBN requires a collaborative effort of visionary leaders. NCSBN in conjunction with Member Boards must focus on problem solving, team building and a proactive approach to leadership. This year as Director-at-Large, I have participated in a number of efforts to increase the collaboration between nursing leaders while representing NCSBN at the AACN meeting and the Hemispheric Conference on Mobility in the Americas.

Committee on Nominations Area I

Mary E. Calkins, PhD, RN

Board Staff, Wyoming Board of Nursing, Area I

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

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

Item Review Subcommittee, 2001–2003
NCSBN PR&E Committee, 2003–2005
PR&E Liaison to International Nursing Subcommittee, 2005
Member Wyoming Sexual Assault Response Task Force, 2004–present

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

The foundation for positive outcomes in nursing regulation is evidence-based practices. Those practices come from a variety of sources: the clinical arena, nursing education practices, governance practice and disciplinary practices. NCSBN possesses the ability to bring together the leaders in nursing and nursing regulation. Staff members with NCSBN are nationally recognized for their expertise in areas of practice, education and regulation. NCSBN is a leader for nursing in the third millennium.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

I have been a registered professional nurse for 30 years. I have seen monumental changes in health care, nursing and nursing regulation during those 30 years, with the last five and a half years in regulation. Because of my nursing experience and committee experience, I want to work with other nurse leaders to help NCSBN move forward as a leader in the third millennium by:

- Advancing NCSBN as a partner in nursing and health care regulations in the United States and internationally;
- Promoting evidence-based practices in regulation, practice and education in order to safe guard the health, safety and welfare of the public;
- Become the leader in development and measurement of continuing competency in nursing to ensure safe practitioners of nursing.

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

Committee on Nominations Area II

Lorinda Inman, RN, MSN

Executive Director, Iowa Board of Nursing, Area II

Professional/Regulatory/Community Involvement including service on NCSBN committee(s):

NCSBN

- Exam Committee, 2001–Present
- Vice President, 2001
- Area II Director, 1997–2001
- Mutual Recognition Master Plan Coordinating Group, 1998
- Finance Committee, 1995–1997
- Resolutions Committee, 1994–1997
- Executive Officer Orientation Planning, 1995
- Long Range Planning Committee, 1989–1995

County Government

- Iowa State University Extension, 1997–2003
- County Historical Commission, 1999–Present
- Iowa State University Extension Youth Committee, 2003–Present

Propose how the activities of NCSBN can influence a positive outcome to a major challenge that is currently facing nursing regulation.

NCSBN is committed and involved in supporting boards in their role to protect the public. Through the strength of its membership, NCSBN has become a recognized leader in nursing regulation. As an organization, we analyze and react to changes in the health care, regulatory and economic environment that impact regulation of the nursing profession and provide structure and support for collaboration among boards as issues are addressed. Collaborating together on challenging issues is the core work of NCSBN that supports Member Boards in their public protection mission.

Describe how you will advance the mission, vision and strategic initiatives of NCSBN.

I have more than 20 years of experience working with NCSBN. As a member of the Nominations Committee, I would work with other committee members to develop a slate of qualified candidates committed to advancing the mission, vision and strategic initiatives of NCSBN.

2005 Report of the Board of Directors

Strategic Planning

The Board of Directors focus for the 2005 fiscal year has been the implementation of the new 2005-2007 strategic initiatives and objectives. The new strategic plan was implemented for the first full year within the framework of the Balanced Scorecard model of strategic management. The Balanced Scorecard model helps organizations translate strategy into operational terms, aligns the organization to the strategy and makes strategy a continual process.

Highlights of Business Activities:

COLLABORATION WITH EXTERNAL ORGANIZATIONS

- The NCSBN Board welcomed South Korean Deputy Consul General Young Suk Do and Dr. Mi Ja Kim from the Academy of International Leadership Development at the University of Illinois – Chicago. Deputy Consul General Young Suk Do thanked the NCSBN Board for establishing a testing site in Korea. Dr. Mi Ja Kim explained current Korean and Pan-Asian initiatives, impact of the globalization of NCLEX® and *VisaScreen™* barriers to practice for international nurses.
- The Board met with Dan Bluthardt, acting director of the Division of Professional Regulation from the Illinois Department of Financial and Professional Regulation to discuss Illinois' request for a Spanish language assisted NCLEX®.
- Dr. Mi Ja Kim, professor, University of Illinois – Chicago, met with the Board to explore issues surrounding global nursing including technology, knowledge, disappearance of national boundaries, global markets and cultural sensitivity.
- Henrietta Scully, program manager with the Standards Facilitation arm of the American National Standards Institute (ANSI), met with the Board to explain the process for standards development. Ms. Scully also explained the governance structure of the international organization — the International Organization for Standardization (ISO).
- Dr. Jean Bartels, president of the American Association of Colleges of Nursing (AACN), and Dr. Polly Bednash, executive director, met with the Board of Directors to discuss the Clinical Nurse Leader (CNL) Role and Doctorate of Nursing Practice (DNP).

Meeting Attendance by NCSBN Board of Directors and/or Staff

- 11th Annual Summer Symposium of the Health Care Improvement Leadership Development Group
- American Association of Nurse Anesthetists (AANA)
- Quality Colloquium
- BoardSource Leadership Forum
- Agency for Healthcare Research & Quality: Patient Safety
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO): Critical Linkages – Patient Safety, Nurse Staffing, Leadership Solutions
- The Council on Licensure, Enforcement and Regulation (CLEAR)
- National League for Nursing (NLN)
- International Regulatory Business Conference
- National Federation of Licensed Practical Nurses (NFLPN)

Board of Directors

August 2004 — August 2005

Donna Dorsey, MS, RN, FAAN
President, Maryland, Area IV

Polly Johnson, MSN, RN
Vice President, North Carolina, Area III

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

Gregory Harris, JD
Area I Director, Arizona

Mary Blubaugh, MSN, RN
Area II Director, Kansas

Mark Majek, MA, PHR
Area III Director, Texas

Myra Broadway, JD, MS, RN
Area IV Director, Maine

John Brion, RN, MS
Director-at-Large, Ohio, Area II

Constance Kalanek, PhD, RN
Director-at-Large, North Dakota, Area II

Staff

Kathy Apple, RN, MS, CAE
Executive Director

Chrissy Ward, Manager, Executive Office Relations

Legal Counsel

Thomas Abram, JD

Attachment

Attachment A – Progress Report

Board Meeting Dates

- August 6, 2004
  Kansas City, Missouri
- September 8–10, 2004
  Chicago, Illinois
- November 29 – December 1, 2004
  Chicago, Illinois
- February 16–17, 2005
  Chicago, Illinois
- May 9–11, 2005
  Chicago, Illinois
- July 13–15, 2005
  Chicago, Illinois
- August 1, 2005
  Washington, DC

- American National Standards Institute (ANSI)
- International Society for Quality in Healthcare
- American Association of Colleges of Nursing (AACN)
- Citizen's Advocacy Center (CAC)
- National Organization for Associate Degree Nursing (N-OADN)
- National Coordinating Council for Medication Error Reporting Practices (NCC-MERP)
- Commission on Graduates of Foreign Nursing Schools (CGFNS) Think Tank
- American Board of Nursing Specialties (ABNS) Fall 2004 Assembly
- Agency for Healthcare Research and Quality (AHRQ) Think Tank
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Nursing Advisory Council
- E3 Summit
- Federation of Associations of Regulatory Boards (FARB)
- American National Standards Institute (ANSI) – First Responders Credentialing Workgroup
- Council on State Governments (CSG)
- National Practitioner Databank (NPDB) Executive Committee
- Agency for Healthcare Research and Quality (AHRQ)/Health Services & Resources Administrations (HRSA) Workshop
- National Student Nurses Association (NSNA)
- National Organization of Alternative Programs (NOAP)
- American Association of Colleges of Nursing (AACN) 2004 Baccalaureate Education Conference
- Nursing Organization Alliance
- National Governors' Association
- American Association of Colleges of Nursing (AACN) Spring Annual Meeting
- National Student Nurses' Association (NSNA) Annual Convention
- American Organization of Nurse Executives (AONE) Annual Meeting
- American Telemedicine Association (ATA) Annual Meeting
- American Board of Nursing Specialties (ABNS) 2005 Spring Assembly Meeting
- Alliance for Nursing Accreditation Meeting
- National Association of Clinical Nurse Specialists (NACNS) Annual Meeting
- National Coalition of Ethnic Minority Nurse Associations (NCEMNA) Meeting
- National Coordinating Council for Medication Error Reporting Practices (NCC-MERP)
- Nursing Workforce Centers

Finance

- The Board approved the budget for the fiscal year beginning October 1, 2004 and ending September 30, 2005.
- The NCSBN Board accepted the 2004 audit results as prepared by auditors Legacy

Professionals LLP.

- The FY05 quarterly financial statements were reviewed, discussed and accepted.
- The Board selected Legacy Professionals LLP to conduct the 2005 audit.
- The Board revised Board Policy 8.5, Investments. The revision instructs the Finance Committee to annually review and recommend a designated permanent reserve amount.
- The Board increased the current permanent reserve to $15 million.
- The Board requested the Finance Committee explore revenue sharing for boards of nursing as an incentive to submit licensure data to Nur*sys*®.
- A $1,000 donation was made to the American Nurses Foundation for a research analysis on the economic value of nursing.
- The Board made the strategic decision to bring licensure data cleansing and de-duplicating in-house based on recommendation from the Finance Committee.
- Board policies 8.2. Financial Planning and 8.5 NCSBN Investment Policy were revised after an independent investment evaluation.
- The Board reviewed the performance of investment manager Richmond Capital and approved the Finance Committee's recommendation to remain with the investment manager.
- The Board supported the conclusion of the Finance Committee's review of a suggestion to create a separate audit committee. The Finance Committee discussed the issue with the auditors and concluded that a separate committee would not provide a more independent review. The committee will monitor and keep the Board apprised of changes in best practices and regulations concerning the use of audit committees.

Governance & Policy

- The Board reviewed and discussed the 2004 Annual Meeting evaluations.
- The Board continuously monitored the NCSBN organizational Balanced Scorecard.
- The Board revised its Board Liaison Policy.
- The Board revised confidentiality agreements for use with consultants and committee members.
- The Board directed the Bylaws Committee to revise the standing rules to further articulate the run-off balloting procedure.
- The Board submitted comments to the International Council of Nurses (ICN) and the World Health Organization (WHO) on the document *Nursing Regulation: Futures Perspective*.
- The Board submitted comments to the International Council of Nurses (ICN) to comment on the document, *ICN NP/APNN Scope and Standards Paper*.
- The Board approved a NCSBN Mutual Recognition Summit in Washington, D.C. The purpose of the summit was to train existing and prospective compact states regarding legislation and compact administration with an additional day structured for invited stakeholders.
- The Board created a Governance and Leadership Task Force to analyze the dynamics and structure of NCSBN and make recommendations to enhance the organizational culture to support change and innovation.
- The Board provided a Strategic Plan progress report at the 2005 Midyear Meeting.
- The Board discussed the role of NCSBN in the international regulatory arena.
- The Board reviewed NCSBN's Board and Delegate Assembly position statements from 1979 to the present day.

- The Board established the Board meeting dates for FY06.
- The Board approved revisions to the NCSBN Service Recognition Award.
- The Board approved revisions to NCSBN Board Policy 2.5, Executive Officer Network.
- The Board approved a policy to subsidize member travel to the NCSBN Annual Meeting.
- The Board revised the NCSBN Travel Policy.
- The Board revised the Executive Director Evaluation Process.
- The Board revised policy 4.5 Role of Committee Chair.
- The Board discussed the proposed Federation of State Medical Boards (FSMB) Position on Assessing Scope of Practice in Healthcare Delivery.
- The Board reviewed its designated strategic partnerships.
- The Board reviewed and discussed the methodology and findings of the Florida Survey on Special Endorsement.
- FY05 committee outcomes were reviewed and discussed.
- FY06 committees and chairs were selected.
- The Board reviewed a proposal from the International Council of Nurses regarding increased organizational interaction and involvement by nurse regulators.

Testing

- The Board reviewed results of a pilot study investigating alternate items
- Further direction of the NNAAP™ Exam was discussed.
- The Board monitored implementation of international testing.
- The Board initiated a feasibility study of developing a Foreign Language Assisted NCLEX® Examination. The NCSBN Examination Committee was charged with reviewing the results.
- The Board viewed a demonstration on the online NCLEX® tutorial.
- The Board reviewed the purpose and outcomes of the Joint Research Committee (JRC) in future NCLEX® innovations.
- The Board approved a passing standard of -.4200 (logits) on the NCLEX-PN logistic scale for the NCLEX-PN® Examination commencing on April 1, 2005.
- The Board approved contract amendments regarding international administration of NCLEX®.
- The Board reviewed quarterly performance reports from testing administration vendor Pearson VUE.
- The Board reviewed a security audit for NCLEX®.
- The Board approved various revisions to the testing policies.

Practice, Education & Regulation

- The Board reviewed the feasibility of an Institute of Regulatory Excellence certification program.
- The Board approved the endorsement of the acute care nurse practitioner competencies developed by the National Organization of Nurse Practitioner Faculties.
- The Board approved the term “Fellow of the NCSBN Regulatory Institute” for attendees of the Institute of Regulatory Excellence that have met the established criteria.
- The Board approved a concept paper on continued competence.

- The Board approved for recommendation to the 2005 Delegate Assembly a delegation position paper, model act and rules for delegation, a regulatory model for nursing assistants, a position paper on clinical instruction, and a concept paper and regulatory model for criminal background checks.
- The Board reviewed evaluations from the second Institute of Regulatory Excellence Program.
- The Board reviewed the *PN Scope of Practice White Paper* developed from the 2004 PN Focus Group.

Information Technology

- The Board monitored all issues related to the use of Nur*sys*®.

Research

- The Board reviewed research department reports on the current status of ongoing projects.
- The Board began discussion of a framework for establishing a NCSBN research agenda.

Attachment A

Annual Progress Report, October 2004 – May 2005

Background

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

I. Strategic Initiative: Member Boards

Facilitate Member Board excellence through individual and collective development.

STRATEGIC OBJECTIVE 1.

Implement and evaluate the member board development plan.

A three year education plan was developed for all education sessions and summits offered by NCSBN to the membership. The plan is currently being populated with dates and locations. All activities planned to date have been provided.

STRATEGIC OBJECTIVE 2.

Facilitate timely information sharing and networking opportunities.

NCSBN is providing at least 10 pertinent activities per quarter to the membership in the form of information sharing or networking opportunities.

STRATEGIC OBJECTIVE 3.

Continuously evaluate the effectiveness of timely education, information sharing and networking opportunities.

The method and framework by which NCSBN evaluates all education, information sharing and network opportunities is under revision. The new framework will focus on participation, number, variety, quality and information pertinent to the needs of the membership. The framework will provide continuous quality improvement to these offerings. 85% of Member Boards attended the 2005 Midyear meeting and the Leadership Development session. 81% of the Member Boards were satisfied with the 2005 Midyear meeting and 91% were satisfied with the Leadership Development session. 45% of Member Boards attended the second Institute of Regulatory Excellence. 90% were satisfied with the Institute.

STRATEGIC OBJECTIVE 4.

Support Member Boards seeking to enter into the Nurse Licensure Compact.

A summit was held in December 2004 for Member Boards seeking legislation to implement the Nurse Licensure Compact. The summit provided current information on legislative strategies and implementation successes. The summit also provided an opportunity for external stakeholders interested in the compact to interact with compact administrators along with the provision of current implementation information.

Presentations on the Nurse Licensure Compact were held in South Carolina, Georgia and Michigan. A formal letter of support for the compact was received by the American Nephrology Nurses Association.

II. Strategic Initiative: Regulatory Excellence

Promote evidence-based regulation that provides for public protection.

STRATEGIC OBJECTIVE 1.

Increase the number of Member Boards participating in CORE.

The CORE Advisory Panel contacted Member Boards that did not participate in the 2003 data collection survey and were encouraged to participate in the upcoming 2006 data collection survey.

STRATEGIC OBJECTIVE 2.

Support Member Board adaptation of best practices.

The CORE Advisory Panel revised the six surveys of stakeholders and began compiling a best practices took kit for identifying, assessing and applying relevant evidence for better decision making by nursing boards.

STRATEGIC OBJECTIVE 3.

Identify linkages among regulatory functions, best practices, standards of excellence and outcomes.

Identification of linkages is under review and discussion by the CORE Advisory Panel.

STRATEGIC OBJECTIVE 4.

Collaborate with other health profession regulatory bodies and organizations in the development of evidence based regulation.

Contacted and discussed collaborative efforts on the model act and model rules with the Korean Nurses Association, a revision of the delegation concept and process with the American Nurses Association, and clinical competence with the National League for Nurses. Provided input into the revision of future regulation perspectives with the International Council of Nurses.

STRATEGIC OBJECTIVE 5.

Analyze the current state of practice for the CNS and NP roles.

A request for proposal was prepared and distributed to companies interested in conducting a practice analysis of clinical nurse specialists and nurse practitioners. A panel of experts was convened and data collection is in process.

III. Strategic Initiative: PERC

Enhance the organizational culture to support change and innovation.

STRATEGIC OBJECTIVE 1.

Assess strengths and weaknesses in NCSBN that impact the organization's ability to be progressive, creative, and responsive to change.

The Board of Directors convened a task force to complete an assessment and provide recommendations that will enhance the organizational culture. The membership has been surveyed on a variety of governance issues and provided input at the 2005 Midyear meeting.

STRATEGIC OBJECTIVE 2.

Implement improvement plan based on evaluation of Member Board satisfaction with communication from the Board of Directors and NCSBN staff.

Evaluation assessment partially completed. Data provided by the membership is currently being analyzed.

STRATEGIC OBJECTIVE 3.

Enhance communication between Member Boards and external stakeholders.

Communication has been facilitated between Member Boards and the American Association of Colleges of Nursing, the Commission on Graduates of Foreign Nursing Schools, the Joint Commission on Accreditation of Hospital Organizations, the American Organization of Nurse Executives, the Department of Labor, the Citizens Advocacy Center and the National League for Nursing Accrediting Commission.

IV. Strategic Initiative: Competence

Position NCSBN as the premier organization to measure entry and continuing competence of nurses and related health care providers.

STRATEGIC OBJECTIVE 1.

NCLEX is the premier examination for entry into practice.

All psychometric standard indicators for success and identified performance measures have been met to date. NCSBN received a consultation request from the Jordanian Nursing Council regarding development of an examination.

STRATEGIC OBJECTIVE 2.

Develop an assessment instrument to measure continued competence of RNs and LPN/VNs.

The purpose and content of an assessment instrument is under exploration. A practice analysis of experienced RNs and LPN/VNs is in process.

STRATEGIC OBJECTIVE 3.

Maintain the quality of the NNAAP™ exam.

All contractual requirements for NCSBN were met to date. NCSBN staff worked closely with Promissor staff regarding administration policy and procedures.

STRATEGIC OBJECTIVE 4.

Explore innovations in testing to measure entry-level competency.

The Examination Committee reviewed a 2000 stakeholder survey considered to be currently relevant. Potential research-based enhancements have been reviewed through the Joint Research Committee. The Examination Committee will establish a plan to investigate new methodologies for subsequent fiscal years.

V. Strategic Initiative: Data

Advance NCSBN as the leading source of data, information and research regarding nursing regulation and related health care issues.

STRATEGIC OBJECTIVE 1.

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

The Registered Nurse and Nurse Aide practice analysis were transferred from the Research Department to the Testing Department and are currently underway. Two Professional and Practice Issues regarding nursing education quality indicators and transition to practice are in the data collection phase. Data collection continues for the Post-Entry Competency Study. The effectiveness of alternative programs for chemically dependent nurses and the nurse aide outcomes study have been placed on hold.

STRATEGIC OBJECTIVE 2

Achieve 100 % participation in Nur*sys*® disciplinary data and increase participation in Nursys® licensure data.

Issues related to lack of disciplinary data from six island jurisdictions were identified. Other Member Boards unable to submit disciplinary actions due to lack of resources are Louisiana-PN, Washington, Indiana, Illinois and the District of Columbia.

Thirty-one (31) Member Boards provide licensure data to Nur*sys*® for purposes of verification.

STRATEGIC OBJECTIVE 3.

Serve as the single source of unduplicated nurse licensure: workforce and disaster volunteer data in the U.S.

System requirements and design of application have been finalized for collection of workforce data. Feasibility of collecting disaster volunteer data is under study.

STRATEGIC OBJECTIVE 4.

Conduct a research study to determine if there is a NCLEX performance differential between U.S. educated ESL graduates and non-ESL graduates and if there is, to identify contributing factors.

Final report is under review by the Examination Committee and will be reported at the 2005 Delegate Assembly.

VI. Strategic Initiative: U.S./International Partner

Advance NCSBN as a key partner in nursing and health care regulation in the U.S. and internationally.

STRATEGIC OBJECTIVE 1.

Develop and maintain collaborative working relationships with key national and international organizations to address major regulatory issues in health care.

The International Council of Nurses, the National League for Nursing and the American Nurses Association were identified for areas of collaboration regarding the role of regulators internationally, clinical competence education and delegation respectively. Collaborative discussions have been held with the membership and the Joint Commission on Accreditation of Hospital Organizations regarding criminal background check issues related to nursing students and JCAHO standards.

STRATEGIC OBJECTIVE 2.

Administer NCLEX effectively and efficiently at international sites.

All three international sites were operational in January 2005. There has been 100% compliance with all testing policies and procedures. Additional countries will be evaluated for possible test sites.

STRATEGIC OBJECTIVE 3.

Facilitate the mobility of safe and competent international nurses by influencing public policy.

Evaluation of language proficiency immigration regulations under discussion.

Section II

2005 NCSBN Annual Meeting

Other Committee Reports

Report of the Disciplinary Resources Advisory Panel

Recommendations to the Delegate Assembly

1. *Adopt the proposed Model Process for Criminal Background Checks and supporting Paper.*

   Rationale

   Boards of nursing have the responsibility of regulating nursing and a duty to exclude individuals who pose a risk to public health and safety. One means of predicting future behavior is to look at past behavior. Checking whether applicants for the privilege of nursing licensure have a criminal history and examining the nature of that history can provide significant information for boards to use in making decisions about who should be granted the privilege to practice nursing. The proposed model process provides background on the topic, the necessary legislative authority, identifies activities that need to be undertaken to implement criminal background checks and discusses how boards can use the information obtained to inform licensure decision making.

Background

The Disciplinary Advisory Panel was first appointed in 2001 and charged with the responsibility of planning an Investigators Summit. In 2002, the Panel planned a second summit, adding an attorney component, and in 2003 the first combined Investigator/Attorney Summit was held. In 2004, the Advisory Panel renamed the program the Investigator-Attorney Workshop and the program again provided offerings for investigators, attorneys and board discipline staff. In 2004, the Advisory Panel planned the program themes for the FY05 and FY06 workshops.

The Advisory Panel developed a Discipline Resources Plan in 2002, outlining a variety of discipline resources. The Board of Directors charged the Panel to continue to implement the plan. Additional resources were completed in 2003 and 2004 and the Plan itself was updated in 2004.

The Board of Directors charge in FY05 was to continue implementation of the Discipline Resources Plan, including planning the Investigators/Attorneys Workshop and to prepare a model process for criminal background checks to be available for Member Boards who are pursuing implementation of this requirement for licensure.

Highlights of FY05 Activities

The Advisory Panel continued implementation of the Discipline Resources Plan developed in 2002 and updated in 2004 (see Attachment A) for each plan category as listed below.

Discipline Resources Plan Category One — Discipline Resources

- Completed the model process for conducting criminal background checks (see Attachment B).
- Completed the guidelines for use of professional evaluators and evaluations.
- Began to develop pain management statement and guidelines.

Discipline Resource Plan Category Two — Communication Networking

- Identified topics and guest speakers for discipline calls.
- Participated in discipline calls held for investigators, attorneys and other staff (calls have had high level participation from Member Board staff):
  - February 8, 2005 — Recovery maintenance with guest Linda Smith, MS, RN, DD;
  - April 12, 2005 — Drug screens with guest Dr. David Martin, toxicologist;

Members

Valerie Smith, MS, RN, Chair
Arizona, Area I

Rene D. Cronquist, JD, RN
Minnesota, Area II

Debra L. Evans, BSN, RN
Washington, Area I

Donald Hayden, BS
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Board Liaison

Gregory Harris, JD
Arizona, Area I

Staff

Vickie Sheets, JD, RN, CAE
Director of Practice and Regulation

Kelly Michale, Practice and Regulation
Administrative Assistant

Meeting Dates

- December 13–14, 2004
- February 28 – March 1, 2005
- April 4, 2005 (conference call)
- May 23–25, 2005 (Investigator Attorney Workshop)

Relationship to Strategic Plan

Strategic Initiative I

Facilitate Member Board excellence through individual and collective development.

Strategic Objective 2

Facilitate timely information sharing and networking opportunities.

- June 14, 2005 — Pain management.

- Identified topics and potential speakers for bimonthly calls in FY06:
  - October 10, 2005 — Criminal background checks;
  - December 13, 2005 — Joint investigations — collaborating with other agencies;
- Promoted participation in discipline and investigator networking.

Discipline Resource Plan Category Three — Consultations/Collaborations

- Provided feedback to NCSBN staff regarding the discipline content in Nur*sys*®.
- Provided feedback to NCSBN staff regarding HIPDB reporting.

Discipline Resource Plan Category Four — Education /Training

- Evaluated the 2004 Investigator/Attorney Workshop.
- Planned the 2005 Investigator/Attorney Workshop held May 23-25, 2005, in Denver, Colorado (see Attachment B).
- Began to explore the feasibility of developing formal certification programs for nursing investigators and nursing attorneys.

Future Activities

- Plan 2006 Investigator/Attorney Workshop theme: Discipline Outcomes: What Good Comes from What We Do? Is Discipline Effective?
- Develop Member Board Resource on Drug Screens:
  - Identify model screening panel parameters to include drug types, screening and confirmation methods, cutoff levels and frequency of drug screening for participants in substance abuse alternative and discipline monitoring program;
  - Compile and make available information regarding adulteration, substitution and other methods to avoid detection in drug screening;
  - Collaborate with the National Organization for Alternative Programs and other health care regulatory groups in developing these standards.
- Collaborate with the NCSBN Nur*sys*® Advisory Panel to review HIPDB reporting (code-mapping, etc.) and make recommendations, including education and training strategies, to NCSBN staff and Member Boards staff.
- Continue to collaborate with NCSBN staff regarding the tracking of nurse imposters via Nur*sys*®.
- Continue to implement other categories of the Discipline Resources Plan:
  - Complete pain management statement and guidelines;
  - Draft model policies and procedures for criminal background checks;
  - Review and update existing discipline resources.

Attachments

A. NCSBN Discipline Resources Plan

B. Using Criminal Background Checks to Inform Licensure Decision Making

Attachment A

NCSBN Discipline Resource Plan (Updated April 2004) 2004-2006

Tactic	Priority	Year
CATEGORY ONE — DISCIPLINE RESOURCES		
1. Pain Management Statement	Medium	2004
2. Identify resources and guidelines for remediation of specific violations	Medium	2005
3. Develop and compile discipline resources and tools	Medium	2005
CATEGORY TWO — COMMUNICATION/NETWORKING		
1. Monitor implementation of Nur*sys*® based imposter alerts	High	2005-2006
2. Maintain state contact list for networking	Medium	Ongoing
3. Develop interactive web tool to address discipline questions	Medium	2005
4. Continue quarterly disciplinary staff conference calls	High	Ongoing
5. Publish regular discipline-related articles in *Council Connector* and on NCSBN Discipline Web page	Medium	2004-2006
6. Continue to explore the use of the Internet and other electronic-based media to expand access to education and training opportunities for boards that are unable to attend meetings due to budgetary restraints and travel limitations	Medium	Ongoing
7. Track discipline cases specific to Nurse Licensure Compact cases	High	2005-2006
CATEGORY THREE — CONSULTATIONS/COLLABORATIONS		
1. Explore implementation of a mentoring program for new discipline staff	Low	2004
2. Maintain a directory of content experts on various topics	Medium	Ongoing
3. Consider need for NCSBN Interstate Discipline Coordinator	Low	2005
4. Consider a Member resource program to provide Member Discipline Consultants to boards needing assistance	Low	2005
5. Explore opportunity for Member involvement and collaboration with CLEAR and FARB	Medium	Ongoing
6. Explore opportunities to recruit sponsors or vendors to defray workshop costs for NCSBN and Member Boards for educational offerings	High	2005
7. Consult with other NCSBN committees and staff	Medium	Ongoing as needed
CATEGORY FOUR — EDUCATION/TRAINING RESOURCES		
1. Conduct workshops/seminars/training	High	Ongoing
2. Expand opportunity for participation in 2004 and future educational programs to other health care professions that impact patient safety	High	2004-2006
3. Explore the feasibility of developing formal certification programs for nursing investigators and nursing attorneys	Low	2006
4. Provide speaking opportunities support for experienced members	Medium	As available
5. Continue to explore potential for enhanced distance education (video conference and other electronic interactive approaches to increase Member participation)	High	2005

Attachment B

Using Criminal Background Checks to Inform Licensure Decision Making

Introduction

The vast majority of encounters between nurses and their patients are positive interactions that allow nurses to meet the health care needs of patients. While the chances are small that a nurse is someone whose behavior may put the patient at risk of harm, incidents of serious incompetence, neglect or abuse traumatizes the victims and shakes public trust in care providers and organizations serving vulnerable populations (Cooper & Sheets, 1998). Health care consumers are dependent upon professional licensing boards to conduct appropriate screening of applicants. This Paper provides guidelines for conducting criminal background checks, from the authority required to mandate criminal background checks to a practical "how-to" section for boards moving toward this requirement, and information to support the use of the data obtained through criminal background checks in nursing licensure decision making.

Nurses work with patients, residents and clients throughout the whole spectrum of health care settings. Nursing care is often of an intimate physical nature and involves therapeutic contact with patients while providing health care services. Nurses are afforded access to the facility rooms and homes of people who are sick, disabled, dependent or infirm. Nurses are in a position to have access to information about a patient as well as to the patient's personal property and loved ones in a way not generally available in a business or social relationship or to the public. Often, vulnerable individuals are unable to protect themselves, voice objections to actions or provide accurate accounts at a future time (RI, 2001). Advocacy for these patients, residents and clients is an important aspect of nursing and is in the finest tradition of nursing practice. Nurses are placed in a position of public trust.

In light of this extraordinary trust, nurses are held to a high standard. Boards of nursing have the responsibility of regulating nursing and a duty to exclude individuals who pose a risk to the public health and safety. One means of predicting future behavior is to look at past behavior. Checking whether applicants for the privilege of nursing licensure have a criminal history and examining the nature of that history can provide significant information for boards to use in making decisions about who should be granted the privilege to practice nursing.

Background

Historically, boards of nursing have obtained information about prior criminal convictions from applicants for nursing licensure by asking questions on licensure applications. Decisions about whether or not to license an individual with a criminal history were determined on a case-by-case basis. In 1990, the California Board of Nursing began to conduct criminal background checks on applicants for nursing licensure. In the mid-1990s, concerns regarding the screening of applicants led other boards to explore the use of criminal background checks to validate the background of applicants for licensure. The 1996 NCSBN Delegate Assembly adopted a resolution directing NCSBN to develop resources to support board of nursing decision-making regarding criminal convictions. In response to that resolution, policy recommendations and a supporting Paper, *Criminal Convictions and Nursing Regulation*, were brought to the 1998 Delegate Assembly. That body adopted a policy recommendation to boards of nursing that criminal background checks be conducted on applicants for nursing licensure. This policy recommendation made a strong statement about the behavioral expectations for nurses.

In 1998, the Nursing Practice & Education Committee developed the *Uniform Core Licensure Requirements* using a competence framework[1] (NCSBN, 1996). The uniform requirements included

[1]The NP&E Framework consisted of *Competence Development* (education); *Competence Assessment* (licensing examination); and *Competence Conduct* (e.g., criminal background checks, questions about functional abilities, and good morale character requirements).

competence conduct expectations for self-reports regarding all felony convictions, all plea agreements and misdemeanor convictions of lesser-included offenses arising from felony arrest. State and federal background checks using current technology (i.e., fingerprinting) were included to validate self-reports. This requirement was noted to be consistent with the 1998 NCSBN policy recommendation to conduct criminal background checks on candidates for nursing licensure. The supporting Paper stated:

> *Crimes that have a potential impact on the ability to practice a profession safely or predict how the nurse might treat vulnerable clients in his or her care should be considered as part of a licensing decision. [Crimes] are indicative … of competence conduct [which is] composed of affective or behavioral elements…[and] may also reflect inadequate critical thinking skills and poor judgment. A felony conviction is a significant event. With the common use of plea bargains, the behavior underlying a misdemeanor should also be scrutinized on behalf of the vulnerable persons who are recipients of nursing care. It is the responsibility of the board of nursing to use the conviction history (including plea agreements) in decision making regarding competence conduct and licensure (NCSBN, 1998, 13).*

When the Disciplinary Resources Advisory Panel was charged to develop a model process for conducting criminal background checks in the fall of 2004, it was clear that for many boards of nursing the question had changed from "whether to conduct criminal background checks" to "how to conduct criminal background checks."

Data Collection

The Panel members began this endeavor by collecting information related to the topic and using this information as the basis for model development. The data sources included current state statutes and rules, information from other professions and a literature review.

REVIEW OF NURSING STATUTES AND RULES

In 1998, five boards of nursing were authorized to conduct fingerprint checks. Only three reported using them to validate background for licensure applicants. In *Profiles of Member Boards 2002*, 13 boards reported conducting both Federal Bureau of Investigation (FBI) National Clearinghouse of Information on Crime (NCIC) checks and state criminal agency checks. An additional 11 boards reported conducting on state checks.

In a 2005 NCSBN survey, 18 boards reported the use of criminal background checks. A review of state statutes and rules identified 25 boards of nursing that reported doing criminal background checks (most were as a routine step in the licensure process; a few boards had authority but limited use for discipline investigations (See Attachment A for a summary of survey findings).

REVIEW OF OTHER PROFESSIONS AND OCCUPATIONS

After a number of high profile cases in the late 1980s alleging misconduct of workers, childcare workers became among the first workers to be required by federal law to have criminal background checks. The National Child Protection Act of 1993 defined child abuse crimes reporting requirements by criminal justice agencies (CJIS, 1995). Other federal mandates for criminal background checks included nursing facilities and home health agencies. There are approximately 15 federal laws that permit criminal background checks for employment and licensure purposes when individuals provide services to children, the elderly or other vulnerable adults.

Teachers and student teachers were also required by states to have criminal background checks, again because their work involves contact with children. School volunteers are included in the screening because they may have unsupervised contact with children. Other services where there is frequent and unsupervised contact with children may be required to have criminal background checks. Examples include park service and recreation department employees.

Many banking and financial service positions are required to have criminal background checks and individuals may be barred from becoming employed, certified or licensed if the individuals have had disqualifying convictions. Criminal background checks are also frequently required in those occupations working with security or investigations, e.g., burglar alarm companies, private security or private investigators. There are requirements for weapons dealers to be checked as well as purchasers of guns in some states.

At least 10 states already require physician applicants for licensure to have criminal background checks: North Carolina, California, Florida, Idaho, Illinois, Kentucky, Louisiana, New Mexico and North Dakota. Nevada requires osteopaths and doctors who embrace holistic medicine to be screened. Florida requires checks of allopathic physicians, chiropractic, osteopathic and podiatric doctors to be screened. Four other states require in-state, but not federal, checks for physicians: Maine, New Jersey, Texas and Washington. The South Carolina and Delaware Boards of Medicine are considering criminal checks for physicians (Sun., Sept. 26, 2004).

Massachusetts, Missouri and Oregon require criminal background checks for most, if not all, professional licensure applicants (CLEAR, 2005).

LITERATURE REVIEW

Criminal background checks are an example of a legislative trend that put obligations on licensing agencies and employers with the intent of protecting children and vulnerable adults. The Committee reviewed various resources, articles and Web sites addressing the use of criminal background checks. Criminal background checks were seen to be a reasonable measure to protect service recipients from harm, by review of the backgrounds of individuals seeking positions requiring direct contact with vulnerable service recipients. According to the Department of Justice, statutes governing state social welfare and licensing agencies have increasingly required that certain screening practices be used for those workers and volunteers working in settings in which individuals come into contact with children, the elderly and individuals with disabilities (DOJ, 1998, p. 1).

Where professional licensure is involved (e.g., attorneys, physicians, nurses, brokers, etc.) the statute will generally provide that the required criminal history information is a prerequisite to the issuance of a license. The more specific a criterion for licensure screening, the better — e.g., "drug arrest" may be too broad. Defining a time frame, like a recent history of drug conviction, is a better criterion. Other factors to consider are the recency and circumstances of conduct, the age of the person at the time of the offense and societal conditions that may have contributed to the nature of the conduct — e.g., neighborhood pressure to join a gang or a perceived threat of retribution for not joining a gang. A person's commitment to change and efforts to rehabilitate, not just remorse but tangible evidence of a desire to become a law-abiding citizen, is an important factor. An example would be making restitution to victims of crime or progress in rehabilitation programs (Patterson, 1998).

Examples of crimes bearing on the fitness of an individual to have contact with, and responsibility for, children or vulnerable adults include any conviction for a sex crime, an offense involving a child victim, a drug felony or other convictions such as crimes involving violence or theft that would pose a concern regarding children or vulnerable adults (Coates, 2000). Another reason for doing criminal background checks is for the protection of personal property, very much a concern when services are provided within the home or to vulnerable individuals who are not attentive to their surroundings.

Criminal law is for the purpose of preventing harm to society, declaring what conduct is criminal and prescribing the punishment to be imposed for such conduct. Substantive criminal laws are commonly codified into criminal or penal codes (Black, 1979). The broad aim of criminal law is to prevent harm to society, with some of the primary societal interests being protection of people from physical harm and of property from loss, destruction, or damage. Other interests include protection of: the public health, the public peace and order, the government (from injury

or destruction), the administration of justice (from interference), safeguards against sexual immorality and other continually evolving interests (Northrop, 1987).

Criminal procedure is concerned with the procedural steps through which a criminal case passes. Limitations are placed on the government so that an individual's liberty and exercise of constitutional rights are not unduly impeded. The definition of a crime cannot be so vague as to fail to provide adequate notice of what conduct is prohibited. Generally, the law requires two elements for a crime, an act (actus reus) and a criminal intent or guilty mind (mens rea), to be present for the conviction of a crime. The specific elements of crimes vary, but typically involve the defendant's mental state, causation (i.e., certain conduct that produces a certain result) and prohibited conduct (Northrop, 1987).

"The necessity of greater procedural protections in the criminal and quasi-criminal setting than those available in the civil context is due to the nature of what is at stake in each of these. In criminal proceedings, life and liberty are usually at stake. In civil proceedings, generally money is the issue. The criminal trail provides the accused with a process that includes full notice of the charges, the right to compel witnesses on the accused's behalf at the trial and the right to confront the witnesses against him or her" (Northrop, 1987, p. 395).

Patterson says use of arrest data in screening processes for paid positions has been adjudicated as a discriminatory practice and is therefore barred under Title VII of the U.S. Civil Rights Act of 1964 (this is in reference to employment). Decisions should be based on convictions. However, employers can consider an arrest for which a disposition is pending to disqualify an applicant until a decision is rendered. Similarly, licensing boards can postpone licensure decision-making when disposition of a criminal matter is pending. Some boards have used arrest records to trigger inquiry into the underlying conduct.

Passed by Congress in 1972, Public Law 92-544 is an appropriations statute (set out as a note under § 534 of Title 28, Judiciary and Judicial Procedure) that provides funding to the FBI for acquiring, collecting, classifying, preserving and exchanging identification records with duly authorized officials of the federal government, the states, cities and other institutions. For a national records criminal background check, the FBI requires that:

1. The applicant provide a complete set of readable fingerprints.
2. The organization inform the applicant it may request a records check for the position sought.
3. The organization inform applicants of their rights to obtain a copy of any background report and to challenge the accuracy and completeness of the information before a final determination of eligibility is made (Patterson, 1998).

An important tool to support accessing criminal background information is the National Crime Prevention and Privacy Compact, which organizes an electronic information sharing system among the federal government and the states to exchange criminal history records for purposes authorized by federal or state law, such as background checks for governmental licensing and employment (Title 42, chapter 140, subchapter II § 14616). Under this compact, the FBI and the Party States agree to maintain detailed databases of their respective criminal history records and to make them available to the federal government and to party states for authorized purposes. The FBI continues to manage the federal data facilities that provide a significant part of the infrastructure for this system. As of June 2, 2005, 24 states had adopted this compact[2]. States that have adopted the compact provide federal data as well as state information from the states that participate in the compact (CSG, 2005).

Another source of information for boards are the sex offender registries. With Megan's Law (RCNL), N.J.S.A. 2c: 7-1 et seq., the New Jersey legislature mandated a list of individuals who have been

[2]States that have passed the compact as of June 2, 2005: Alaska, Arkansas, Arizona, Colorado, Connecticut, Florida, Georgia, Idaho, Iowa, Kansas, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Wyoming. Six other states have legislation pending. (Commodore, 2005)

convicted of criminal sexual misconduct, ranging from child molestation to rape/sexual assault, be accessible to the public. The state registries list offenders by state of residency regardless of where the conviction occurred. Internet access to sex offender regulation and community notification registries is available at www.klaaskids.org/pg-legmeg2.htm. Information on Megan's Law and related topics is available at a variety of other Web sites accessible via internet search engines. According to the Bureau of Justice Statistics, as of September 2004, all 50 states and the District of Columbia have centralized sex offender registries. All 50 states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands submit records on sexual offenders to the National Sex Offender Registry (BJS, 2005).

While not a panacea, careful screening is an important patient safety activity. A criminal history record describes any arrests and subsequent dispositions attributable to an individual (BJS, 2005). The probability of continuation of the behavior is at issue — a continuing pattern of criminal offenses justifies concerns about future conduct. Certain crimes such as sexual molestation have a high probability of repetition (Patterson, 1998).

Recidivism is measured by criminal acts that resulted in the rearrest, reconviction or return to prison with or without new sentence during a three-year period following the prisoner's release. The Bureau of Justice Statistics stated the following regarding recidivism:

- *Of the 272,111 persons released from prisons in 15 States in 1994, an estimated 67.5% were rearrested for a felony or serious misdemeanor within three years, 46.9% were reconvicted and 25.4% resentenced to prison for a new crime.*
- *The 272,111 offenders discharged in 1994 accounted for nearly 4,877,000 arrest charges over their recorded careers.*
- *Within three years of release, 2.5% of released rapists were rearrested for another rape and 1.2% of those who had served time for homicide were arrested for a new homicide.*
- *Sex offenders were less likely than non-sex offenders to be rearrested for any offense — 43% of sex offenders versus 68% of non-sex offenders.*
- *Sex offenders were about four times more likely than non-sex offenders to be arrested for another sex crime after their discharge from prison — 5.3% of sex offenders versus 1.3% of non-sex offenders.*

(BCJ, 2005)

In the current criminal justice system, a felony conviction is a highly significant event (Cooper & Sheets, 1998). The regulatory agency reviewing an individual with a criminal history must be aware that the individual has interfaced with the police, prosecutors, defense attorneys, judges, correctional officials and parole and/or probation authorities in the investigation, prosecution and sentencing aspects of the conviction (Northrop, 1987). It is not the role of the licensing board to retry, or second-guess these authorities. It is the role of the licensing board to use the conviction history in decision-making regarding competence conduct and licensure.

PREMISES

1. It is critical to focus on what the public needs rather than what states are currently doing.
2. Licensing boards must maintain a balance between the board's responsibility to protect the public health, safety and welfare and the individual's right to practice a chosen profession.
3. Criminal law is for the purpose of preventing harm to society, declaring what conduct is criminal and prescribing the punishment to be imposed for such conduct.
4. Past criminal behavior raises concerns regarding the behavioral competence of the individual.
5. It is not the role of the licensing board to retry or second-guess decisions made by the justice system. It is the role of the board to use conviction history in decision-making

regarding competence conduct and licensure.

6. Boards are more aware when persons with histories of criminal convictions are applying for licensure.
7. Choices made at an earlier time in an individual's life have significant impact and consequences in later life activities. Getting involved in criminal activities represent a choice that affects the person's subsequent ability to exercise selected privileges in our society.
8. The burden is upon the individual applicant to provide evidence that he/she has met all requirements for education, examination and behavior, in addition to other requirements for nursing licensure. This means the burden is on the individual applicant to provide any documentation that would prove or disprove a criminal conviction, or if appropriate, provide any aggravating or mitigating evidence regarding criminal conviction.
9. The model developed should provide the most rational approach for assuring public safety. Public safety includes access to safe and competent nurses.
10. Appropriate licensing and/or disciplinary actions based on criminal convictions should reflect any aggravating or mitigating circumstances.

OBTAINING AUTHORITY FOR CRIMINAL BACKGROUND CHECKS

Statutory authorization is needed to access the FBI database when the data is used for matters that do not involve police or courts (FBI, 2005). Public law (PL) 92-544 authorizes the Federal Bureau of Investigation (FBI) to conduct a criminal background check for boards empowered by a state statute approved by the United States Attorney General. Boards must comply with jurisdictional requirements to obtain access to state criminal records. Required safeguards to assure the security of criminal history record information reflect the concern for the proper use, security and confidentiality of such information (FBI, 2005).

The FBI has established the following mandatory elements of a state statute enacted under the auspices of PL 92-544. The state statute must:

1. Exist as a result of a legislative enactment;
2. Require that the criminal background check be fingerprint-based;
3. Authorize the submission of fingerprints to the State Identification Bureau for forwarding to the FBI for a national criminal history check;
4. Identify the categories of licensees subject to criminal backgrounds; and
5. Provide that an authorized government agency be the recipient of the results of the record check (DOJ, 2005).

PL 92-544 does not allow federal criminal records to be directly shared with health care employers or others (DOJ, 2005).

EXAMPLES OF THE GRANTING OF AUTHORITY

Many of the states that are conducting criminal background checks have been granted legislative authority through language in the Nurse Practice Act. This is the approach used in the NCSBN *Model Nursing Practice Act* and *Model Nursing Administrative Rules*, where the authority first appears in an article granting powers to the board, and is also addressed in the articles describing the licensure process.[3]

[3]An example of statutory language granting the board authority to conduct criminal background checks, from the Arizona Nurse Practice Act: Require each applicant for initial licensure to submit a full set of fingerprints to the board for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation (Arizona Statues 32-1606, 15. revised 2002).

The states that have broad requirements for criminal background checks as a requirement for most professional licenses in that state often have the authorization to do criminal background checks in an article or chapter pertaining to all health professional boards. Additional language pertaining to the implementation of criminal background checks may also be in the general chapter or may be included in each profession's practice act and/or rules.[4]

Another approach that has been used when agencies do not have a state legislative mandate to conduct criminal background checks is to use federal law to obtain the necessary authority. The National Child Protection Act of 1993 encouraged states to adopt legislation meeting the criteria of PL 92-544, to authorize national criminal history background checks to determine employee and volunteer fitness to care for the well being of children and also, as added by PL 103-322[5], the elderly or individuals with disabilities. However, numerous jurisdictions did not enact the necessary legislation granting authority to conduct criminal background checks. As a result, Congress enacted the Crime Identification Technology Act of 1998 (PL 105-251). A part of this law is the Volunteers for Children Act (VCA) (42 USC § 14601)[6], which relieves the states of the necessity to enact language consistent with 92-544 by authorizing national fingerprint checks in the absence of existing state procedures (CJIS, 1995). The Iowa Board of Medical Examiners used authority obtained through the VCA to conduct criminal background checks on prospective licensees. This was based on a determination by the Access Integrity Unit (AIU) of the FBI that the board was a "qualified entity." (Inman, 2004)

Model Process for the Use of Criminal Background Checks

WHY USE CRIMINAL BACKGROUND CHECKS?

The use of criminal background checks in the licensing of occupations and professions began with the childcare industry as a response to numerous allegations of misconduct and identification of providers with questionable backgrounds. While a lack of criminal history is no guarantee against future criminal acts, it is an indicator that the person is less likely to commit crimes in the future.

Nurses provide services for vulnerable people, often of a personal and intimate nature, so it is in the public interest to determine that those seeking the authority to practice nursing are qualified to do so, including in the areas of behavior, attitude and conduct. In the past, many boards included a "good moral character" requirement, an approach intended to seek information about this aspect of qualification; some jurisdictions continue to use this as a requirement for licensure. The trend in recent years has been for boards to move away from "good moral character," the term being vague, subjective and difficult to define. Criminal background checks were seen as a more objective and reliable source of information regarding an applicant's behavior and conduct.

Although most states ask questions about criminal convictions on licensure applications, applicants may not be motivated to be truthful. Criminal background checks provide validation of the information reported on applications.

WHO SHOULD BE CHECKED?

Applicants for licensure as registered nurses and licensed practical/vocational nurses by either examination or endorsement should be screened. Similarly, applicants for licensure/authority to practice as advanced practice registered nurses should be screened for both initial licensure

[4]N.J. SA 45:1-28, et.seq.

[5]Codified at (42 U.S.C. §5119a(a)(3)

[6]The VCA amended the National Child Protection Act to authorize national criminal fingerprint background checks of volunteers, job applicants and employees of qualified entities who provide care for children, the elderly or individuals with disabilities as well as those who have unsupervised access to such populations (regardless of employment or volunteer status) to determine if the individual has been convicted of crimes that bear upon their fitness to have such responsibility, see 42 U.S.C. §5119a(a)(1).

and licensure by endorsement.[7] Boards that regulate nursing assistive personnel should screen these individuals as part of requirements for being on the Nurse Aide Registry and/or as part of a certification process for nursing assistants.

WHAT KIND OF CRIMINAL BACKGROUND CHECKS SHOULD BE CONDUCTED?

Some states do only state-wide (or sometimes regional) criminal background checks. But as we live in a mobile society, there are significant limitations to only state or regional checks. Boards are advised to check both state and federal criminal records. Fingerprint identification is a method of identification using the impressions made by the minute ridge formations or patterns found on the fingertips. No persons have exactly the same arrangement of ridge patterns and the patterns of one individual remain unchanged throughout life. Other personal characteristics may change, but fingerprints do not. FBI fingerprint searches are highly preferable to name checks for screening (FBI, 2005). Fingerprint comparison is the accepted standard for establishing positive identification of criminal history record subjects in the United States.

WHEN SHOULD CRIMINAL BACKGROUND CHECKS BE CONDUCTED?

Obviously, applicants for licensure should be screened at the point of application. Since a criminal background check is in essence a snapshot at a point in time, a few states are beginning to consider approaches for conducting checks of licensees, as well. When a board first undertakes criminal background checks, retroactive testing — a process for screening licensees previously licensed without criminal background checks — may be considered, e.g., screening a portion of the licensees annually until all have been checked. Other states may choose not to take on this approach and simply grandfather previously licensed individuals. The point of regular contact with licensees is when the license is renewed; this may be a logical opportunity to implement this requirement. Given the number of nurses, it may be resource-prohibitive to do a check with each renewal (particularly for states that have moved to annual renewal).

The Committee has identified two possible approaches for ongoing screening. If the board were to enforce such a requirement, a check conducted every five years could be staggered, so that 20% of licensees are screened each year. The other approach that the Committee discussed was having the board do initial and subsequent licensures by endorsement and employers would do periodic screens for nurses. Employer criminal background checks are becoming more common at the point of hire and could be done periodically while a nurse is in the facility/agency employ. Like boards, employers cannot share specific criminal background check information, but employers should be expected and encouraged to report to the boards of nursing a denial of employment or a release from employment for a criminal conviction (however, they cannot report the nature of the crime or the particulars if obtained via the FBI criminal background check).

The other time for the board to conduct a criminal background check would be during an investigation. Criteria for screening as part of an investigation include whether the subject nurse has previously been screened, the nature of the allegations and whether there are multiple boards involved in the case. Some boards may choose to screen all nurses under investigation but if the screening involves fingerprinting, they would need statutory authority.

HOW — SUGGESTED PROCESSES FOR CONDUCTING CRIMINAL BACKGROUND CHECKS

The state agency obtains state (and possibly regional) records and transmits the fingerprints to the FBI. Fingerprinting, either through electronic "live scans" or paper and ink "hard cards," is required for all federal criminal background checks conducted for employment and licensing purposes. New technology is being developed in many areas all the time, so states are advised to use terminology in statutes and rules that is broad enough to accommodate new developments,

[7]There may be situations when an individual who holds two types of nursing license chooses to apply for both at the same time, e.g., someone who is both an LPN/VN and an RN, who wants to keep both licenses current; or when RN licensure is required for APRN licenses/authority to practice. In these situations, one criminal background check should be used for both applications.

but specific enough to articulate what is intended and required by the statute.

Once a board is authorized to conduct criminal background checks a process is needed for implementation. The Committee identified these key steps in the process, based on review of the processes used by nursing boards already conducting criminal background checks.

1. Consider the impact and resources that will be required by this activity. Identify a lead staff person for process development and provide adequate staff support. Other areas of board operations that will be affected by new information should be involved in the planning and implementation. Planning should include consideration of security issues, as the information obtained through checks is confidential and should be managed as such.
2. Identify the state agency or bureau responsible for conducting state results and transmitting fingerprints to the FBI. It is helpful to develop contacts and a working relationship with these individuals. Obtain fingerprint cards or identify locations and agencies that perform fingerprinting or obtain instructions for conducting electronic screening.
3. Develop policies and procedures to guide staff in the implementation of screening and triage. Prepare educational materials for applicants that describe the purpose of fingerprinting, the procedures for screening, places to get fingerprinted and information noting that the applicant is responsible for any costs from local law enforcement, the state agency and the FBI.
4. Prepare staff for the phone calls that will come in from the applicants. Questions often arise related to clarifying disqualifying arrests or convictions. Having some standard scripts prepared in advance can be of assistance. Plan for those situations when staff need to refer calls to supervisors.
5. Try to anticipate the unexpected. Plan for those individuals whose fingerprints cannot be read by having a back-up procedure for background checking by name and other identifiers. Some states have included a provision in the law to address situations when an individual cannot be fingerprinted. This typically involves doing a records check on the person's name, social security number and other vital statistics.
6. The FBI will report the results of the search to the requesting agency, which will forward both the state and the FBI results to the board. The state requesting agency is the conduit for submitting criminal background checks and returning results.
7. Train staff for receiving and reviewing the criminal background reports. Prepare staff to read the reports that will include arrests as well as convictions.
8. Develop criteria to establish those arrests or convictions that will require further review and those that do not. It is effective for the board to establish criteria for decision-making and delegate to staff the initial review of positive findings. Procedures should be established for staff review and recommendations using the board criteria.
9. The applications of those with criminal records should be reviewed for how questions about criminal convictions were answered.
10. Develop and establish policies for the ability of applicants to sit for the licensure exam prior to receipt of the criminal background records and/or to receive a temporary permit pending the receipt.
11. Develop a policy to guide staff in those situations involving very old convictions where court records are unavailable.[8]
12. Criminal background checks provide a valuable tool for boards, but boards should be cognizant that not all arrests/convictions are recorded and there are, at times, errors made in the reporting. It is important to confirm and validate findings. The burden, however, is

[8]For example, a criminal background check identifies a conviction that occurred twenty years earlier but the applicant claims it was never a conviction, or that it was expunged, or it was her sister who actually sustained the conviction. The court reports that there are no records remaining to substantiate or refute the applicant's story.

ultimately upon the individual applicant to provide any documentation that would prove or disprove a criminal conviction, or if appropriate, to provide any aggravating or mitigating evidence regarding criminal conviction.

CRITICAL POLICY CONSIDERATIONS AND DECISIONS

Whether exploring or already implementing criminal background checks, boards of nursing should address the following policy considerations and make decisions regarding how the process is to be conducted:

- Whether to conduct criminal background checks from a point forward, with grandfathering of individuals already licensed or to look retroactively at previously licensed individuals.
- What questions should be on application regarding criminal background.
- Management of the length of time required to complete the criminal background checks leads to these considerations regarding the application process:
  - Whether to allow an individual to sit for the licensing examination prior to the receipt of the criminal background checks (See Table 1).
  - Whether to grant a temporary permit to a nurse applying for licensure via endorsement pending the receipt of the criminal background checks (See Table 1).
- Security provisions to keep criminal background checks results confidential.
- Exception and waiver processes for individuals whose fingerprints are not readable (as discussed in the suggested process above).
- Appeal procedures if an applicant for licensure or a licensee requests a reconsideration of a board's decision based on a criminal conviction.

Table 1 — CBCs and Exams/Permits: Timing Considerations

Sits for exam while criminal background checks processed	**Sits for exam after criminal background checks results received**
PRO: ■ Allows new graduates to test more quickly after graduation (applicants do better on the exam if not delayed in taking). CON: ■ May be more efficient for boards to deal with positive criminal background checks before individuals be allowed to sit for the examination.	PRO: ■ Individuals disqualified for licensure do not go through time and expense of exam. CON: ■ New graduates prevented from sitting for the exam closer to graduation.
Issue a temporary permit to endorsement applicant	**No temporary permits**
PRO: ■ Allows experienced nurses who have met all other qualifications to work sooner, allows public access to nursing care. ■ Many more endorsement applicants have no criminal history than those who do. CON: ■ Potential for nurses with criminal backgrounds to have access to vulnerable individuals before the board knows about conviction.	PRO: ■ Strictest standard, prevents individuals with criminal histories from practicing before board has review opportunity. ■ Does not rely on the expectation of low numbers to protect the public. CON: ■ Majority of endorsing nurses do not have conviction history yet are prevented from practicing until criminal background checks process is complete.

DISCUSSION

The determination to do criminal background checks from a point forward or to conduct criminal background checks on previously licensed nurses as well as new applicants involves financial and resources issue as well as policy consideration. The advantage of doing criminal background checks for all is that the public can be assured that the board has considered the criminal backgrounds of every licensed nurse at some point in time. The chief disadvantage is related to the sheer volume of nurses and the resources required to process all these individuals. Applicants are required to pay for the criminal background checks screening and boards would likely require licensed nurses to pay as well. Boards may expect some challenge from already licensed nurses. Another issue that would need to be addressed with the state law enforcement agencies and FBI is the impact on the workload of those organizations. Advance notice of the numbers of screenings that would be required to check all licensed nurses should be given to the agencies involved in doing the screening. An evaluation of the percentage of positive checks in states currently doing criminal background checks on applicants would provide an estimate of the numbers of positive checks that might result from all licensed nurses.

Another policy issue for consideration regards questions about criminal convictions on licensure applications. Most boards, if not all, have some questions about criminal background. For example, the NCSBN *Model Nursing Practice Act* and *Model Nursing Administrative Rules* include reporting of criminal conviction, *nolo contendre* pleas, Alfred pleas, or other plea arrangement in lieu of conviction. This language allows the board to consider both felony and misdemeanor convictions. The concern with criminal convictions is with the underlying behavior rather than the label attached to the crime. Some serious behavior can be pled down to a lesser plea. Some boards may choose to consider arrests (reported on the FBI records) as well as convictions. If a board does this, it is important to use the arrest as a flag to check other sources regarding the underlying behavior.

Some boards doing criminal background checks have moved toward asking only about felony convictions or convictions which disqualify an applicant for licensure. These boards rely on the information in the criminal background checks to inform licensure decisions as they relate to criminal convictions that are not a bar from licensure. Other boards ask questions related to prior arrests and convictions and track the differences between the application response and the criminal background checks and pursue actions related to fraud and deceit in procuring a license when an applicant is not truthful on the application.

Among the boards of nursing currently conducting criminal background checks, the more common practice is a simultaneous process, where an applicant by examination is allowed to sit for the exam while the criminal background check is being processed, and the applicant by endorsement, who has met all other requirements, is granted a time-limited temporary permit while the criminal background check is being processed, if they have not otherwise disclosed a disqualifying conviction. Providing access to nurses is another element of public protection. However, some states require the completion of the criminal background checks prior to sitting for the examination or being allowed to practice in the jurisdiction. This is the stricter standard and arguably a safer approach.

Planning for the security of the information received is an important step in the criminal background check implementation process. In the past year, the FBI audited two boards regarding the management of criminal background check information. Regarding FBI data, the law requires that the information is kept confidential and not shared except with the subject of the criminal background report. The confidentiality requirements also mean that in order to take action on the basis of a criminal conviction, the respondent must admit to the conviction; the board must obtain court documents or otherwise independently verify the information to identify the conviction in any public documents.

The board needs to plan for those individuals who do not have readable fingerprints by determining how many attempts should be made before concluding an individual has unreadable prints. The

board needs to consider what other types of background checks could be used — e.g., electronic scanning, review of records or full investigation. As with other aspects of administrative law and practice, individuals who have been denied licensure on the basis of information first identified in criminal background checks have due process rights and must have the opportunity to appeal board decisions.

USING CRIMINAL BACKGROUND CHECKS TO INFORM LICENSURE DECISION-MAKING

Criminal convictions are grounds for discipline or denial of licensure for all boards of nursing. Courts have historically deferred to the expertise of administrative agencies regarding rules and decisions if there is a rational basis for their enactment (Tribe, 2000). Applicants have the burden of proving that all requirements for licensure are met. In most jurisdictions, once a license is issued, an individual is seen to have a property right in a professional license that cannot be revoked to otherwise disciplined without affording the individual due process. The burden of proof to demonstrate that a nurse does not meet ongoing requirements or violates grounds for discipline shifts to the board once an individual is licensed. The right to a professional license is not typically deemed a fundamental right, thus the standard for review is the rational basis test. The courts have upheld statutes requiring automatic suspension or revocation of a license based on criminal conviction. To date, courts have declined to question the state's authorization of sanctions for a broad class of convictions and the courts have uniformly held that the action of a state regulatory body in suspending or revoking an individual's license on the basis of a criminal conviction does not constitute double jeopardy (State of Oklahoma v. Giger). The legal basis for using criminal history to inform licensure decision-making is firm. The question for boards of nursing becomes how to use the information.

To Bar or Not to Bar

Currently, there are a number of approaches for how to use the information among the boards already conducting criminal background checks. There are several possible approaches:

- A case-by-case review of applicants and nurses with criminal convictions;
- A time limited bar to felony convictions;
- A permanent bar to certain categories of felonies;
- An absolute bar to felony convictions.

Case-by-case review. The case-by-case review has been the historical approach for boards of nursing making licensure decision involving applicants with criminal convictions. Boards have traditionally asked for self-disclosure; in recent years there is trend for boards to validate self-disclosure by criminal background checks. This approach allows for boards to evaluate the nature and context of the crime, rehabilitative efforts, the time elapsed and other factors. Using case-by-case review, boards have the discretion to deny or grant licensure. At its best, this approach gives individuals a chance. At its worst, boards may be manipulated into an unsound decision. There may be inconsistency of decisions due to changing board composition over time or inconsistency between jurisdictional policies and/or approaches that may have implications for individuals moving between states. The majority of boards of nursing currently decide cases in this manner.

Criteria for Consideration in Case-by-Case Decisions

While some boards have identified bars to licensure, the majority of boards continue to review cases on a case-by-case basis. This allows the board the discretion to consider the context of the conviction as well as aspects of the applicant's life since conviction. Some of the aggravating circumstances that the board may consider as exacerbating the situation are that the case involves:

- Multiple or repeat criminal violations;
- Prior disciplinary action;
- Conviction for a crime against a child or vulnerable adult;

- Conviction determined to be related to professional practice;
- Abuse of trust in order to commit the violations;
- Exploitation of unique position or knowledge;
- Financial benefit accrued by respondent;
- Knowing, willful or reckless conduct;
- Lack of rehabilitation potential;
- Lying under oath and/or on an application for a credential;
- Currently subject to court oversight (e.g., under probation for previous criminal convictions).

There are also circumstances that may mitigate the context of convictions. Mitigating circumstances in a case include:

- Lack of previous convictions, in this or any other jurisdiction;
- The respondent acted under strong and immediate provocation;
- At a time prior to detection, the respondent compensated or made a good faith attempt to compensate the victim for the injury or loss sustained;
- The respondent was suffering from a mental or physical condition that significantly diminished his or her capacity for understanding the ramifications of or ability to control his or her conduct. This can only be applied if such condition is not an element of the violation (e.g., charges under impaired practitioner);
- Identified potential for rehabilitation;
- The respondent sought and/or completed appropriate remedial measures prior to institution of disciplinary actions, i.e., responsible and accountable for the respondent's own actions;
- Isolated incident;
- Minimal risk of harm to patients or clients.

Time limited bar to felony convictions. Another approach is a time-limited bar to felony convictions. This option looks at the time elapsed since the felony conviction. Since most recidivism occurs in the first three years, this approach provides a safety cushion and time for the individual to get his/her life back together following the felony conviction. This approach is currently used in Arizona, Kentucky and Oklahoma. The time limit reflects a minimum period of time that the applicant with a prior felony would be required to have completed all court requirements (absolute discharge) before being eligible to apply for licensure.

Permanent bar to certain categories of felonies. Another policy option is the identification and bar of felonies involving serious or violent offenses. Violent crimes represent the highest risk of dangerousness. The high recidivism rate for property crimes (e.g., theft, check forgery, credit card theft, auto theft, receiving stolen property and property damage) raises concerns regarding the vulnerability of patients to property crimes, especially in autonomous settings. This approach does not bar other felonies that continue to be reviewed case-by-case. The Panel identified the following crimes as those crimes that should be considered for a permanent bar to licensure:

1. Murder
2. Felonious assault
3. Kidnapping
4. Rape/sexual assault
5. Aggravated robbery

6. Sexual crimes involving children
7. Criminal mistreatment of children or vulnerable adults
8. Exploitation of vulnerable individuals (e.g., financial exploitation in an entrusted role)

Absolute bar for felony convictions. The broadest consideration for possible screening mechanisms for individuals caring for vulnerable populations is the elimination of applicants who have been convicted of a felony. This approach recognizes that a felony conviction is a significant event. Samenow wrote about the criminal mind, stating that criminals need to be seen as responsible for their behavior, held accountable and be assisted in altering their thinking patterns (Samenow, 213). To determine if cognitive change has truly occurred requires extensive assessment, with review of court records, clinical and forensic interviews as well as evaluation of the situational context (Cohen, 1996). With increasing numbers of applications with felony convictions and with limited resources of boards of nursing, the comprehensive assessment necessary to screen effectively for those few (by recidivism standards) felons who might be rehabilitated from those individuals who continue to pose a danger to vulnerable consumers may be beyond the resources available to boards of nursing. This option allows boards to focus their administrative processes on other applicants and licensed individuals needing special scrutiny. Some think this approach is harsh and cite examples of former criminals who have rehabilitated and gone on to model lives. However, given the serious concerns regarding recidivism, this is arguably the safest approach; however, no states currently enforce a felony bar.

Conclusions

Increasingly, health care is provided away from traditional institutional settings. More care settings are in the home or community, away from the scrutiny of supervisors or close association with colleagues. Patients have short hospital stays and are sent home with significant care needs and increased vulnerability because of those needs. Everyday, the media brings home reports of shootings, murders, terror and war. We live in a complicated, dangerous world.

Responding to the problems of life with anger, violence and exploitation is not limited by geography, culture or age group. Society reflects its environment, and the pool of licensure candidates and nurses reflect society. The nursing board's role in screening and identifying those individuals who may pose a threat to consumers has never been more important.

Life is all about choices; the choices made have impact and may have significant consequences on later life activities. If a person chooses not to pursue post-secondary education, many professional opportunities, including nursing, are not available. If a person makes poor judgments and gets involved in criminal activities, this affects the person's subsequent ability to exercise selected privileges in our society.

The truth is that regulation does pose barriers — necessary barriers that provide assurance that complex professional activities are reserved for those individuals who have demonstrated competence to practice a profession. Whenever mandatory requirements for entering a profession are implemented, some people are denied the privilege to practice the profession. The fact that there needs to be a disciplinary process indicates that entry requirements alone cannot screen every unsafe applicant or licensee.

Criminal background screening is a tool to support boards in licensure decision-making. The requirement for criminal background checks may discourage individuals who have disqualifying convictions from even applying for licensure. Nurses who commit crimes tarnish the reputation of the profession as well as diminish the confidence of the public. An applicant with a history of felony conviction presents a confirmed history of serious deviance from societal standards. Consumers needing health care are vulnerable. Nursing is a stressful profession. Stress tends to cause bad habits to reappear. It is appropriate to establish high behavior standards for applicants for nursing licensure and for licensed nurses.

Based upon the recidivism rates, the changing society, the increasing autonomy of nursing practice and prior court decisions in this area, as well as limited state resources for licensing agencies, there is a rational basis for a policy approach limiting access to nursing licensure for convicted felons.

II. Recommendations

The recommendations of the Discipline Resources Advisory Panel regarding criminal background checks include that:

A. State and federal criminal background checks be conducted on applicants for nursing licensure.

B. Applicants for licensure not receive a permanent license prior to receipt of criminal background check results and the meeting of all licensure requirements.

C. It is not the role of the board of nursing to retry a case or second-guess the criminal justice system. It is the role of the board to use conviction histories in decision-making regarding competence conduct and licensure.

D. There is a continuum of criminal behavior, with lesser offenses on one end and dangerous violent crimes on the other. Policy decisions regarding how boards of nursing use criminal histories are also illustrated on the continuum (See Table 2).

Table 2 — Offense and Board Action Continuum

E. There be an permanent bar to the most serious felonies as listed below:

1. Murder
2. Felonious assault
3. Kidnapping
4. Rape/sexual assault
5. Aggravated robbery
6. Sexual crimes involving children
7. Criminal mistreatment of children or vulnerable adults
8. Exploitation of vulnerable individual (e.g., financial exploitation in an entrusted role)

F. There be a time-limited bar for other serious crimes, including:

1. Drug trafficking
2. Embezzlement
3. Theft
4. Arson

G. That the behavior, underlying plea bargains and lesser offenses be evaluated using the criteria for mitigating and aggravating circumstances (see Table 3).

Table — Mitigating and Aggravating Circumstances	
Mitigating Circumstances	Aggravating Circumstances
■ No previous convictions ■ Strong and immediate provocation ■ Compensation (or attempt to compensate) to the victim for the injury or loss sustained ■ Mental or physical condition that significantly diminished individual's capacity for understanding the ramifications of or ability to control his or her conduct (such condition is not element of offense) ■ Rehabilitation potential	■ Multiple or repeat criminal violations ■ Prior disciplinary action ■ Crime against a child or vulnerable adult ■ Conviction related to professional practice ■ Abuse of trust ■ Exploitation of unique position or knowledge ■ Financial benefit ■ Knowing, willful or reckless conduct ■ Lack of rehabilitation potential ■ Lying ■ Currently subject to court oversight (LA)

H. That boards retain the discretion, under defined circumstances and following a strict and predetermined process, to determine that extraordinary circumstances warrant a waiver of either the time-limited or permanent bar.

Appendices

B-1. Member Board Survey Results Summary — Criminal Background Checks

B-2. States That Do Not Require Criminal Background Checks (CBC)

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Attachment B-1

Member Board Survey Results Summary – Criminal Background Checks (Fall 2004)

Board	Source of Authority	When Required							What Required			Comments
		Examination	Endorsement	Renewal	Reinstatement	Investigation	Student	Other	State Fingerprint	Fed Fingerprint	Other	
AK		✓	✓		✓				✓	✓		
AZ	Nurse Practice Act	✓	✓		✓				✓	✓		
AR	Nurse Practice Act	✓	✓			✓				✓	✓	State check on driver's license and social security #.
CA-RN	Business/prof. Code Section 480 (a)(1)	✓	✓		✓				✓	✓		
CA-VN	Statutes	✓							✓	✓		Will require for anyone if not previously printed in state.
FL		✓	✓		✓				✓	✓		
HI	Nurse Practice Act/Uniform code	✓	✓	✓	✓	✓					✓	State/federal: all documents relating to criminal conviction.
ID	Nurse Practice Act	✓	✓		✓					✓		
IL	Nurse Practice Act	✓	✓						✓	✓		
KY		✓									✓	State criminal check.
LA-PN	Revised Statutes	✓	✓						✓	✓		
LA-RN	Nurse Practice Act	✓	✓		✓	✓	✓	✓	✓	✓		
MO		✓	✓						✓	✓		
NV	State Law — revised statute	✓	✓			✓				✓		
NH				✓	✓			✓				
NJ		✓	✓					✓	✓	✓		
NM	Nurse Practice Act	✓	✓						✓	✓		
NC	Nurse Practice Act	✓	✓						✓	✓		
OH	Nurse Practice Act	✓	✓						✓	✓		
OK	Nurse Practice Act	✓	✓								✓	State criminal records search requested.
OR	Oregon Revised Statues § 181.710	✓	✓	✓	✓	✓	✓		✓			Law Enforcement Data Systems (LEDS); moving toward federal Criminal Background Check (CBC).
RI	Department of health policy	✓		✓	✓	✓					✓	State name search.
TX	Texas Occupations Code § 301.2511 Texas Government Code § 411.125	✓	✓	✓	✓	Have authority	Have authority					Doing RN CBC for 18 months; will begin LVN in near future. Plan to check all previously licensed nurses (10% a renewal cycle) for the next 10 years; researching doing checks on students.
UT	Nurse Practice Act	✓	✓		✓				✓	✓	✓	State/federal Name ID check.
WA		✓	✓						✓			
WI	Nurse Practice Act and State Law S. 440.03 (13)	✓	✓			✓					✓	State name search: Department of Justice.
WY	Nurse Practice Act and State Law	✓	✓		✓				✓	✓		

Attachment B-2

States That Do Not Require Criminal Background Checks (Winter 2004 — Spring 2005)

STATE	WHAT THEY DO
Alabama	Limited CBC phasing in now, board initiative and specific case/reason; Authority: Nurse Practice Act, only for licensees under investigation or others who give reason to believe they may have criminal histories, no fingerprints, just state databases.
Colorado	Only on nurse aides, questionnaire filled out, based on honor system; if applicant says yes, he or she must provide more information, such as letter of explanation, court documents, charges/convictions. A misdemeanor that is more than three years old can be on registry; if felony conviction is more than five years old, then board decides on case-by-case basis; if on current probation, typically not listed on registry.
Connecticut	No pending legislation.
Delaware	Ask applicants if they have been convicted of crimes and to submit the related court documents. It is an honor system.
District of Columbia	Facilities are required to do CBCs before hiring – so board feels it would be redundant.
Georgia	Waiting for change in statute.
Guam	Currently revising Practice Act and Rules and Regulations and will include CBCs as a requirement.
Indiana	Honor system.
Iowa	Committee beginning to working on it; currently asks two questions; honor system.
Kansas	Forms ask questions and applicant is required to self-report. If there are questions, may run a KBI check. Looking into CBCs and how to do it.
Maine	Endorsement and Examination, then check Nur*sys*®.
Massachusetts	Require "satisfactory evidence of good moral character," five yes/no questions with penalty of perjury; if found to be lying, automatic removal of license.
Michigan	Only if indicated on application, answers determine if investigation; penalty of perjury and discipline if found to be lying.
Minnesota	Initial intake form asks specifically, if found to be falsifying, nurse practice section — up for review.
Mississippi	Have specific questions on the application and there is a law requiring anyone employed/volunteering, etc., in licensed health care facilities.
Montana	MUST document in questionnaire; lying results in license removal (www.discoveringmontana.com/dli/nur).
Nebraska	Self report – one question, honor system. Grounds for discipline if found to be lying, not necessarily revocation of license, determination made on case-by-case basis.
New York	Only used in certain situations, legislative mandate, NYS Education Department Law, only required on applicants who answer yes to moral character questions, if answer is yes then they must submit documentation.
North Dakota	Check each applicant on Nur*sys*®. Also have a list of regulatory questions that need to be completed on a notarized document.
Northern Mariana Islands	Since response was not received, assumption is that CBCs are not required.
Pennsylvania	Only required when person reports, one question on application, case-by-case basis for those that report.
Puerto Rico	Since response was not received, assumption is that CBCs are not required.
South Carolina	Questions: if answer yes, do CBC; if no, honor system.
South Dakota	Indicated by questionnaire — do CBCs on those who admit to convictions. If lying, under investigation before board of nursing results in revocation or suspension. Convicted felons voluntarily refrain from practice or face emergency suspension.
Tennessee	Ask this question: "Have you ever been convicted of a crime other than a minor traffic violation?" If the response is yes: put a "hold" on the application and follow up with a request for additional information.

STATE	WHAT THEY DO
Vermont	Rely on disclosure on applications.
Virginia	On all applications individuals are asked to declare any and all misdemeanor and felony convictions with the exception of driving convictions. They then have to provide a certified copy of the court documents. All Nursing homes run criminal background checks on individuals and most hospitals do also. When Nursing students go to a hospital for their clinical experience the hospital will do a background on them.
Virgin Islands	Attorney Generals office pending.
West Virginia RN	Based on questions, case-by-case, if found to be lying goes to discipline.

Report of the Practice, Regulation and Education (PR&E) Committee

Recommendations to the Delegate Assembly

1. *The PR&E Committee members recommend adoption of the Position Paper, "Clinical Instruction in Prelicensure Nursing Programs."*

   Rationale

   This Position Paper was written in response to the 2004 Delegate Assembly resolution whereby NCSBN Members asked for guidance with evaluating clinical experiences in prelicensure programs. The Committee members reviewed the literature, consulted with experts, surveyed NCSBN Boards of nursing and education organizations, sought stakeholder input and participated in simulation in order to comprehensively study this question. The evidence supports the recommendations made in this Position Paper (Attachment A).

Background

The PR&E Committee was represented on the PN Focus Group that met in April of 2004. This Focus Group was an assemblage of national experts in practical nurse issues that convened to make recommendations to the Board of Directors about the LPN/VNs scope of practice. While PR&E was not charged with writing the "White Paper on the Scope of Practice of Practical Nurses" that was one of the outcomes from the PN Focus Group, the PR&E Committee members did make recommendations to and reviewed this White Paper. The "White Paper on the Scope of Practice of Practical Nurses" is available for the NCSBN membership (Attachment C) and will be distributed to external groups to begin a national dialogue on issues regarding the scope of practice of practical nurses.

The Committee charges related to developing transition models and identifying evidence-based indicators for quality nursing education programs are both ongoing charges. For the latter charge the Committee members developed a systematic review of nursing education studies that will provide boards with some evidence about strategies for teaching prelicensure nursing students. This can be found in Attachment D.

The Delegation and Assistive Personnel Subcommittee will be dissolved after this year.

Highlights of FY05 Activities

- After reviewing the literature, surveying the boards of nursing and nursing education organizations, seeking stakeholder input, consulting with experts and participating in simulated experiences, wrote a Position Paper, "Clinical Instruction in Prelicensure Nursing Programs."
- Wrote a systematic review of the evidence related to nursing education strategies: educational outcomes were cited; design was identified; sample was identified; comparison was identified, and in a noncomparison study the objective was identified; and implications for boards were identified.
- Reviewed status of elements study with the Director of Research and made recommendations.
- Gathered nursing literature that addresses transitioning new graduates to practice.
- Reviewed status of the transition study with the Director of Research and made recommendations.
- Continued to collaborate with the Vermont Nurse Internship Project (VNIP) regarding our transition study.

Members

Gino Chisari, MSN, RN, Chair
Massachusetts, Area IV

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Staff

Nancy Spector, DNSc, RN
Director of Education

Meeting Dates

November 4–5, 2004

February 10–11, 2005

April 1–2, 2005

April 15, 2005 (Conference Call)

April 20, 2005 (Conference Call)

May 10, 2005 (Conference Call)

Relationship to Strategic Plan

Strategic Initiative II
Promote evidence-based regulation that provides for public protection.

Strategic Objective 2
Support Member Board adaptation of best practices.

Strategic Initiative VI
Advance NCSBN as a key partner in nursing and health care regulation in the United States and internationally.

Strategic Objective 3
Facilitate the mobility of safe and competent international nurses by influencing public policy.

- Reviewed the work of the Delegation and Assistive Personnel Subcommittee and assigned a PR&E liaison to that committee and made recommendations.
- Reviewed the work of the International Nurse Issues Subcommittee via the PR&E liaison to that committee and made recommendations.
- Reviewed the continued competence documents and made recommendations.

Future Activities

- Review the work of PR&E Subcommittees. Recommended subcommittees for FY06 are:
  - Medication Aide Subcommittee: It is recommended that this committee investigate the use of medication aides in patient care delivery and develop a model and resources to assist Member Boards in planning for the incorporation of a medication aide into current regulations.
- Review the actions taken and the decisions made at the Delegate Assembly to determine if there are implications for the PR&E Committee and if so, recommend to the Board of Directors how that work should be conducted.
- Based on NCSBN research, PR&E's previous work and collaboration with nurse educators, develop evidence-based elements of nursing education programs that lead to safe entry-level practitioners to assist boards of nursing in making education regulatory decisions based on the data.
- Based on NCSBN outcomes research and PR&E's previous work on the transition, develop a regulatory model for transitioning new nurses into practice to assist boards of nursing to in making education regulatory decisions.

Attachment

A. Clinical Instruction in Prelicensure Nursing Programs

Appendix 1: Survey to the Boards of Nursing

B. Meeting the Ongoing Challenge of Continued Competence

Appendix A: NCSBN Timeline — Continued Competence Activities

Appendix B: Discussion of Continued Competence Challenges

Appendix C: Principles and Premises Identified in Previous NCSBN Documents"

C. "Practical Nurse Scope of Practice White Paper"

Appendix I: PN Focus Group Members

Appendix II: Algorithm for Discussion

Appendix III: The Desired Evolution of Regulation

D. "Systematic Review of Studies of Nursing Education Outcomes: An Evolving Review"

Attachment A

Clinical Instruction in Prelicensure Nursing Programs

National Council of State Boards of Nursing (NCSBN) Position Paper

April 18, 2005

NCSBN Practice, Regulation and Education Committee
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Executive Summary

Since the mission of the boards of nursing is to protect the public, the boards of nursing have the responsibility of making sure that new graduate nurses are prepared to practice safely. Therefore, the National Council of State Boards of Nursing (NCSBN) presents this Position Paper to provide guidance to the boards of nursing for evaluating the clinical experience component of prelicensure programs. NCSBN's Practice, Regulation and Education (PR&E) Committee members reviewed the available literature, surveyed the boards of nursing and nursing education organizations, sought stakeholder input, consulted with experts and participated in simulated experiences to provide the rationale for this Paper. The PR&E Committee members realize that there is the need for more research of clinical education in nursing. The recommendations, therefore, are based on the best available evidence at this point in time.

The PR&E Committee recommends the following positions:

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

Premises

1. The mission of the boards of nursing is the protection of public health, safety and welfare.
2. Regulation criteria for nursing programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection.
3. The curriculum in nursing education programs is faculty driven, reflective of the parent institution's mission and based on national standards.

4. Nursing is a practice discipline.
5. Program outcomes are consistent with the knowledge, skills and abilities required for safe and effective provision of nursing care.
6. Nursing programs prepare lifelong learners who practice in complex and dynamic environments.
7. Nursing faculty members facilitate the students' development of clinical judgment and critical thinking abilities necessary for safe and effective practice.
8. Prelicensure nursing education programs prepare nursing students for entry into practice as generalists.
9. Nursing regulation recognizes the value of evidence-based innovation in meeting nursing education program outcomes.

Definitions

1. Across the lifespan — An understanding of all phases of human life.
2. Competence — Competence is 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 (Model Practice Act and Rules, NCSBN, 2004).
3. Clinical judgment — Clinical judgment is the application of the nurse's knowledge and experience in making decisions about client care (Model Practice Act and Rules, NCSBN, 2004).
4. Critical thinking — Critical thinking is the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning or communication, as a guide to belief and action (Scriven & Paul, 2005).
5. Deliberate practice — Deliberate practice takes place with an engaged learner and involves repetitive performance of intended psychomotor or cognitive skills in a focused domain, coupled with (1) rigorous skills assessment that provides learners (2) specific, informative feedback, that results in increasingly (3) better skills performance, in a controlled setting (Issenberg et al., 2002).
6. Distance education — Distance learning incorporates teaching/learning strategies used to meet the learning needs of students, when the students and faculty are separated from each other (Adapted from the Model Practice Act and Rules, NCSBN, 2004).
7. Hands-on clinical instruction — Hands-on learning situations are those where students directly care for patients within the relevant setting. "Sufficient" hands-on clinical instruction means adequate time spent directly with patients under the supervision of a qualified faculty member, so that program outcomes are met.
8. Qualified nursing program faculty — Qualified faculty members in nursing programs are those who meet the board of nursing faculty qualifications for that state, as well as the qualifications for the parent institution.
9. Program outcomes (expected) — Expected program outcomes are specific, measurable indicators of program quality and effectiveness as reflected in both student and faculty outcomes. Evidence of program effectiveness is shown in the evaluation of actual outcomes in relation to expected outcomes (CCNE, 2003).
10. Simulation — Simulations are activities that mimic the reality of a clinical environment and are designed to demonstrate procedures, decision-making and critical thinking through techniques such as role-playing and the use of devices such as interactive videos or mannequins. A simulation may be very detailed and closely simulate reality, or it can be a grouping of components that are combined to provide some semblance of reality (Jeffries,

2005).

11. Situated cognition — Situated cognition is a learning theory that is based on the premise that learning is influenced by the situation in which it occurs. This theory of learning requires interaction by the learner and is most effective when it takes place in an authentic environment with learners working on real-world activities (Scheppke, 2004).
12. Supervised clinical instruction — The role of qualified nursing program faculty in facilitating student clinical learning (Adapted from the Model Practice Act and Rules, NCSBN, 2004).

Introduction

The Practice Regulation & Education (PR&E) Committee was charged with writing a Position Paper to provide guidance to boards of nursing for evaluating the clinical experience component of prelicensure nursing programs. Since the mission of the boards of nursing is to protect the public, boards have the responsibility of making sure that new graduates are prepared to practice safely. Recent discussion has focused on whether nursing educational programs leading to initial licensure can successfully educate nurses with alternative methodologies that take the place of traditional clinical experiences. In response to this concern, the 2004 Delegate Assembly passed the following resolution:

Resolved that NCSBN and its Member Boards support the necessity for inclusion of planned, structured, supervised clinical instruction across the life-span as essential to nursing education; and be it further resolved that the issue of ensuring clinical competence in prelicensure programs be referred to NCSBN's Practice Regulation and Education Committee to research and develop a position statement that provides guidance to nursing boards in evaluating whether entry-level nursing applicants have received sufficient hands-on, effective, supervised clinical nursing education to ensure safe nursing practice, in both traditional and alternative educational nursing programs utilizing distance learning, simulation laboratories and other technical innovations; and that the PR&E Committee shall report back at the 2005 Delegate Assembly.

The PR&E Committee engaged in the following activities in response to this charge:

- Reviewed the relevant literature, including systematic reviews of medical simulation, computer-assisted learning in undergraduate medical education and nursing education strategies.
- Surveyed all the boards of nursing.
- Surveyed nursing education organizations and reviewed their responses regarding comments on clinical education requirements in prelicensure nursing programs.
- Consulted with a renowned expert in simulation, Dr. William McGaghie from the Northwestern University Feinberg School of Medicine, about simulation.
- Participated in a facilitated, simulated experience at the Patient Safety Simulator Center at Northwestern University Feinberg School of Medicine.
- Engaged in dialogue with a simulation facilitator at the Patient Safety Simulator Center.
- Sought stakeholder input and reviewed the recent position statement by the American Organization of Nurse Executives (AONE), "Position Statement: Prelicensure Supervised Clinical Instruction."

The NCSBN Position Paper was presented at the May Board of Directors meeting, where it was unanimously approved.

Literature Review

Through other work being conducted by the PR&E Committee, it was determined that the online databases of CINAHL, Medline and ERIC be used with the keywords of: *education, nursing, teaching,*

education research, learning methods, learning strategies, research-based education and *outcomes of education*. These studies were evaluated for relevance for this position statement. The primary research on nursing clinical education research was limited. Specifically, there was no research on the outcomes of programs that exclusively use alternatives to clinical experiences.

The following is a focused review of relevant studies in clinical education on how students learn to practice safely in clinical situations. In order to be evidence-based this review includes either studies or systematic reviews (Mayer, 2004), though PR&E also included some relevant state-of-the-art reviews from nursing or health care literature.

Theoretical background

Dr. Patricia Benner is well known in the nursing community for her work over the past 21 years with the Dreyfus model of skill acquisition. Recently she has written about her studies in nursing using the Dreyfus model, in an article entitled "Using the Dreyfus model of skill acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education" (Benner, 2004). The Dreyfus model is developmental and is based on experiential learning. Benner writes that nursing requires both *techné* and *phronesis*. Techné is defined as explicit knowledge that can be captured from procedural or scientific knowledge. For techné, Benner gives the example of providing clear parameters and guidelines to students for determining fluid balance. At this stage the learner cannot rely on previous experience, so the student must be given safe, clear directions on how to proceed. For adequately teaching techné the nursing program must provide for specific situated learning in the clinical situation, though students would benefit from previous simulated experiences.

Phronesis, on the other hand, is more complex; it is a reasoned practice employed by expert clinicians through experiential learning, where the nurse is continually improving her or his practice. According to Benner, the integrated, rapid response is the hallmark of phronesis (Benner, 2004, p. 196). Benner (2004, p. 197) gives a complex example of phronesis where the nurse made some rapid decisions when the patient developed a carotid hemorrhage. Phronesis is learned in the authentic situation with patients and feedback from experts.

Dr. Benner's stages of skill acquisition include the "novice," or the period in the nursing program when students have no experiential background on which to base their approach or their understanding of the clinical situation; "advanced beginner" or new graduate; "competent" or one to two years in practice; "proficiency," a transitional stage on the way to expertise; and "expertise," which involves practical wisdom or phronesis. For the purpose of this position statement, the focus is on the stages of the novice and advanced beginner. In the novice stage the nursing instructor carefully selects patients that are stable and predictable. As with the earlier discussion of techné, Benner (2004) suggests that the novice operates from the perspective of inflexible, rule-governed behavior. Benner (2004, p. 191) states, "Skills that are performed easily on a mannequin in a skills lab require adaptation and communication and reassurance skills when performed on a range of patients who may be calm or highly anxious." Qualified faculty provides coaching, feedback and reflection throughout the nursing education program. As graduation approaches, students are expected to function at the "advanced beginner" stage of skill acquisition. Newly licensed graduates, who function as advanced beginners, have a heightened awareness of feedback and they frequently experience anxiety and excessive fatigue (Benner, 2004).

Closely linked to Benner's work with the Dreyfus model is Ericcson's (2004) sentinel review of deliberate practice. Ericcson (2004, p. S74) analyzes deliberate practice in this review, which he defines as practice that must be designed to improve specific aspects of performance that can easily be integrated into one's practice. The concept of deliberate practice would support learning nursing skills and even critical thinking and judgment, in sophisticated simulation centers or in a controlled environment with mentor guided feedback. However, it also would require that the student or practitioner become engaged in deliberate practice with patients in the representative

context (the clinical setting) with a master teacher who can give excellent feedback. Deliberate practice also means that clinical teaching should be designed to improve specific aspects of performance, thus providing students with specific expected outcomes.

There is further support for clinical learning from the Situated Cognition theory, which is a theory of learning that is based on the premise that all learning is influenced by the situation where it occurs (Scheppke, 2004). This is an emerging theory that has been studied in education, anthropology, sociology, cognitive science and psychology. Situated cognition theory represents a shift in some of the traditional psychological theories of learning to view learning as emergent and social (Lave & Wenger, 1991). While health professions have not yet formally studied this theory, it is highly relevant to this profession. The goal of Situated Cognition, according to Scheppke (2004), is to help the student develop higher-level thinking and reasoning skills, which are an integral part of nursing. This research has focused on the importance of the faculty in bringing the student to an authentic environment (the real world) to learn. Applying the principles of Situated Cognition theory, student nurses must practice in authentic situations.

The role of the teacher in the Situated Cognition theory is that of a facilitator. The clinical teacher models effective strategies in an authentic environment, serving as a coach by providing feedback and advice. The assessment of students in this theory focuses on the process of learning as well as the product, so that portfolios are often one method of evaluation (Scheppke, 2004). Because learning is a social experience, teachers often create "learning communities" where the students can exchange ideas and provide feedback to each other (Lave & Wenger, 1991).

Studies with students and faculty

White (2003) studied how 17 fourth-year nursing students learned clinical decision-making, using a qualitative study design. This study identified five components that are associated with clinical decision-making, including: gaining confidence in their skills, gaining comfort in self as a nurse, building relationships with staff, connecting with patients and understanding the clinical picture. These components require deliberate practice within the authentic environment, which is essential to teaching nursing students.

The confidence component in the clinical setting, as well as gaining comfort in one's role as a nurse, has been mentioned by other studies as being important when learning from the clinical context (Benner, 2004; Bjørk & Kirkvold, 1999; Yates, Cunningham, Moyle & Wollin, 1997). Yet, there is a paucity of studies on relating these clinical decision-making components with improved outcomes of learning in the clinical setting. Many agree that lack of confidence and anxiety can interfere with student learning in the clinical setting (Benner, 2004; Yates et al., 1997). Therefore, Yates et al. (1997), in Australia, conducted evaluation research on a peer mentorship program that was used to prepare students for learning in the clinical setting. The mentorship program consisted of five group sessions with first year students (four to seven volunteers per mentor) meeting with second year students. The mentors were identified by faculty members using set criteria and the mentors attended a six-hour orientation session to teach them about the role. Evaluation of the program was comprehensive, with pre- and post-program questionnaires, a focus group interview, review of peer mentors' journals and a statistical analysis of the differences in clinical performance (from clinical instructor ratings) between the 55 protégés and 55 randomly selected students who weren't in the program. While they found no significant differences between the mentored group and the control group related to the clinical instructor ratings, they did find from qualitative data that the protégés and mentors reported increased confidence and decreased anxiety before entering the clinical setting because of this program. The first-year students also reported that the mentorship experience helped them to understand the importance of integrating theory and practice before they began to practice with actual patients. While there were limitations of this pilot study, such as the selection effects (because the protégés were volunteers), the evidence showed benefits in increasing confidence levels and it is worthy of future investigation.

The components of building relationships with staff and connecting with patients are particularly

important in light of the Institute of Medicine's Report on education in the health professions. This highly regarded Report identifies working within an interdisciplinary team and patient-centered care as two essential competencies for all members of the health care team (Greiner & Knebel, 2003). The other essential competencies identified by the IOM Report are evidence-based practice, quality improvement approaches and informatics. The Report particularly criticizes health care educators for not teaching students in health care professions how to work within interdisciplinary teams. The Report laments the fact that in many education settings the health professionals are socialized in isolation and the Report stresses the importance of cooperation and coordination in caring for patients. NCSBN has found that when newly licensed nurses did not work effectively within a health care team or did not know when and how to call a patient's physician, they were more likely to report being involved in patient errors (Smith & Crawford, 2003). This finding provides evidence that working within an interdisciplinary team is important for patient safety.

Angel, Duffey & Belyea (2000) studied critical thinking performance in nursing students, related to White's (2003) clinical decision-making component of understanding the clinical picture. In this longitudinal, quasi-experimental design with 142 junior nursing students, they used two interventions (structured versus non-structured health pattern assessment) to study learning outcomes in two areas: acquisition of knowledge and development of critical thinking skills. Their results showed that the characteristics of their learners (e.g., age or previous degree) affected which teaching strategy was more effective. Age and a previous degree did not influence changes in critical thinking or the knowledge score. However, the results did show that the younger learners tended to have better outcomes with the more structured approach, while the older learners improved more with the unstructured approach. Students without previous degrees tended, as well, to benefit more from the unstructured approach to the health assessment assignment. Most importantly, though, this study clearly provides evidence that a learner's knowledge and critical-thinking improve after a semester of faculty-supervised clinical experiences. This evidence suggests that clinical experience with actual patients improves nursing practice.

In Norway Bjørk & Kirkvold (1999) videotaped three sessions of four newly graduated nurses over a one-year period while they performed two nursing skills. This study clearly showed the importance of feedback and reflection in order for new nurses to improve their practice. By the third filming the four nurses had practiced for eight to 14 months and had accumulated about 25 experiences with both skills. While there was some improvement, there were many omissions and faults with their performances. Often the nurses were working in isolated situations so that to receive feedback and then to reflect, they'd have to seek guidance on their own. New nurses are often reluctant to seek guidance from experienced nurses, partly because of the pace in clinical nursing. Though the study focused on graduate nurses, the study supports the need for qualified faculty members to provide students with feedback so that they can reflect on their performances and ultimately improve.

Platzer, Blake & Ashford (2000) likewise studied reflective practice in two cohorts of students in England for more than two years, via a qualitative study methodology using audio-recorded interviews and categorizing the themes that emerged. Students involved in reflective practice reported significant development of their critical thinking ability, greater autonomy in decision-making and more self-confidence to question the status quo and make their own judgments. Engaging in reflective practice was instrumental in assisting them to relate their theoretical knowledge to practice. Similarly, Joubert, Viljoen. Venter, & Bester (2002) report in their study of 120 nursing students that immediate feedback can increase student application of knowledge in the clinical setting. It is clear from studies that the themes of immediate feedback and the opportunity to reflect in the context of practice are essential for the development of entry into clinical practice competencies.

Online and simulation teaching methods.

A recent systematic review on simulations in medicine shows that, while research on simulations needs improvement in terms of rigor and quality, simulations in health care are educationally effective and simulation-based education complements medical education in patient care settings (Issenberg, McGaghie, Petrusa, Gordon & Scalese, 2005). In their rigorous systematic review of the literature, Issenberg et al. (2005) originally identified 670 articles, with 109 surviving after their use of four screening criteria. The following are the best available evidence, to date, on how simulations can enhance learning:

- Providing feedback (47% of articles)
- Repetitive practice (39% of articles)
- Curriculum integration (25% of articles)
- Range of difficulty level (14% of articles)
- Multiple learning strategies (10% of articles)
- Capture clinical variation (10% of articles)
- Controlled environment (9% of articles)
- Individualized learning (9% of articles)
- Defined outcomes (6% of articles)
- Simulator validity (3% of articles)

Similarly, Nehring, Ellis & Lashley (2001) describe the use of human patient-simulators in nursing education as an excellent tool to measure competency in the application of knowledge and technical skills. Debriefing, or feedback to the students, is as essential for simulation as it is for instruction in the clinical setting. Nehring et al. (2001) describe the advantages of simulation, based on the literature, as being able to:

- Visualize and observe the physiological effects on the human body;
- Observe effects of medications;
- Practice in a safe environment, seeing the consequences when wrong decisions are made;
- Enhance prior learning;
- Improve student confidence, decision-making and critical thinking;
- Provide opportunities for self-study;
- Utilize structured experiences;
- Involve undergraduate and graduate students;
- Allow for the evaluation of the students' competencies.

The disadvantages may include:

- Students feel inadequate in handling critical incidents ;
- Students focus on the incident and not the total picture;
- Students sense the artificiality;
- Cost;
- Only small numbers of students can practice at once;
- Faculty time and training.

There is some research that has shown that clinical performance improved with students who were

educated with simulators (Steadman, Oyesola, Levin, Miller & Larson, 1999). Further research is needed on simulation in nursing education and on other innovative teaching strategies.

Greenhalgh (2001) conducted a systematic review of computer-assisted learning with medical students. The author identified 200 potentially relevant studies from the databases and terms he used, though only 12 met his criteria of being prospective, randomized studies of medical students, with objective, predefined criteria. He found that the results with using online education were mixed, but generally positive. Greenhalgh (2001) concluded that computer-assisted teaching should be employed by senior (not junior) faculty members, because it needs to be conceptually integrated with other forms of learning. Yet, younger faculty members are often more computer savvy than older, more experienced faculty. Therefore, currently these inexperienced faculty members are frequently the ones in an institution who teach computer-assisted learning. A barrier that was identified was the ability to engage learners with this methodology. It was strongly recommended that this method of teaching be used with other traditional methods of teaching, and not by itself.

Other Evidence

The PR&E Committee worked with the NCSBN Director of Research to construct an online survey that was sent to all 60 boards of nursing and the LPN and RN nursing educational organizations: American Association of Colleges of Nursing (AACN), Commission on Collegiate Nursing Education (CCNE), National League for Nursing (NLN), National League for Nursing Accrediting Commission (NLNAC), National Organization of Associate Degree Nurses (N-OADN), National Association of Practical Nurse Education & Service (NAPNES) and National Federation of Licensed Practical Nurses (NFLPN). This electronic survey was sent out January 26, 2005. A total of 36 boards of nursing replied to the survey, though not all of the boards replied to every question. A majority of the boards of nursing replying to the survey defined clinical experiences as "hands-on" nursing experiences. The boards tended to require higher faculty qualifications for classroom teaching than for simulation or clinical teaching. While many boards say that "supervised" clinical experience is defined as a clinical instructor being physically present, a majority of the boards that responded do not define that term. Of the 31 boards that answered the question asking whether students should practice on actual patients, 28 said yes, while three said no. The boards responded that nursing is a practice discipline in which safety is involved, and that students cannot learn critical thinking without practicing with actual patients. Similarly, when asked whether students can achieve their objectives in a nursing program without supervised clinical experiences, 27 said no and four said yes. A large majority of the boards of nursing favored clinical experiences in prelicensure programs to be across the lifespan. Of the 31 boards answering this question, 27 thought the experiences should be across the lifespan, while 4 said that wasn't important. Therefore, it is clear that a large majority of the respondents think that direct care of patients across the lifespan is essential in a nursing program.

Yet, there is variability on how structured the boards of nursing should be in requiring clinical experiences with actual patients. Of the 28 answering the question on whether predetermined hours should be required, the results were more variable. While 17 said yes, 11 said no. The nursing boards, by a large majority (19 of the 30 comments), replied that the measure they use to demonstrate clinical competency of new graduates is graduation from an approved nursing program. In other words, the boards of nursing say that their approving a nursing program means presuming that when students graduate they will be clinically competent.

When asked about the future of education, the boards' responses addressed two major issues: increasing use of technology for teaching clinical experiences and making the most of clinical sites and learning centers. The boards of nursing predicted that there would be more clinical education using simulation, clinical laboratories and online learning. Because of the shrinking number of clinical sites that are available, the boards anticipated that there would be enhanced and smarter use of clinical sites by the nursing programs, as well as sharing of sophisticated simulation centers. One board stated, that the nursing programs and boards of nursing "…will

need to focus on the quality and not the number of hours."

Some of the boards predicted an increase in the use of preceptors, along with partnership agreements between practice and education so that more clinical agency nurses would assist in the education of students. One board stated that this would require competency updates on faculty members. Yet, an increased use of preceptors clearly concerned some boards. One board stated, "I don't think this speaks well for the profession, to be predominantly apprentice learning rather than being exposed to research-based clinical education." Other boards predicted the future would bring more postgraduate internship or residency programs for newly graduated nurses.

The nursing education organizations did not all respond (two out of five responded) to the electronic questionnaire; those that did respond did so mainly with comments. One nursing education organization commented that the clinical nursing literature focuses on competent performance and student-centered learning in nursing programs, moving away from rigid parameters. Another organization stated "…it is our responsibility to offer educational opportunities for our members that encourage innovative teaching strategies, including exploration of clinical settings and experiences." None of the nursing educational organizations responded to the question about whether nursing programs should have clinical experiences where students work with actual patients. When commenting about the future of nursing clinical education, one organization responded that their members have difficulty finding acute care settings for pediatrics, obstetrics and psychiatry, and the programs are exploring alternative experiences. The organizations lamented the decreased availability of clinical sites for nursing programs and one organization worried that the nursing shortage would mean less acceptable staffing on units, thus not providing students with optimal clinical experiences. Another organization predicted that there would be alternative approaches to teaching clinical application to nursing students because of the nursing faculty shortage, including an increased use of part-time faculty members and more simulated experiences.

The American Organization of Nurse Executives (AONE) disseminated the following position statement, regarding supervised clinical experiences in nursing programs, in September 2004:

Position Statement: Prelicensure Supervised Clinical Instruction

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

AONE also believes that the education programs for the nurses of the future will require a balance of didactic content and supervised clinical instruction. Although innovative approaches may be developed, it is the position of AONE that all prelicensure nursing education programs must contain structured and supervised clinical instruction and that the clinical instruction must be provided by appropriately prepared registered nurses.

Simulation experience

Dr. William McGaghie, Professor at the Northwestern University Feinberg School of Medicine and a renowned expert on simulation, consulted with the PR&E Committee about simulation and Committee members participated in a simulation session at Northwestern's Patient Simulator Center. The group learned that simulation is a complement to clinical experience, and it's valuable because it incorporates deliberate practice, as discussed by Ericcson (2004). Simulation provides self-paced education with outcomes that are safe for everyone. Educators do not need the most expensive simulation devices in order to teach clinical practices. Sometimes very simple devices can be quite valuable. When used correctly, the students can learn how to improve their practice. While simulation technology works well and helps a great deal with clinical practice,

Dr. McGaghie stressed that simulation is not a substitute for, but a complement to, supervised clinical practice. When students experience good simulation before their clinical experiences, they develop a sense of self-confidence, which was identified in the literature review as being important. This is a methodology that not only teaches excellent individual performance, but it enhances team performances. Working in a team was discussed in the literature review as being essential for nurses. Feedback is the key to both in simulation and in supervised clinical experiences.

It was clear that the faculty teaching simulation must be trained in this methodology in order to engage the students and to give excellent feedback. The cost of simulation not only means the initial investment, but there is ongoing maintenance and training. High fidelity simulation centers (providing authentic situations) are not universally affordable. It was estimated that Northwestern University Medical School spends about $1,000 per each hour of simulation education. Therefore, nursing programs might choose to collaborate with other health care educators in order to maintain a sophisticated simulation center or choose to purchase less sophisticated equipment.

Conclusion

Because the mission of the boards of nursing is to protect the public, the boards asked for guidance with evaluating prelicensure nursing programs that do not provide experiences with actual patients. Therefore, the NCSBN Practice, Regulation and Education Committee, using various methodologies, studied clinical education. Premises were identified and terms were defined. The theoretical literature supported situated learning and practicing deliberately in the authentic situation, along with the need for specific educational goals. The nursing literature particularly addressed the importance of feedback and reflection in learning to think critically and to assist with improving students' confidence levels. Building interdisciplinary relationships was identified as important for nurses, and this competency is learned best contextually. The online and simulation literature supported the complementary use of these methodologies for teaching prelicensure nursing students, though they cannot take the place of actual patient care. The survey results showed that boards of nursing strongly support clinical experiences with actual patients across the lifespan, but they are more divided as to requiring specific hours. The nursing education organizations did not address the question of whether it is essential for prelicensure nursing students to practice with actual patients, though their comments were similar to those from the boards of nursing when asked about the future of clinical education in nursing. One nursing organization (AONE) took the position that nursing programs should provide structured, supervised clinical instruction. Meetings with renowned simulation experts stressed that deliberate, controlled practice with simulators is an important asset for clinical learning, but that it cannot take the place of learning in the authentic setting.

Recommendations

It is the position of NCSBN that:

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

References

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Attachment B

Meeting the Ongoing Challenge of Continued Competence

Properly conceived and executed, regulation can both protect the public's interest and support the ability of health care professionals and organizations to innovate and change to meet the needs of their patients.

— *Crossing the Quality Chasm*, 2001

I. Introduction and Purpose

Nursing is a profession that requires the application of substantial knowledge, skills and abilities. The unsafe or unethical practice of nursing could cause harm to the public unless there is a high level of accountability (Sheets, 1999). Thus, it is the responsibility of boards of nursing to hold nurses professionally accountable. The regulation of nursing is all about public protection and patient safety. As the pace of technological and scientific development accelerates, one of the greatest challenges to all health care practitioners is the attainment, maintenance and advancement of professional competence. In 1995, the Citizen Advocacy Center (CAC) asked the question, "Can the public be confident that health care professionals, who demonstrated minimum levels of competence when they earned their licenses, continue to be competent years and decades after they have been in practice?" CAC's response in 1995 was: "No" (Swankin, 1995). Ten years later, nursing is still seeking an answer.

The National Council of State Boards of Nursing (NCSBN) has long acknowledged continued competence as a critical regulatory issue for boards of nursing. In an effort to have language applicable to all practitioners at every level of practice, NCSBN defined competence as "the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health" (NCSBN, 1996) (See Attachment A for a chronological listing of NCSBN activities, beginning in 1985).

Continued competence has been studied and discussed. There have been proposed regulatory approaches but there has not been agreement on what to do about it. The nursing profession "…has clearly seen the need for continuing competence but has grapple with how this can be universally accepted by all nurses." (Bryant, 2005, p. 25) Increasingly, licensing boards are being challenged to provide assurance to the public that licensees meet minimum levels of competence throughout their careers, and not only at the time of entry and initial licensure. Continued competence is a critical challenge for regulatory boards in the 21st century and it is time to address that challenge.

II. Background

While some boards of nursing have addressed the challenge with state initiatives, there has not been an elegant national regulatory solution for evaluating continued competence. Why is this so?

- Competence is multifaceted and may be difficult to measure.
- The sheer volume of nurses in practice makes it difficult to identify feasible and meaningful, yet cost-effective, regulatory approaches.
- There is no agreement on who should be responsible for continued competence.
- Nursing careers take widely divergent paths, varying by professional roles, settings, clients, therapeutic modalities and other professional criteria as well as level of health care delivery.
- In addition, there is the inherent evolution of practice from the new graduate entry-level to the experienced-focused practice level of competence.

- It is not clear what standard should be used to evaluate continued competence. Should the standard be based upon:
  - Current entry-level competency for the profession (i.e., NCLEX)?
  - Generalist core competency at each licensure level (RN, LPN/VN, APRN)?[1]
  - Focused areas of practice?
  - Essential emerging knowledge?
  - Some combination of the above?
  - Something not yet identified and/or articulated?
- It is not clear how to evaluate whether a standard has been met.
- It is not clear what to do if a licensee cannot demonstrate continued competence (NCSBN, 1996).

These are challenging issues that NCSBN has been struggling to address (See Appendix A for a more detailed discussion of these background questions), but after many years there are still insufficient answers. Rouse observes that a "…perfect solution — simple, effective, inexpensive and acceptable to all — does not exist and is unlikely to ever be realized." (Rouse, 2004) A better approach may be to work around these issues and ask some new questions.

III. New Questions

What are some new questions that may help us look out of, around, under and over the box?

A. How can boards of nursing be more effective in protecting the public?

Boards could be more proactive in providing the public assurance that practitioners continue to be safe years after completing education and first becoming licensed. When legal authority for nursing practice was granted to registered nurses at the beginning of the 20th century, and to licensed practical/vocational nurses mid-century, it brought nursing a new level of professionalism. Now, at the beginning of the 21st century, in a time of unprecedented challenges and coping with new knowledge and advancements in technology, knowing that at one point in time a nurse was qualified is not enough. Boards have a role in assuring the public that licensed nurses meet minimum standards of competence throughout their professional lives.

B. Assuming there is not a perfect regulatory solution that would guarantee the continued competence of all nurses, what could the boards require that would be credible with the public and acceptable to the profession?

In the interest of public protection, jurisdictions have strict requirements for obtaining initial licensure. However, requirements for licensure renewal are generally less stringent. One approach is to replace current periodic renewal processes with more substantive requirements for "licensure maintenance."

C. Why should nurses have to do more to maintain licensure?

Licensure is a privilege and each licensed nurse has responsibility to the licensing entity granting the authority to practice and to the public who receives nursing services. This responsibility includes the duty to attain and maintain licensure. Just as the board identifies the requirements for initial licensure, the board also identifies the requirements to renew licensure. Currently, for most boards, that means paying a fee and avoiding serious disciplinary action. Requiring a licensee to maintain licensure means the board would need to articulate credible and meaningful requirements for ongoing licensure.

[1] Generalist core competence could consist of those content areas that course all nursing roles and all nursing settings for each level of licensure.

D. What could demonstrate licensure *maintenance?*

Licensure maintenance could include multiple elements, but should start with an assessment of the nurse's practice to direct professional development activities. In 1991, NCSBN first articulated that learning strategies, such as continuing education, should be selected on the basis of assessment to identify learning needs.

E. What are activities that have credibility with the public and are meaningful to nurses?

The public needs assurance that nurses have current knowledge and are safe practitioners. The nurse needs the incentive of value added to a nurse's career and practice. Accordingly, the public looks for requirements that demonstrate currency and ability to practice safely. Nurses would benefit from requirements that are relevant to the nurse's practice, promote professional development and can be used to meet the multiple demands of employers, boards and others.

F. Licensure maintenance rather than continued competence — isn't this just semantics?

How language is used is important for how a proposal is perceived. For example, if a nurse does not obtain continuing education (CE) hours, does that really mean that he or she is incompetent? Or does it mean the nurse didn't take CE courses? If a nurse takes the requisite continuing education course, does that show that the nurse is really competent? Or does it mean that the nurse signed an attendance sheet at a class?

Talking about continued competence makes professionals feel singled out and vulnerable. The concept of continued competence is intended to encourage practitioners to maintain their practice. But it is threatening to many. There is fear of the licensing board. There is fear of losing one's livelihood. There is fear of failure.

Licensure maintenance implies universality, something required of everyone. It may allow people to get past the rhetoric and focus on the real challenge — the identification of substantive content for renewal requirements.

IV. Who is Asking?

Ben Shimberg, who was a nationally recognized expert in testing, credentialing and professional regulation, first became interested in continued competence in 1967 because of the work of a governmental commission created to address the question of "medical obsolescence." That commission stated that simply making educational opportunities available was not enough — there had to be incentives to insure that physicians and other health professionals kept up-to-date and maintained the skills to deliver high quality care (CAC, 1996). In 1970, the U.S. Public Health Service called for the development of more sophisticated approaches tied to relicensure or recertification (suggesting the consideration of peer review, reexamination, self assessment and supervisory assessment as well as continuing education) (CAC, 1996).

The NCSBN Nursing Practice & Education (NP&E) Committee considered the measurement of competence from an empirical and standard-setting perspective in the 1991 Paper "The NCSBN Conceptual Framework for Continued Competence." This Paper stressed the importance of both assessment (to determine learning needs) as well as strategies to promote continued competence (NCSBN, 1996).

In "Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century," the Pew Task Force on Health Care workforce Regulation recommended, "(3) States should base their practice acts on demonstrated initial and continued competence… [and] (7) States should require each regulatory board to develop, implement and evaluate continuing competence requirements to assure the continuing competence of regulated health care professionals…" (Pew, 1995).

In 1996, the Essential and Continued Competence Subcommittee completed a new Position Paper entitled "Assuring Competence: A Regulatory Responsibility," that incorporated the definition of competence referenced above, standards for competence (see Appendix B) and a Model for

Individual Competence Evaluation (NCSBN, 1996).

In 1998, the NP&E Committee, building upon previous NCSBN work, developed the Continued Competence Accountability Profile (CCAP). CCAP was a portfolio approach where the nurse applied the steps of the nursing process — assessment, planning, implementation and evaluation — to the nurse's own professional development (NCSBN, 1998). CCAP was presented at the 1998 Area Meetings as an alternative to continuing education. The response of the Membership at that time was that the concept was interesting, with many excellent elements. However, CCAP was viewed as too complex and not administratively feasible as a regulatory approach to continued competence.

The Institute of Medicine (IOM) stunned the nation in 1999 with, *To Err is Human: Building a Safer Health System*, which reported that between 44,000 and 98,000 people die each year from preventable medical errors (IOM, 1999). This Report addressed a whole range of errors from omissions to commissions to inappropriate therapies. A major concern identified is the length of time between the discovery of more effective treatments and their incorporation into routine patient care. This has direct implications for how practitioners stay current in their knowledge and skills. The IOM recommended the implementation of periodic reexamination and relicensing of physicians, nurses and other providers based on competence and knowledge of safety practices, and to work with certifying and credentialing organizations to develop more effective methods to identify and take action when providers are unsafe (IOM, 1999).

In *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine observed that "There are no consistent methods for ensuring the continued competence of health professionals within the current state licensing functions or other processes" (IOM, 2001).

In April 2003, the IOM issued another Report entitled *Health Professions Education – A Bridge to Quality*, which viewed professional competency assurance as the shared responsibility of public and private sectors.

> Recommendation #4: *All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care — as defined by the five competencies defined by the Committee*[2] *— through direct measures of technical competence, patient assessment, evaluation of patient outcomes and other evidence-based assessment methods. These boards should simultaneously evaluate the different assessment methods* (IOM, 2003).
>
> Recommendation #5: *Certification bodies should require their certificate holders to maintain their competence throughout the course of their careers by periodically demonstrating their ability to deliver patient care that reflects the five competencies, among other requirements* (IOM, *Bridge*, 2003, p. 9).

Keeping Patients Safe: Transforming the Work Environment of Nurses acknowledged that "prelicensure or pre-employment education cannot provide sufficient frequency and diversity of experiences… in the performance of every clinical nursing intervention needed for every clinical nursing intervention needed for patients." (IOM, *Nurses' Work Environment*, 2003, p. 203). This is amplified in the face of the growth of new knowledge and technology.

The NCSBN research project, *Evaluating the Efficacy of Continuing Education Mandates* (Smith, 2003) revealed how professionals perceive they have attained professional development. That study showed that work experience is a stronger contributor to the growth of abilities than continuing education, working with mentors or self-study. This research was used to support the continued competence approach used in the current *NCSBN Model Nursing Practice Act* and

[2]The authors of the IOM Report believe that all health care professionals should be educated to deliver patient centered care, as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches and informatics (IOM, 2003).

Model Nursing Administrative Rules, adopted by the 2004 NCSBN Delegate Assembly, require 960 practice hours rather than continuing education (NCSBN, 2004).

In 2004, the Citizen Advocacy Center (CAC) presented the *CAC Road Map to Continued Competence*, built upon ten principles:

1. Using **collaboration** among a broad base of stakeholders
2. For the purpose of **quality**
3. Using **evidence-based** approaches
4. That **build upon what works**
5. With a **uniform definition of competence** across all health field professions
6. It must be **mandated** to be successful
7. It must be a **clinician responsibility** that positively develops careers.
8. The cost should be borne by health professionals, **using licensing fees to pay for competency assurance**
9. **Due process** must be respected and balanced with the public's **right to know**
10. **Licensing boards should have ultimate authority** (CAC, 2004).

The CAC Road Map consists of a two phased plan built upon the action areas of conducting research, seeking legislative and regulatory mandates, using evidence-based methods to demonstrate continuing competence, changing education programs, financing, continued competence programs and reforming continuing education programs (CAC, 2004). The plan includes national meetings to build consensus and identify priorities as well as pilot projects to study the reliability, validity and accuracy of various assessment and assurance methods (CAC, 2004). The targeted destination to be reached via the road map is "a destination where all health care professionals periodically demonstrate their competence through one of a variety of acceptable methodologies." (CAC, 2004). A final resource put forward by CAC is a five-step model for the individual practitioner that includes routine periodic assessment, the development of a personal plan, the implementation of a personal plan, documentation of all steps and demonstration/evaluation of competence (CAC, 2004).

V. Review of Approaches Already in Use

NURSING REGULATION

Currently, the most common continued competence requirement for nursing licensing boards is continuing education, which is required of RNs by 25 boards and of LPN/VNs by 24 boards. Of these, 12 boards require specific subject matter as part of licensure maintenance (NCSBN, 2002). Other nursing board approaches to continued competence include requiring a specified number of practice hours (21 boards for RNs, 22 board for LPN/VNs; also see NCSBN Models) or a nursing refresher course if a nurse who has had an inactive license seeks to return to practice (24 boards for both RNs and LPN/VNs). Three states require a competency examination under specific circumstances (e.g., an extended number of years out of practice) (NCSBN, 2002). Several states have completed continued competence initiatives or have an initiative under way.

Although the Colorado Board of Nursing discontinued its continuing education requirement in 1994 because it found no evidence that it was effective in assuring continued competence, as noted above (Karen Brumley, personal communication February 1994), other states continue to have CE requirements. For example, the Arkansas Board of Nursing's recent work on continued competence determined to keep continuing education requirements for nurses holding active licensure. The Arkansas Board must recognize the approval bodies that approve the continuing education programs that are used to meet this requirement. More information regarding the

Arkansas CE requirements can be found at www.arsbn.org (personal communication Faith Fields).

The Kentucky Board of Nursing held a number of open forums in 1997 to examine competency issues. A professional portfolio including skills assessment inventories, peer review, formal nursing courses and continuing education was developed. Currently, the continued competence requirements for Kentucky, which is moving to an annual renewal process, offers a number of alternative activities that nurses can select (ranging from continued education hours to research to publication to a combination of CE and work evaluation) (Spur, 2004). The Texas Board of Nurse Examiners was authorized by the Texas Legislature to offer grants for conducting pilot programs to study the questions (1) What constitutes basic competency and (2) Can valid and reliable methods of measurement be developed? (Green, 1999) The eight funded projects considered tests, skill demonstration, peer evaluation, critical thinking skills tests and portfolios. Currently, the Texas Board of Nurse Examiners is authorized to recognize, prepare or implement continuing competency programs for license holders and may require participation in continuing competency programs as a condition of renewal of a license. Such programs may allow a license holder to demonstrate competency through various methods, including targeted continuing education programs, consideration of the license holder's professional portfolio (including certifications). The board may not require more than a total of 20 hours of continuing education in a two-year period and may not require more than 10 hours consisting of classroom instruction in approved programs (Texas Administrative Code, Title 22 Part II, Chapter 216).

The North Carolina Board of Nursing has a project underway, based on a determination that continued competence is both an evaluative process carried by the nurse, employer and board of nursing and a self-directed and ongoing process by the nurse for purposes of licensure renewal. Their pilot project includes a broad-spectrum sample of nurses from a variety of settings who are expected to complete a self-assessment and action plan. The board has developed a number of tools to support nurses in *reflective practice* — defined as "a process for the assessment of one's own practice to identify and seek learning opportunities to promote continued competence." After six months, the nurses will be assessed as to how they have implemented their work plans. The North Carolina Board of Nursing plans to seek legislation in 200,5 with implementation in 2006 (NCSBN, 2005).

In Ontario, the College of Nurses and other health colleges were mandated to develop and implement continued competence programs in the 1990s. The Ontario College of Nursing developed a reflective practice and portfolio model that began as a voluntary program and is now mandatory as part of the licensure renewal process.

OTHER HEALTH PROFESSIONS

Many health professions continue to require continuing education (CE) as the primary continued competence activity. According to the Federation of Chiropractic Licensing Boards (FCLB), doctors of chiropractic are required to have a certain number of hours of continuing education in order to qualify for licensure renewal in most U.S. jurisdictions (FCLB, 2005). Optometric licensing boards use continuing education to certify the continuing competence of licensed optometrists. The American Association of Regulatory Boards of Optometry (ARBO) found that state boards were duplicating work when many boards approved the same CE courses every year. In response, ARBO created the Council on Optometric Practitioner Education (COPE), a national clearinghouse for all CE courses of a statewide, regional or national scope, to prevent duplicative efforts by state boards (ARBO, 2001). Similarly, the Association of Social Work Boards (ASWB) created its Approved Continuing Education (ACE) Program to provide a national system to review and approve the providers of continuing education programs for social workers. Approved providers include universities, professional associations and both for-profit and not-for-profit organizations. ASWB does not approve individual courses. Most social work boards require social work continuing education (ASWD, 2002).

One of the first health professions to look for new approaches to continued competence was the Commission on Dietetic Registration who first developed self-assessment modules in 1989. Their first step was to identify the scope of practice of an experienced dietician. Then they developed a self-assessment module, using case studies, to evaluate the dietician's performance. An important aspect was establishing a feedback system allowing the dietician to receive an individualized commentary on their performance. The Commission has gone on to develop a variety of modules focusing on key areas of dietary practice (CDR, 2005).

Continuing competence requirements for physical therapists is most often through continuing education and practice hours. The Federation of State Boards of Physical Therapy (FSBPT) passed a motion at its 2004 Annual Meeting to support regulatory boards in the development of standards for measuring continuing competence. FSBPT has also developed standards for competence and some tools to support ongoing competence, including a jurisprudence examination and a self-assessment examination that is being currently being tested in pilot states (FSBPT, 2002).

Continuing Professional Development (CPD) for pharmacists is an approach to lifelong learning that is being discussed as a possible model for use in the United States. CPD does not replace continuing education, but quality-assured CE is an essential component of CPD. Rouse believes that a quality improvement of the existing system for pharmacist CE can be achieved (Rouse, 2004)[3]. In addition, the National Association of Boards of Pharmacy is developing a self-assessment examination for pharmacists.

The National Certification Board of Occupational Therapists (NCBOT) developed a portfolio approach that requires occupational therapists (OT) to accumulate a set number of professional development activities for each renewal cycle. Half of the activities must be directly related to the delivery of occupational therapy services. NCBOT provides a number of tools and case studies on their web site to assist practitioners in the development of their professional portfolios (NCBOT, 2005).

The Federation of State Medical Boards established a Special Committee on the Evaluation of Quality of Care and Maintenance of Competence in 1998. This group defined competence as, "Possessing the requisite abilities and qualities (cognitive, noncognitive and communicative)." They also considered the concept of dyscompetence, which they defined as "failing to maintain acceptable standards in one or more areas of professional physician practice," and incompetence, defined as "lacking the requisite abilities and qualities …to perform effectively in the scope of professional physician practice." The Committee's recommendations included to develop and implement methods to identify physicians who fail to provide quality care and to identify the dyscompetent physician. In addition to providing opportunities for improving physician practice in problem areas, they recommended that state medical boards develop programs to enhance overall physician practice (FSMB, 2005).

The members of the American Boards of Medical Specialties (ABMS) have, until recently, concentrated on initial certification. Since 1998, the physician specialty boards have been moving toward periodic recertification to maintain board certification. In 2000, ABMS Member Boards approved the establishment and basic elements of a system for "Maintenance of Certification." This system would eventually replace periodic recertification (Brennan, 2004). Member Boards are working on establishing specialty-specific requirements and processes for "Maintenance of Certification" or MOC. There are four components to the MOC: 1) evidence of professional standing (e.g., unrestricted license); 2) Evidence of a commitment to lifelong learning and involvement in periodic self-assessment to guide learning; 3) evidence of cognitive expertise based on an examination and 4) evidence of evaluation of performance in practice (ABMS, 2005).

[3] Pharmacy continuing education is approved by the Accreditation Council for Pharmacy Education, which also offers a service to link pharmacist to appropriate CE courses.

III. New Directions

NCSBN 2005 MIDYEAR MEETING

Continued competence was a major discussion at the 2005 Midyear Meeting. Small groups of participants were asked to discuss three questions. The first question was: *Is it the duty of the board of nursing to assure consumers that competence is maintained throughout the lifetime of the license?* Each table of participants talked about this question and each table reported on their discussions. The majority of participants said yes, boards do have such a duty or they indicated that it was a shared responsibility. There were some attendees who perceived continued competence as an employer responsibility. One person asked, in the face of the nursing shortage, how vigorous the process should be.

The second question for discussion was: *Describe how your Practice Act & Rules address the maintenance of competence*. The identified approaches were: minimum practice hours; mandatory reporting of unsafe practice; standards on the expected knowledge, skills and abilities; continuing education requirements and "pay your fees and stay out of trouble." The most common approaches in current use were continuing education requirements and minimum practice hours.

The third discussion question was: *What are the essential components of an effective regulatory model for the maintenance of competence?* The most common element reported was some form of assessment (examples included: self assessment, core competency tests for practicing nurses, Dorothy Del Bueno's model, measurement processes, measurement tools, core competency measurement by an affective-cognitive-sensory monitor and regional assessment centers). Other suggested elements were portfolios, demonstration and observation, general guidelines provided by Member Boards, tracking systems, manage or remove the non-competent nurse, evidence based discipline, remediation courses, Web-based resources and continuing education.

FY05 STRATEGIC INITIATIVE

The 2004 Delegate Assembly adopted a strategic plan to guide the organization for the next three years. Part of that plan is "Strategic Initiative IV: Position NCSBN as the premier organization to measure entry and continuing competence of nurses and related health care providers." Utilizing the Balanced Scorecard strategic management model, a strategic objective was developed by the Board of Directors to accomplish this initiative. The following Strategic Objective was assigned to the Testing Services Department: "Strategic Objective 2: Develop an assessment instrument to measure continued competence of RNs and LPN/VNs."

Based on this directive, the NCSBN Testing Department is developing a practice analysis of post entry-level nurses. In addition, a public opinion survey regarding public perceptions of continued competence for nurses is in the process of being conducted. As part of the usual development process for a job analysis, at least two subject matter expert meetings are expected to occur this summer: One meeting to develop a comprehensive list of LPN/VN nursing activity statements to assess LPN/VN practice, and the other to develop a comprehensive list of RN nursing activity statements to assess RN practice. After comprehensive lists of RN and LPN/VN nursing activity statements have been developed, post entry-level RNs and LPN/VNs will be surveyed regarding the frequency and importance of nursing activities. Data collection is scheduled for FY06 with initial reports expected in late spring/early summer of 2006. The purpose of the job analysis is to describe the practice of experienced nurses with the idea of developing an assessment instrument for experienced nurses. What is learned from this study may be very useful for devising a continued competence regulatory model.

VII. Discussion

Unlike other health professions which number in the thousands, there are more than two million nurses in the United States. Such huge numbers have tremendous impact on the resources needed, and thus the approaches used to assure continued competence of nurses. It is estimated

that less than 20% of nurses are professionally certified. Thus, the medical model is not a good fit for nursing.

The NCSBN strategy of analyzing the practice of experienced nurses is a crucial first step toward the development of a regulatory model. It will help us describe the practice of an experienced nurse. That will inform whatever model is eventually developed.

NCSBN has been looking at continued competence since 1985. Physicians first began to focus on continued competence in 1998. Since then, several member boards of the American Boards of Medical Specialties began to require periodic reexaminations to maintain board certification. Other medical specialties are also moving in this direction. Most physicians are board certified, so that 85-90% of physicians could be assessed by mandatory periodic recertification examinations allowing this approach can be used as the primary continued competence mechanism for doctors. Boards of medicine have to develop continued competence mechanisms for the much smaller number of practitioners who are not board certified.

The CAC Road Map put forward in 2004 is very similar to the steps of the CCAP portfolio approach developed by NCSBN in the late 1990s.[4] So, one possibility for nursing is for NCSBN to revisit the CCAP and the portfolio approach. However, the criticisms that were raised in 1998 would still be concerns today: it is a paper trail, it is difficult to quantify and it raises questions of reliability and validity. While developing a portfolio can be an enriching experience, it can also be seen as busy work with little relation to actual practice.

What the Pew Task Force, the Institute of Medicine and the Citizens Advocacy Center advocated is the periodic demonstration of competence. There is more than one way to demonstrate competence. There are formal examinations, but there are also self-assessment tests and reflection upon one's practice. There are open book tests that look less at what you can recall and more at how you think, and how you synthesize and apply knowledge. In the current health care environment, isn't how a nurse problem-solves, and where she or he goes to find answers, more important than just retained facts?

Assessment results do not have to determine "in or out." Results could be used to provide feedback and direction to the nurse. Boards could provide licensees time to study and work on improvement and then reassess. Boards would have to make challenging policy decisions about how long, number of tries and how to deal with nurses who cannot meet requirements. If the licensure maintenance requirements are reasonable, substantive and rationally related toward meeting the goal of assuring the currency of nurses, it is the role of the board of nursing to enforce those requirements.

Periodic assessment is not an unrealistic expectation — it is opportunity for quality improvement. Continuous quality improvement is a logical requirement for licensure maintenance.

VIII. Conclusions

We are living in a complex, complicated world. Given a constant onslaught of new knowledge and technology, an individual's success in completing nursing education, passing an examination and meeting other requirements at one point in time is not enough. Licensure renewal and staying out of trouble is not enough. Licensees need to demonstrate that they are taking substantive steps to maintain licensure.

Some nurses will ask, "Where is the evidence we aren't competent?" It is true that research is needed to study the practice of experienced nurses. Research is needed to assure that there is evidence to support that a continued competence strategy is effective. It is disingenuous to suggest that in the current environment, and in the face of startling, frightening statistics

[4] The CAC is taking on even more daunting a challenge than NCSBN, because it is trying to move multiple health professions to implement continued competence requirements.

involving error that assuring the maintenance of continued competence of health professionals, including nurses, is not needed. Patient safety initiatives must address individual competency as well as system redesign and improvement. IOM has identified five competencies for all health care professionals (patient centered care, interdisciplinary team, evidence-based practice, quality improvement and informatics). This may provide a starting place for determining substantive requirements for licensure maintenance.

Boards of nursing cannot go it alone. This has to be a collaborative effort. Nurses, employers, educators, nursing organizations, CE providers, consumers and boards of nursing are all stakeholders and have perspectives to share and expertise to offer. Stakeholder buy-in to any regulatory model is important. But the bottom line is that only governmental licensing boards have the authority to enforce change.

Appendices

A. NCSBN Timeline – Continued Competence Activities

B. Discussion of Continued Competence Challenges

C. Principles and Premises Identified in Previous NCSBN Documents

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Appendix A

NCSBN Timeline — Continued Competence Activities

NCSBN has struggled with the concept of continued competence for many years, having explored the regulatory role in continued competence, and attempted to develop some practical approaches toward implementing a regulatory role. Those activities are summarized in this timeline.

1985 — The first NCSBN Paper was published.

1991 — *The NCSBN Conceptual Framework for Continued Competence* considered the measurement of competence from an empirical and standard-setting perspective. This Paper stressed the importance of both assessment (to determine learning needs) as well as strategies to promote continued competence.

1993 — The Nursing Practice and Regulation Committee (NP&E) presented *A Paradigm Shift Regarding Competence*, which advanced the licensee's responsibility for individual competence. The board of nursing role was envisioned as that of a collaborator with licensees and employers. The licensee's responsibility for self-assessment was the focal point of a goal to facilitate collaboration.

1994 — The NP&E Committee incorporated work from 1991-1993 in the revision of the NCSBN *Model Nursing Practice Act* and *Model Nursing Administrative Rules*.

1995 — The Essential and Continued Competence Subcommittee presented a definition of competence, standards for competence and a Model for Individual Competence Evaluation, along with the working draft of a new Paper on continued competence.

1996 — The Essential and Continued Competence Subcommittee completed a new Position Paper entitled *Assuring Competence: A Regulatory Responsibility*.

1998 — The NP&E Committee, building upon previous NCSBN work, developed the Continued Competence Accountability Profile (CCAP), which was presented at the 1998 Area Meetings as an alternative to the continuing education approach. The response of Member Board representatives at that meeting was that the concept was interesting, with many excellent elements, but it was too complex in administrative feasibility to be an effective way for boards to approach continued competence. CCAP was tabled.

1999 — The NP&E Committee used the continued competence framework — competence development, competence assessment and competence conduct — in developing the Uniform Core Licensing Requirements.

2003-2004 — The PR&E Models Revision Subcommittee incorporates a practice requirement in the revised models, based upon NCSBN research showing that professionals rely largely on practice experience for professional development. The subcommittee viewed this as a transition position and anticipated that with additional research and information, a different regulatory approach would evolve.

2004 — The NCSBN Board of Directors directed staff to prepare an updated Paper and to explore approaches for assessment of continued competence.

Appendix B

Discussion of Continued Competence Challenges

While some boards of nursing have moved forward with state initiatives, there has not been a national, "elegant" regulatory solution for evaluating continued competence. Why is this so?

- *There is not agreement on who should be responsible for continued competence.*

  Traditionally, professional organizations have promoted professional development. The problem is that those professionals who seek out such development are not likely to be the professionals who experience problem practice. The regulatory role in continued competence is also needed because licensing boards have the authority to enforce requirements. Both, and more, are needed. Continued competence needs to be a collaborative effort.

- *The sheer volume of nurses makes it difficult to identify feasible and meaningful yet cost-effective regulatory approaches.*

  Unlike other health professions which number in the thousands, there are more than two million nurses in the United States. Such huge numbers have tremendous impact on the resources needed, and thus the approaches used to assure continued competence.

- *It is not clear what standard should be used to evaluate continued competence.*

  Nursing careers take widely divergent paths, varying by professional roles, settings, clients, disease conditions and therapeutic modalities as well as level of health care delivery. In addition, there is the inherent evolution of practice from the new graduate entry-generalist level to the experienced-focused practice level of competence. Considering these multiple characteristics, should the standard be based upon:

  - *A standard based upon the current entry-level competency for the profession?*

    This standard makes sense from the perspective that the renewed license is no different in what it authorizes and represents to the consumer than the initial license. For some types of health provider roles, the repeated validation of a focused area of practice will suffice, e.g., the Emergency Medical Technician (EMT) has a focused role in which an EMT may be called upon for any EMT skills on any day, in any situation. Some argue that since a nursing license authorizes a nurse to practice in any role, in any setting and with the mobility of all professionals, nurses can and do change their roles, etc. Therefore, a nurse should continuously meet current entry competency.

  - *A standard based on a generalist core competency for the profession?*

    This approach acknowledges that nursing has great breadth and depth of knowledge and scope of practice, and would focus on what is needed across roles and settings.[1]

  - *A standard based on the competence needed for safe and effective practice in the focused area of practice?*

    This approach makes sense in that it would require the board to focus on the nurse having the knowledge, skills and abilities needed in the current area of practice are sufficient such that safe and competent care is delivered. This would seem to benefit the consumer — requirements that have no relationship to daily practice become an academic education, and may even detract (by using time and resources) from the advancement of needed knowledge, skills and abilities. But is this a de facto limited license? What if a nurse does change practice focus between renewals?

  - *A standard based on essential emerging knowledge?*

[1] It is likely that these might well include fundamental nursing principles, critical thinking, interpersonal interactions, and communication skills, as well as legal and ethical issues.

This approach acknowledges that there is a constant generation of new medical evidence that may completely outdate previous nursing strategies. Should the board, in collaboration with nursing organizations, educators and employers, select essential new concepts to require of all nurses?

- *A standard based on a combination of the above?*

  This approach, selecting the most positive elements of two or more of the above may the best approach to assure the public that nurses are continually prepared to provide safe and competent nursing care.

- *It is not clear how to evaluate whether a standard has been met.*

  A major concern for nursing boards and nurses alike is that of resources. The aim should be to select continued competence activities that would bring the most value to the public. Should boards try to deal with all licensees on a regular basis (recognizing that this often means a shallow, superficial sweep)? Would it be more effective to do periodic in-depth interactions with a selected group of licensees? If periodic in-depth interactions are done, the next concern is how to choose the selected group of licensees. Should it be a random selection for review, or could competence assessment "triggers" be identified (e.g., nurses changing their practice focus, nurses working in high-risk areas or nurses working in isolation)? Should assessment focus on critical practices that are used infrequently (e.g., CPR in a psychiatric setting) or routine practices used every day?

  And what should be the goal with continued competence requirements? Is it competence assurance or competence promotion or something else, e.g., requiring assessment and learning strategies related to the five critical competencies identified by the Institute for Medicine? (IOM, 2003)

- *It is not clear what to do if a licensee cannot demonstrate continued competence.*

  From a regulatory perspective, this is the most challenging decision. If continued competence expectations are promulgated as regulatory requirements, what if a licensee cannot meet the requirements? Should the licensee be given a period of time to upgrade knowledge and skill? If so, what is that licensee's legal status during the interim period? Should this interim status be public information? What if the licensee is unable to meet requirements after the interim period? At what point does a board have to intervene to separate a licensee from practice in order to protect the public?

From: National Council of State Boards of Nursing. (1996). *Assuring Competence: A regulatory responsibility.* Chicago: Author

Appendix C

Principles and Premises Identified in Previous NCSBN Documents

Guiding Principles and Premises

These concepts, identified in previous NCSBN work, continue to be applicable to current nursing practice and regulation, and were considered in the work of the 2004 PR&E Models Revision Subcommittee as well as in the development of this Paper.

- The primary responsibility of boards of nursing is to protect the public.
- Licensure is a privilege, not a right; therefore, each licensed nurse has responsibility to the licensing entity granting the authority to practice and to the public who receives nursing services.
- Boards have a role in assuring the public that licensed nurses meet minimum standards of competence throughout their professional lives.
- Regulatory approaches to continued competence, in order to be viable, must be:
  - Administratively feasible
  - Publicly credible
  - Professionally acceptable
  - Legally defensible
  - Economically affordable.
- Attaining, maintaining and advancing competence is a joint responsibility between the individual nurse, employer, licensing board, educator and profession.

In addition, the following statements identify other premises considered in developing the revised models:

- The public expects safe and competent nursing care.
- The public expects boards of nursing to regulate the practice and monitor the competence of nurses throughout their careers.
- The nurse is responsible for maintaining competence in nursing practice through the process of life-long-learning. It is an essential component of professional accountability.
- Professional accountability also requires nurses to recognize limitations and place themselves in settings and roles that allow them to function safely.
- Minimum, essential competence for safe practice includes elements such as critical thinking, interpersonal relations, basic nursing principles and aspects of jurisprudence/ethics.
- Continued competence requirements apply to endorsement, renewal and reinstatement of licensure.
- Reentry into nursing practice following a significant period of absence from practice requires evidence of current knowledge, skills and abilities.
- What constitutes “minimal, essential” varies over time, just as advances in knowledge and technology vary over time.
- Excellence is desirable but is within the purview of the professional rather than the regulatory community. Collaboration between the professional and regulatory communities is both logical and reasonable since growth and excellence are on a continuum with minimal, essential.

In addition to the definition of competence, the following standards were identified in 1996:

The nurse is expected to:

1. Apply knowledge and skills at the level required for a particular situation.

   Indicators:

   - Determines actions needed to achieve desired outcomes
   - Performs nursing activities in a safe/effective manner
   - Demonstrates current knowledge necessary to provide safe client care
   - Delegates in accordance with established guidelines
   - Collaborates with appropriate professionals to attain client health care outcomes.

2. Demonstrate responsibility and accountability for practice and decisions.

   Indicators:

   - Exhibits ethical behavior
   - Assures client welfare prevails
   - Establishes and maintains therapeutic boundaries
   - Limits practice to current knowledge, skills and abilities
   - Clarifies expectations of the role
   - Intervenes when unsafe nursing practice occurs
   - Practices within the legal authority granted by the jurisdiction
   - Implements professional development activities based on assessed needs.

3. Restrict and/or accommodate practice if cannot safely perform essential functions of the nursing role due to mental or physical disabilities.

   Indicators:

   - Identifies abilities necessary to perform the essential functions of the nursing practice role
   - Implements accommodations when needed
   - Safely performs essential functions of the nursing practice role
   - Limits practice when accommodations are not sufficient to enable safe performance of essential functions of the nursing practice role.

From: National Council of State Boards of Nursing. (1996). *Assuring Competence: A regulatory responsibility.* Chicago: Author

Attachment C

Practical Nurse Scope of Practice White Paper

April 2005

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Introduction

At the December 2–4, 2003, NCSBN Board of Directors meeting, one key action of the Board was stated as, "Based on the *2003 LPN/VN Practice Analysis* findings, the Board discussed the expanding role of PNs, questioned whether PNs receive adequate preparation for practice and if regulatory boards need to reevaluate the PN scope of practice. The Board approved a focus group to be convened to identify PN practice and education issues and provide the board with options for next steps." Therefore, a practical nurse (PN) focus group was convened in Chicago to discuss the findings of the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2003) and to make recommendations to the NCSBN Board of Directors.

One of the recommendations of the PN focus group was to write a White Paper about the focus group discussion of the scope of PN practice and highlighting any PN data that has either been collected here at NCSBN or by external groups. By distributing this White Paper widely to all the stakeholders, the focus group anticipated that it would stimulate an important dialogue about the PN scope of practice. One of the issues that the focus group would like to be addressed is the wide disparity in the PN scope of practice in the nurse practice acts and the nursing administrative rules. The focus group also hoped there would be discussion of developing a national PN curriculum and of educating practice about the role of the PN.

April 29, 2004, PN focus group

SCHEDULE OF THE MEETING

An experienced focus group facilitator helped to plan the focus group, presided over the group that day and assisted with the various reports from the group. The facilitator, Richard English, from Surrey, England, was chosen because of his expertise in facilitation and his objectivity. He is not a nurse, nor does he live in the United States, so it was anticipated that his fresh perspective would stimulate rich discussions that otherwise might not occur.

To ensure the broadest possible range of experience and knowledge, participants were selected from a range of nursing-related disciplines across the United States. The full list of participants is in Appendix I to this Report. There was representation from the boards of nursing, the National League of Nursing Accrediting Commission (NLNAC), the National Association of Practical Nurse Education and Service (NAPNES), NCSBN, NCSBN's Exam Committee, NCSBN's Practice, Regulation and Education (PR&E) Committee, Joint Commission's Longterm Care Accreditation, Institute for the Future of Aging Services, National Federation of Licensed Practical Nurses (NFLPN) and the American Organization of Nurse Executives (AONE).

The group members were aware of the background of this meeting. All members were supplied with a copy of the 2003 PN Practice Analysis and a detailed discussion guide was prepared that gave direction to the group discussion. The event was specifically designed to allow for the maximum participation of delegates and thus a large amount of time was spent on small group work. Dr. Spector, director of education at NCSBN, and Mr. Richard English, the facilitator, worked closely in planning the meeting, and they devised an algorithm (Appendix II) for preparing for the discussion. To allow for return travel, the day was scheduled to finish early — by 4:30 pm — and this necessitated an early start with a working breakfast. This worked very well and, in spite of the volume of work to be undertaken, the day finished slightly ahead of time and most

participants were able to stay until the close of the meeting.

To help delegates to understand the background of the study and of the relationship to the NCLEX® test plan, presentations were given by June Smith, PhD, RN, former NCSBN associate director of research services, and Casey Marks, PhD, NCSBN associate executive director of operations.

GROUP SESSIONS

Considering that many of the delegates had never met prior to this event, the group bonded quickly, with all the breakout sessions generating many good ideas. The various groups were asked to look at the four main questions posed in the discussion guide, and the findings of each session are summarized here. Throughout all group discussions the ideas of listening to the consumers in this debate and putting patient safety first, were implicit in all decisions that are made.

Discussions by the PN focus group members included:

1. What do the findings of the *2003 LPN/VN Practice Analysis* mean, considering the scope of practice of LPN/VNs?

Group 1 — Yellow Group

- Is there a difference between the reports from LPN/VNs about their practice, versus what is actually happening? There was considerable discussion about this, and some thought the employers' surveys and the panel of experts validated the findings of the LPN/VN survey.
- Are LPN/VN roles expanding? Are LPN/VNs being educated adequately for practice in the long-term care settings or the acute care settings? Some thought there was a gap between practice and education.
- Some boards of nursing have looked at RNs placing LPN/VNs in bad positions by asking them to practice outside their scope of practice. The group asked whether boards of nursing are seeing more discipline cases with LPN/VNs, regarding scope of practice. Some boards of nursing are, while others are not.
- The bottom line is that safety of the patient must be considered; this is a regulatory question.
- Consider the difference between the "care plan" and the "service plan." What is nursing? What is not nursing? Who decides which is which?
- The question of adequate supervision was raised. Oftentimes an LPN/VN may be supervised by someone who doesn't understand the legal scope of practice.

Group 2 — Blue Group

- What precisely is meant by "scope?" It is a legal term and refers to the body of knowledge in a profession and it is mandated by legislation.
- "Scope" encompasses the nurse's judgment and is affected by the setting, staff mix, etc.
- When legislating "scope," one must think towards the future, at least five years in advance.
- "Knowledge" can't be delegated, though technical tasks, etc. can be. Delegation is an important part of this discussion of "scope of practice."
- Consider the patient. Our responsibility is to protect the patient.

Group 3 — Red Group

- What do these findings mean? It is hard to generalize because it varies from jurisdiction to jurisdiction and facility to facility. Do these facilities make their decisions based on the practice act and rules and regulations in that state?
- There is a variance between education and practice of the LPN/VN. Practice evolves over time. A third of LPN/VNs need more education to practice in entry-level jobs.
- RNs don't have an understanding of the LPN/VN scope of practice.
- What are the differences between LPN/VN practice? Does the RN think more critically? The intangible differences (i.e., synthesis, application, critical thinking) are harder to measure.
- Supply and demand issues often drive using the LPN/VN in a more expanded role, sometimes outside their legal scope of practice.
- Safety is the most important consideration in all of this discussion.

Summary of Group Discussion: The delegates concluded that the practice of LPN/VNs is evolving and they questioned whether there is a gap between education and practice. Further, all three groups mentioned safety and protection of the patient as the most important consideration in these discussions. One group asserted that RNs and facilities don't always understand "scope of practice issues," and many of the delegates lamented that often employers and RNs don't understand the responsibilities associated with delegation and supervision. The groups made the point that the survey represented the perceptions of LPN/VNs, and some questioned whether this was necessarily an accurate vision of what is happening in practice. One group thought the discussion of scope of practice would be clearer were we able to specifically spell out the differences between LPN/VNs, yet the delegates realized that there are hard-to-measure intangibles.

2. What are the implications of the *2003 LPN/VN Practice Analysis*, related to the LPN/VN scope of practice, to NCSBN?

Group 1 — Yellow Group

- Why is the core curriculum of the LPN/VN so inconsistent?
- Why are the LPN/VN scopes of practice in different states so inconsistent?
- Is there a better regulatory model?
- Are practice acts too restrictive?
- What are the drivers of change?
- More clarity with delegation is needed.
- More information on transition from education to practice is needed.

Group 2 — Blue Group

- Revisit the model practice act and rules to differentiate basic differences of the RN/LPN. Don't leave the nursing assistants out of the loop.
- A white paper on LPN/VN and RN differences would be helpful.
- Raise the level of discussion between the boards of nursing so as to address the inconsistency with practice acts and rules and regulations.
- NCSBN should create dialogue between the consumers, education, regulation and practice to address this scope of practice issue. Patient rights were specifically addressed, referencing the American Nurses' Association "Social Policy Statement."

- NCSBN should be a clearinghouse for LPN/VN data, including NCSBN data (from the Taxonomy of Error, Root Cause Analysis and Practice Responsibility or TERCAP project, Profiles of Member Boards and Research Services), as well as other organizations that might collect such data.
- Collaboration with other groups and organizations was stressed.
- Drivers of society were discussed, such as the economy and technology.

Group 3 — Red

- We need to tap the resources of other groups — be a resource of data.
- Is the Member Board Profiles publication collecting enough data on LPN/VNs?
- First and foremost, the concern of NCSBN should be safety. Can NCSBN encourage states to collect and analyze data regarding practice issues/complaints?
- The LPN/VNs stated that they were best prepared for direct patient care, documentation, care planning and medications. They stated they were least prepared to interact about the patients and to supervise the care of others. These are important aspects for nursing education/regulation/practice to address.
- Delegation should be addressed by NCSBN.
- Labor Unions may be an issue.
- We can't look at LPN/VNs in isolation.

Summary of group discussion: NCSBN needs to revisit the model rules regarding scope of practice of the LPN/VN versus that of the RN. NCSBN should summarize their own data regarding PN practice, as well as look at the findings of studies of other groups. NCSBN should create a dialogue about LPN/VN scope of practice between the boards of nursing, consumers, educators and practice. Again, clarifying delegation came across strongly, as well as NCSBN's goal being to address patient safety. Two of the groups also mentioned the importance of not just looking at the LPN/VN practice issues in isolation, but with other health care providers, such as nursing assistants and RNs.

3. What are the implications of the *2003 LPN/VN Practice Analysis*, related to the scope of practice, for education and practice?

Group 1 — Yellow

- Increased collaboration and communication.
- Support mentoring.
- Drivers
  - Practice: third party payers, special interests, consumer, society, quality outcomes and safety.
  - Education: best practices, model curriculums.

Group 2 — Blue

- Developed excellent models of current practice, evolving practice and future visions.
- Is regulation futuristic enough to be a driver?
- See Appendix III: The Desired Evolution of Regulation (p. 121)

Group 3 — Red

- Regulation

- Too restrictive.
- Boards of Nursing need to be active in order to drive health care decisions.
- Mutual recognition is a means of evolving.

- Education
  - Need more uniform LPN/VN curriculums.
  - Competencies should be spelled out.
  - How time is counted should be uniform across programs.

- Practice
  - Need to deliver safer care
  - Do their job descriptions fit the state's scope of practice?
  - Are expectations of new graduates too high?
  - Yet, need to utilize LPN/VNs to their capacity.

Summary of group discussion: There should be stronger links and more collaboration between education, regulation and practice because of the disconnect between practice and education. Perhaps there is the need for a national model LPN/VN curriculum and/or best practices. Likewise, regulation needs to be more proactive in promoting health care decisions. The mutual recognition model is one way for regulation to continue to evolve. The utilization of the LPN/VN should be discussed in the practice arenas, especially regarding safe practice. Two of the groups identified the drivers of health care, including the consumer and quality care, economics, special interests, education, practice and regulation.

4. What are possible strategies of attaining greater universality regarding the scope of practice of LPN/VNs, across jurisdictions?

Group 1 — Yellow

- Develop white paper of these discussions and share with stakeholders to open a discussion.
- Develop model scope of practice and base national curriculum on it.
- Develop PN education best practices/standards.
- Research PN outcomes.

Group 2 — Blue

- Practical nurses need to be at the table when these education/regulation/practice decisions are being made (e.g., ANA, JACHO, etc.). This seldom occurs.
- Model curriculum — will it work?
- Identify regulatory barriers that inhibit the scope of practice.
- Educate RNs about the LPN/VN scope of practice in that state.
- Likewise, the employer must understand the state's scope of practice in order to decide upon the correct qualifications for the job.

Group 3 — Red

- There needs to be better communication of LPN/VN needs with organizations; encourage more LPN/VN representation on panels, committees, etc., that address health care issues.

- The data at the federal level should clearly differentiate LPN/VN data from RN data.
- There should be more online offerings geared toward the LPN/VN.
- We should establish a forum where educational, practice and regulatory consistency are discussed in order to increase consistency across the states, increase competency and ultimately to increase safety.

Summary of the discussion: The overwhelming finding here was that there should be greater cooperation and communication between all parties and that there is a clear need for a forum (e.g., a white paper was brought up several times) to facilitate this. PN involvement in panels, committees, etc., was also felt to be very important. Again, the idea of a model curriculum, or even a model scope of practice, was discussed. Collecting LPN/VN data and researching the LPN/VN role was also discussed by two of the groups.

Recommendations to the NCSBN Board of Directors

Based on the discussions that were held that day, the following recommendations were presented, by motion, to the NCSBN Board of Directors at the July 2004 Board of Directors meeting. The Board unanimously approved the recommendations:

1. White Paper: There was strong consensus, both during small group sessions and in the large group, that the most important recommendation was for NCSBN to write a white paper capturing the discussion of the day. As much data should be included in this Paper as possible from the various research projects at NCSBN, thus making it evidence-based.

   This White Paper can be used as a vehicle to develop partnerships and begin dialogue about the scope of practice of LPN/VNs with employers, associations, boards of nursing, nurse executives and educators. These partnerships can begin to promote mobility of the LPN through articulation programs, such as those that exist in Texas, Washington, Colorado and Kentucky.

   This White Paper might begin dialogue to create a model LPN curriculum. It was thought that this would decrease some of the regulatory barriers that exist today. Collaboration and input from various stakeholders would be important when designing this model curriculum. Some of the groups to include would be practice, education, boards of nursing and consumers. Consumer suggestions included AARP, CAC and groups working with Alzheimer's disease.

   It was this recommendation that stimulated the writing of this White Paper. It will be disseminated to practice, education and regulatory groups in order to create discussion about the LPN/VN scope of practice. Other steps taken to make nurses aware of this discussion have been:

   - Articles summarizing the focus group were published in a regulatory journal and in a publication to all nursing educators from and boards of nursing (Spector, 2004; Spector, 2005).
   - PN Focus Group summary on NCSBN Web site (http://www.ncsbn.org/regulation/nursingeducation_DOE4EEEC95DA434CB223B4CEEAD8B193.htm).

2. Model Rules: While the group realized that the Model Rules were going to be voted on in 2004 Delegate Assembly, they emphasized that this should be a dynamic document that should change as LPN/VN practice changes. Specific LPN/VN-related questions will be addressed annually at the Practice, Regulation and Education (PR&E) meetings and appropriate recommendations will be made to the NCSBN Board of Directors.

3. NCSBN as a Central Clearing House for LPN/VN Data: It was recognized that there are a lot of LPN data available, but those data haven't been shared with various groups. Groups

that collect data on LPN/VNs should collaborate and share their data and NCSBN should make available all of the shared data. Some groups currently that are collecting data on LPN/VNs include NCSBN (practice analyses, Profiles of Member Boards, employer surveys, etc.), NLNAC, NAPNES, workforce data, AACC (American Association of Community Colleges) and discipline data from boards of nursing discipline. As to the latter source of data, the group recommended that NCSBN encourage the use of the use of the Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP) instrument by all boards of nursing. One board of nursing has statewide initiatives where they are investigating the LPN/VN scope of practice. The results of all individual studies, from boards of nursing taken together, will help us to identify best practices.

The LPN/VN data should be held in one central place. NCSBN should summarize the available in a readable form and distribute it to all stakeholders. It was emphasized that stakeholders would benefit by a two- or three-page document summarizing these results, rather a longer one that is full of raw data and graphs.

Organizations and boards of nursing were contacted, and the following sources of data were identified and will be included in this Paper:

- June Smith, PhD, RN, former NCSBN associate director of research, collected the recent NCSBN research that has addressed the LPN/VN role and scope of practice and summarized it for this Paper.
- NLN, NLNAC, NAPNES and NFLPN were contacted for research data that they might have.
  - Dr. Lin Jacobson, director of research at NLN, stated that they are conducting a survey of LPN/VNs, but that it is not yet ready to cite in this White Paper.
  - NAPNES and NFLPN cited the work done by Seago, Spetz, Chapman, Dyer, Grumbach (2004) and that study was retrieved.
    - Dr. Seago provided NCSBN with the first national sample survey of LPN/VNs, from 1984 (Bentley, Campbell, Cohen, McNeill, & Paul, 1984)
- Minnesota Board of Nursing study (McEvoy, 2005).

4. NCSBN's Committee Format Should Support LPN/VNs: While there are subcommittees at NCSBN that support other groups of nurses (e.g., the APRN Subcommittee), there is not a committee that just addresses LPN/VNs. Concern was expressed that not all LPN/VN issues are discussed in NCSBN committees. There wasn't consensus, however, on whether to have a separate LPN/VN subcommittee of PR&E. While some thought it a good idea, others worried it would further separate RNs from LPN/VNs. However, there was consensus that the committees should specifically address LPN/VN issues and the Board should consider LPN/VNs when committee charges are written and when the committee members are selected. Consequently, when the NCSBN Board of Directors met in July to name committee members and to approve committee charges, care was taken to consider LPN/VN members for committees and to consider their issues with committee charges.

In summary, as can be seen, more questions than answers arose from the PN Focus Group, though that was to be expected. This was the first time a national group of people with varied LPN/VN experiences and talents met to discuss the scope of practice of LPN/VNs. The group proposed, using this White Paper as their forum, to create a dialogue and future discussions, especially related to developing a national curriculum, advocating for more LPN/VN regulatory consistency across the states, and educating practicing RNs about the LPN role.

Some of the problems the groups pointed to are already being addressed at NCSBN. For example, for two years a subcommittee studied delegation and working with others. They have written an in-depth Paper, entitled, "Working with Others: A Concept Paper" and they have developed a proposed article for the NCSBN *Model Nursing Practice Act* and a proposed

chapter in the *NCSBN Model Administrative Rules*. When these are reviewed and approved by NCSBN Board of Directors and Member Boards, they will be available to guide LPN/VNs, boards of nursing, education and practice at: www.ncsbn.org. Similarly, the Practice, Regulation and Education (PR&E) Committee at NCSBN has been studying transition of education and practice for two years. They have developed a model for transition programs (available at www.ncsbn.org on the Education page) that addresses:

- The importance of the same mentor for new LPN/VNs.
- The pros and cons of specific versus general knowledge in the structure of transition programs.
- The ideal placement of transition programs (that is, are the programs best when offered before or after graduation?).
- The advantages of mandatory versus voluntary transition programs.

Further, the PR&E Committee is continuing to study transition of new LPN/VNs by investigating the outcomes of specific transition programs.

Available LPN/VN Data

NCSBN LPN/VN DATA FROM RESEARCH BRIEFS

In an unpublished Paper summarizing NCSBN's research with LPN/VNs, Smith (2004) reports that all U.S. states and territories identify a scope of practice for either LPNs or LVNs. However, Smith (2004) asserts, the practices allowed by those scopes vary widely. While most LPN/VN scopes of practice stipulate a directed role under the supervision of a registered nurse (RN), many differ in the areas of care planning, assessment, intravenous (IV) therapy, teaching and delegation. For example, some states hold the LPN/VN accountable for performing assessments, while others only allow the LPN/VN to contribute to the assessment by 'collecting data.' Similarly, some states restrict the LPN/VN role in patient education to following a previously developed teaching plan, while others do not restrict this role. The area with the most disagreement among state scopes, however, is IV therapy. Some states expect LPN/VN education programs to provide training in IV therapy and allow LPN/VNs a liberal range of IV tasks in their practice settings, while other states strictly forbid IV therapy activities and still others allow the performance of various limited IV therapy tasks after the LPN/VN has completed additional coursework.

Several recent NCSBN research studies have demonstrated a wide variety of LPN/VN practice patterns throughout the nation. While some of the variation in practice may be attributable to different state scopes of practice, it is possible that some nursing employers are requiring LPN/VNs to perform many tasks that exceed their state-mandated scopes of practice.

The *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2003) found that 43% of LPN/VNs spent various proportions of their time performing administrative roles such as coordinator, team leader or area manager, with 31% working as charge nurses. Respondents to that study reported spending equal amounts of time providing routine care and managing client care.

A total of 163 activity statements were included in the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2004). The activity statements were developed by a panel of experts to cover the full range of possible LPN/VN practice topics. Survey respondents indicated whether or not the activities applied to their specific work setting and if they did apply, they recorded the frequency with which they personally performed the activities on their last day of work. Some activities (such as those relating to care planning, assessment and teaching) were included on the survey in two ways, one indicating independent performance of the activity and the other describing a more directed role.

Of those newly licensed LPN/VNs responding to the *2003 LPN/VN Practice Analysis*, 48% reported that they independently developed clients' plans of care and 83% reported that they contributed

to the development of clients' plans of care. In the area of education, 91% reported that they assisted in or reenforced education to clients/families about safety precautions and 78% reported that they independently planned and provided education to clients and families on the same topic. When asked about components of assessment, 84% reported collecting data for initial or admission health histories and 72% reported comparing the data collected for the health history to expected norms for decision-making or care planning.

Ten activity items on the *2003 LPN/VN practice analysis* addressed various aspects of IV therapy. Respondents reported involvement in those activities in the following proportions:

- 58% gave IV fluids or IV piggyback medications through peripheral IV lines.
- 32% provided medications through peripheral IV lines by IV push.
- 38% gave IV fluid, IV piggyback or IV push medications though central venous catheters.
- 53% gave total parenteral nutrition (TPN).
- 55% started initial peripheral IV lines on adult clients.
- 47% restarted IV lines on adult clients.
- 19% started or restarted IV lines on pediatric clients (age 16 years or younger).
- 28% administered blood products.
- 40% monitored the transfusion of blood products.
- 74% assessed clients' IV sites and flow rates.

An Employers Survey (Smith & Crawford, 2004a) and a Practice and Professional Issues Survey (Smith & Crawford, 2004b) were performed during the fall and winter of 2003. These surveys were designed to collect the same types of information from nurses in their first six to 18 months of practice and from nurse employers. Respondents to each of these studies were asked to comment on the working relationships of RNs and LPN/VNs in their settings. Of those respondents writing comments about RN and LPN/VN working roles, 39% of employers, 52% of LPN/VNs and 62% of RNs wrote that RNs and LPN/VNs in their settings held the same role and performed the same work or that their roles were the same except for specific activities that the RN performed for the clients of the LPN/VNs, such as admitting assessments or IV medications.

This brief overview of NCSBN research findings illustrates that LPN/VNs are being utilized to perform tasks that may or may not be included in their state's scope of practice. These findings have a number of implications for boards of nursing, nursing education programs and nurse employers.

NCSBN LPN/VN DATA FROM PROFILES OF MEMBER BOARDS

The *2002 Profiles of Member Boards* (Crawford & White, 2003) is a triennial publication that provides an overview of the regulatory environment of the 60 boards of nursing. These 60 boards of nursing comprise the Membership of (NCSBN. This rich publication includes LPN/VN data about the various requirements of the 60 boards of nursing. Relevant LPN/VN data includes:

- Approval/Accreditation data by boards of nursing.
- Minimum credit hours required for theory courses.
- Minimum number of clinical experience hours required.
- Minimum educational requirements of program administrators.
- Minimum educational requirements of program faculty.
- Mandatory and voluntary articulation programs.

- Student/Faculty ratios.
- Boards requiring clinical education facilities to be approved by the board of nursing or boards that mandate on-site visits be made to clinical facilities.
- State requirements for clinical teaching assistants in LPN/VN programs and LPN/VN student-preceptor ratios.
- Regulation of students in clinical settings.
- Guidelines for clinical experiences in non-traditional settings.
- Curriculum guidelines in LPN/VN nursing programs.
- Distance learning guidelines.
- LPN/VN criteria by for licensure by examination, including equivalency programs, such as the military programs.
- Eligibility to sit for the NCLEX-PN® examination, including those from military programs, limitations on number of times a candidate can sit for the exam and limitations on the number of times a candidate can attempt to pass the NCLEX-PN® exam without further study.
- LPN/VN qualifications for licensure by endorsement.
- Eligibility for LPN/VN licensure by endorsement.
- Temporary or Interim Permits.
- Verification of licensure.
- Required course work.
- American Disabilities Act guidelines.
- Licensure data, such as number of years license is valid, fees and licensure questions.
- Continuing education requirements.
- Periodic refresher courses.
- Competency requirements.
- Criminal background checks.
- Mandatory reporting of violations of the nurse practice act required in state.
- Investigation of complaints.
- Standard of proof.
- Alternative disciplinary approaches.
- Formal disciplinary processes.
- Disciplinary remedies.
- Characteristics of probation and fees.
- Telenursing information.

Information in the *2002 Profiles of Member Boards* (Crawford & White, 2003) that is particularly important to the LPN/VN scope of practice is the question about whether delegation appears in the nurse practice act or rules and regulations for LPN/VNs. Please see Table 1 for that information.

Table 1 — Delegation is Addressed for LPN/VNs (Crawford & White, 2003)	
Delegation in the Rules, Practice Act or Other References	**Delegation is Inferred**
Alabama Alaska Arkansas District of Columbia Idaho Iowa Kansas Kentucky Maine Maryland Massachusetts Montana New Hampshire New Jersey New Mexico New York North Carolina North Dakota Ohio Oklahoma Oregon Rhode Island South Carolina South Dakota Tennessee Utah Vermont Washington Wisconsin Wyoming	Arizona — Questions referred to scope of practice committee — review and recommend to board. California-VN — In basic nursing program within supervision content area. Florida — Listed in statute, board rule. Louisiana-PN — Board memo, newsletter, Web site. Missouri — Specific board opinions/decisions, MSBN newsletter, board position statements, MSBN Web site, etc. Pennsylvania — Licensees may not delegate. Virgin Islands — Planning workshop for nurses and employers. West Virginia-PN — Published "guidelines on scope and delegation" approved by RN and LPN boards, mailed to all RNs and LPNs and used to answer all practice questions. West Virginia-RN — Special joint publication between RN and LPN boards which includes a scope of practice model and a delegation model.

NCSBN SCOPE OF PRACTICE SURVEY RESULTS

In preparation for writing this White Paper the Practice, Regulation and Education (PR&E) Committee at NCSBN recommended that we conduct an electronic survey of the boards of nursing and the two LPN/VN organizations to answer some important questions on the LPN/VN scope of practice. The survey to the two organizations was slightly adapted from the survey to the boards of nursing. The specific questions on LPN/VN tasks that were addressed (e.g., IV therapy, administering blood transfusions, etc.) all were questions asked in the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2003). Since the PN Focus Group was convened to discuss the results of that survey, it made sense to use those specific task questions in this survey of the boards of nursing and LPN/VN organizations. The PR&E Committee reviewed the final draft of the survey and it was sent out electronically in February of 2005. Of the 60 boards of nursing, 48 completed the survey. The results and individual comments can be reviewed on the Education page of our Web site, which is www.ncsbn.org. Each question will be summarized here.

Question 1 — Do LPN/VNs independently develop the client's plan of care?

A large majority of the boards (46 to 2) responded "no" to this question. A large number of respondents (14) commented that the LPN/VN should contribute to the plan of care, but that the RN or physician must approve it. One board of nursing said that this might be allowed with further education of the LPN/VN.

Question 2 — Can the LPN/VN make changes to the client's plan of care?

Again, a large majority of the respondents replied "no" (41) to this question, with five saying yes. Again the preponderance of comments was that the RN must approve changes in the plan of care. One board of nursing said that LPN/VNs may be allowed to make changes with further education and another said that it depended on the nature of the change.

Question 3 — Can the LPN/VN decide on the level or type of care needed from a phone conversation with the client, that is can the LPN/VN perform telephone triage?

Thirty-one boards of nursing answered "no" to this question, while eight replied yes. Four of the boards said that is was allowed only when protocols or standing orders were in place. Another said that all abnormal findings must be reported to the physician or RN, while two boards of nursing said that this may be allowed with further education.

Question 4 and 8 — Can the LPN/VN independently plan and provide education to clients/ families about safety precautions or on ways to manage clients with behavioral disorders?

A majority of the boards of nursing said that LPN/VNs couldn't provide education about safety precautions (29), though 11 said yes. Five respondents said that the LPN/VN could provide education to the clients, but they also said that the total plan of care is the responsibility of the RN. Two boards of nursing said that the LPN/VN provides routine health information and instruction recognizing individual differences. One board said that the RN could assign this activity to the LPN/VN after the RN has determined that the LPN/VN is competent to provide such teaching.

The response for providing education on ways to manage clients with behavioral disorders was even more skewed; 39 said no, while four said yes. Here, four boards said that the LPN/VN needs to follow the educational plan developed by the RN supervisor. Some of these can be semantic issues; for example, one board said, "the regulation states 'participate in health teaching.'" That means the LPN/VN and his or her supervisor has to discriminate between "participating" and "independently planning."

Questions 5, 6, 7 and 20 — Comparing data collected for health history, psychological status, potential for violence and the client's nutritional or hydration status to expected norms for decision making or care planning?

Table 2 — Boards of Nursing LPN/VN Requirements for Decision Making

Decision-Making or Care Planning	Yes	No
Compare health history data to norms for decision-making or care planning?	25	17
Compare psychological data to norms for decision-making or care planning?	21	18
Compare potential for violence data to norms for decision-making or care planning?	21	19
Compare nutritional or hydration status data to norms for decision-making or care planning?	29	12

See Table 2 for a summary of how the boards differ regarding comparing data to the normal values and then making decisions or care plans based on that interpretation. The following discussion summarizes the comments for those questions.

Thirteen of the boards of nursing commented that LPN/VNs could compare the data collected for the health history to the norms and make decisions or revise the care plan when they collaborate with the RN or physician. Another said that they could do this if there were prepared guidelines and another said it could be done if it were a part of the plan.

When asked about comparing psychological status data to norms for decision-making and care planning, 10 boards said that LPN/VNs could do this in collaboration with the RN or physician.

Another said that the LPN/VN would need further education to do this and yet another said the LPN/VN would have to be evaluated to see if he or she had this ability.

Similarly, when comparing the data on potential for violence to norms, for decision-making and care planning, eight boards indicated that the LPN/VN would need to collaborate with an RN or physician in order to do this. As in the above question, boards indicated that further education or evaluation would be needed before LPN/VNs could carry out these functions.

When comparing nutritional or hydration data to the norms and making decisions about the care plan, 10 boards commented that LPN/VNs could do this, but that they would need to report to the RN or physician. Another board included the distinction that the RN develops the care plan, while the LPN/VN contributes to it.

Questions 9 and 10 — Can LPN/VNs monitor and administer transfusions of blood products?

Thirty-six boards of nursing allow LPN/VNs to monitor blood transfusions, though five do not. However, only 18 boards of nursing allow LPN/VNs to administer blood products, while 22 do not. One board commented that its law is silent on both issues. Five boards said that LPN/VNs aren't taught to monitor blood transfusions in their basic programs so they must document further training in this area before they are allowed this responsibility. Another three boards say that LPN/VNs can administer blood transfusions when they provide evidence that they have had further training.

Questions 11, 12, 13, 14, 15, 16 and 18 all address intravenous (IV) responsibilities: Can LPN/VNs assess client's IV site and flow rate? Give a medication through a peripheral IV line by intravenous piggyback (IVPB) or IV? Provide medications by intravenous push (IVP)? Give IV fluid or IVPB/IVP medication through a central venous catheter? Give total parenteral nutrition (TPN)? Start or restart an IV line on a client 16 years or younger? Restart an IV line on a client 16 years or older?

Table 3 — Boards of Nursing IV Requirements for LPN/VNs

IV Activity	Yes	No
Assess IV site and flow rate?	40	3
Give medications through a peripheral line (IV or IVPB)?	39	2
Medications given IVP through a peripheral line?	22	18
Medication given IVPB or IVP through a central line?	23	19
Give TPN?	27	16
Start or restart an IV on a client 16 years old or younger?	29	13
Start or restart an IV on a client older than 16 years?	34	7

As can be seen from Table 3, there is much variation with IV requirements for LPN/VNs in the boards of nursing, as has been stated (Smith, 2004). Assessing the site and monitoring the flow rate, along with starting or restarting IVs on adults seem to be the most universal of the IV responsibilities. Giving medications IVP has the most divergence across the 60 boards of nursing. Some of the comments with IVs addressed the necessity of the LPN/VN needing further education, or becoming certified, in order to carry out these functions. One board of nursing stated that its rules were silent on this issue. Another board of nursing gave a very detailed list of specific drugs that could be given by LPN/VNs; with these details the RN or pharmacist must mix the medication and the first dose of all medications must be given by the RN. Other boards also said that the LPN/VN could administer medications by the IV route as long as they were premixed and prelabeled and other boards indicated that there were certain medications that LPN/VNs are allowed to administer by the IV route. Another board of nursing stated that only the LPN/VN who works in chronic dialysis could give specific IVP medications. Still another board of nursing said that LPN/VNs could only administer heparin or saline by the IVP route. Another board wrote in detail

about IV responsibilities being a delegated function; that means then that the RN must make the decision that the LPN/VN has been adequately trained to carry out these responsibilities. A few boards of nursing leave the decision to the agencies where the LPN/VNs work.

With TPN, again, three boards commented that the LPN/VN would need to be certified before they could administer TPN. Another board of nursing said that the RN would have to initiate TPN, but the LPN/VN could then administer TPN.

On the question referring to starting or restarting IV lines on clients 16 years or younger, six boards of nursing commented that the LPN/VNs could do so with additional training. Some boards of nursing had different age requirements: one board said an LPN/VN cannot start or restart an IV on a client 12 years of age or younger or under 80 pounds; another board just said under 12 years old. Another board has age two as the cutoff, another has age four and yet another has age 18. Two boards mention that RNs can delegate this responsibility, but they must verify the training and competence of the LPN/VN before doing so. Another board specified that the IV could be started or restarted using a peripheral access device that is three inches or less in length.

Question 17 — Can LPN/VNs lead group discussions?

Twenty boards of nursing allow LPN/VNs to lead group discussions, while 14 do not. Four boards of nursing said that it depends on the discussion and three more say that it is allowed only if the LPN/VN has had further education. Three boards of nursing say that the law is silent on that issue. One board of nursing said that this would be considered "counseling" and that is considered outside the scope of an LPN/VN. Another said that the RN could delegate this responsibility, though he or she would have to verify the competency of the LPN/VN.

Questions 26 a-f — Definitions for independent LPN/VN practice, LPN/VN decision making, assessment by LPN/VN, focused assessment by LPN/VN, delegation and assignment.

Table 4 — Board of Nursing Definitions

Written Definitions?	Yes	No
Independent practice	10	33
Decision-making	9	34
Assessment	18	27
Focused assessment	9	34
Delegation	27	17
Assignment	11	32

Table 4 lists the number of states that do have written definitions of these terms. The states that have definitions were asked to provide them, but those comments were too detailed for the purposes of this Paper; however, the results can be found at www.ncsbn.org, on the Education page. The following are some highlights of that discussion:

- Independent practice
  - While one state comments that the LPN/VN practices under the guidance of an RN on a selected basis, within safe limits, the role of the LPN/VN may be expanded.
  - Little or no supervision.
- LPN/VN decision making
  - Makes decisions about care.
  - Depends on the level.
  - Linked to the process of delegation.
  - One state has a decision-making model.
- Focused assessment

- Assessment with recurrent health problems.
- Collection of "additional data."
- Initial and ongoing data collection.
- Decisions that are focused within the LPN/VN scope of practice.

- Delegation
  - Transfer of authority.
  - Delegator retains accountability.
  - Must delegate to those who are qualified, competent and legally able to perform those duties.
  - One board defined it as "assigning."
- Assignment
  - Giving others duties to perform.
  - Person receiving assignment must be authorized to perform that care.
  - Job description for a particular day.

Questions 29 & 30 — Do you allow your LPN/VNs to delegate or assign?

While 28 boards of nursing allowed their LPN/VNs to delegate, 33 allowed them to assign. Twelve boards of nursing responded that they do not allow delegation, while seven do not allow LPN/VNs to assign. Generally, the comments addressed to whom the LPN/VNs can delegate or assign, including LPN/VNs or assistive personnel (e.g., certified nurse assistants). One board said that they are requiring the LPN/VN programs to teach delegation information, with a focus on long-term care.

Questions 27 & 28 — Does your state have provisions for certification of LPN/VNs (i.e., LPN licensure designation)? If so, is that scope of practice different?

Only six boards of nursing have certification provisions, whereas 36 replied that they did not. Of those six who do have certification provisions, four allow a broader scope of practice. The specific certification addressed in the comments was IV certification.

Table 5 — Other LPN/VN Responsibilities Allowed by Boards of Nursing

Activity	Yes	No
Change/reinsert gastrointestinal tube (g-tube)	30	10
Laser removal of unwanted hair	8	30
Perform a microderm abrasion procedure	6	30
Assist in the removal of body wastes by peritoneal dialysis	31	6
Assist in the removal of body wastes by hemodialysis	30	5
Monitor a client recovering from conscious sedation	25	16

Table 5 lists whether the boards of nursing allow six very specific functions that also were addressed in the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2003). In the comments section of the survey, some boards of nursing made some very specific comments, such as, when referring to the g-tube insertion, "Yes, if the tract is well-healed with no complications such as infection, etc." Other boards, for many of these functions, said that they would be allowed if the LPN/VN had further education. Some boards spelled out their policy on delegation in the comments section. Other boards commented that they did not have regulations that addressed these tasks. One board, regarding conscious sedation, said, "We have not addressed this, but I imagine it is happening."

Question 31 — Does your state have a statewide LPN/VN articulation program?

Nineteen boards of nursing stated that they have a statewide articulation program, while 20 said that they don't.

In summary, this survey to the boards of nursing and the LPN/VN organizations documents the wide variance in the practice acts and the administrative rules regarding LPN/VN practice. This variation particularly seems to exist with allowing LPN/VNs to administer IV medications and blood transfusions, make decisions based on comparing data to the normal and independently plan and provide education to clients and their families. The boards of nursing had some agreement in that they generally didn't allow the LPN/VN to independently develop the plan of care, make changes in the plan of care and perform telephone triage.

SEAGO ET AL., 2004, "SURVEY, DEMAND AND USE OF LICENSED PRACTICAL NURSES"

Seago et al., 2004, wrote an excellent, comprehensive document on LPN/VNs that included demographics, scope of practice and practice acts, education, factors affecting supply and demand and perspectives of the employers, educations and state boards of nursing. They collected data from primary and secondary sources and they selected four states where they conducted in-depth qualitative research, using focus groups and interviews with LPN/VN employers, educators and state boards of nursing. The complete document can be accessed at http://bhpr.hrsa.gov/healthworkforce/reports/lpn/LPN1_5.htm. This White Paper will focus on Chapter 3 of that document, which addresses the scope of practice and practice acts.

The Report states that points of contention surround the words "assessment," "delegation," "supervision," "decision making" and "critical thinking." NCSBN found that a majority of the boards responding to this question (28 out of 40 that answered that question) allow "delegation" in their states, though there was wide variance with "decision-making." As Seago et al. (2004) assert, it is difficult to distinguish between collection of data and assessment.

Seago et al. also collected data from the boards of nursing that regulate LPN/VNs and they found substantial variation in the restrictiveness in the scopes of practice, as was found in the NCSBN survey. Further, after reviewing the board of nursing practice acts, they found some to be highly specific, while some were quite vague. Seago et al. (2004, p. 31) defined "restrictiveness" as "limiting the level of autonomy, flexibility or independence in the practice of LPNs." These authors then rated each board of nursing on restrictiveness in Appendix C of their publication, with 4 being the most restrictive and 1 being the least restrictive. They also, in the same appendix, rated each board of nursing as to specificity (4 most specific; 1 least specific), which they defined as "explicating defined parameters of practice of LPNs" (Seago et al., 2004, p. 31). Three principal investigators of the study categorized the practice acts of the boards of nursing and they had established criteria to denote agreement. On the restrictiveness scale, 15 boards of nursing were rated as 1 (least), 24 as 2, 11 as 3 and 2 as 4 (most). On the specificity scale, 14 boards were listed as 1 (least), 20 as 2, 6 as 3 and 12 as 4 (most). Their focus group data from Louisiana, Massachusetts, California and Iowa indicated that the employers restrict LPN/VN practice even more than the regulations require.

This publication has some very specific information about board of nursing requirements of LPN/VNs, such as the results of a board of nursing survey regarding IV medications, as well as an excellent table showing each state's specific scope of practice with certain functions (such as IVs, dressings and care planning), along with requirements of supervisors (such as cosigning documentation).

Again, these data point to wide variations across the country with LPN/VN regulations for scope of practice. Interestingly, in their conclusion, Seago et al. (2004) wonder if the expanded scope of practice of an LPN/VN leads to increased salary in the workplace. In their recommendations, they suggest that:

- States with the most restrictive scopes of practice should reduce those restrictions, unless it

is clear that a restriction would negatively impact patient care.

- Workplaces create teams of LPN/VNs that share the workload.
- The RN and the LPN/VN should have a better understanding of the scope of practice and that the difference between the workplace scope of practice and the state board of nursing scope of practice should be clarified.
- Educational work toward standardization of LPN/VN educational preparation.
- States create articulation pathways between the LPN/VN and RN.
- While LPN/VNs cannot substitute for RNs, many tasks traditionally carried out by RNs can be carried out by the LPN/VN.
- While the LPN/VN could be used to augment the workforce during the current nursing shortage, this will depend on the ability of states to create a more flexible LPN/VN scope of practice.
- It is unlikely that the LPN/VN will substantially ease the RN shortage because LPN/VNs fall into the same worker pool.
- Employers should consider increasing wages when LPN/VNs receive additional training or education.
- Consider using the LPN/VN predominantly in long-term care, and not in acute care.
- Educate the public about the LPN/VN, both to give them recognition and to encourage people to pursue a career in practical nursing.

"FIRST NATIONAL SAMPLE SURVEY OF LICENSED PRACTICAL AND VOCATIONAL NURSES, 1983"

Bentley et al. (1984) conducted the first national survey of LPN/VN data. A survey was sent to 22,004 LPN/VNs between November 16–23, 1983. Of those sent out, they received 8,240 completed questionnaires back. The sampling design was a two-stage, multiple-frame alphabetic cluster design, with the population being all licensed LPN/VNs. The lists of LPN/VNs were obtained by the state boards of nursing in all 50 states and the District of Columbia. There are a number of tables in this document, though beyond a very brief explanation of the study design and a summary of the results, there was no analysis of this study, nor were there any conclusions or recommendations.

The categories of data collected in this survey were:

- Number of LPN/VNs
- Sex and race
- Age
- Marital status and children
- Employment status
- Spouse education
- LPN/VN license data
- Educational background
- Continuing education
- Employment settings
- Employment titles
- Hours and earnings
- Temporary employment services

- Status of those not employed
- Geographic mobility
- Change in employment status

"SCOPE OF LPN PRACTICE STUDY TO IDENTIFY CONGRUENCIES AND INCONGRUENCIES AMONG LPN REGULATIONS, EDUCATION AND PRACTICE, JANUARY 2005" MINNESOTA BOARD OF NURSING AND MINNESOTA COLLEAGUES IN CARING

McEvoy's (2005) Report to the Minnesota Board of Nursing outlined the purpose of the LPN Task Force, which was to:

- Identify congruencies and incongruencies among LPN regulations, education and practice.
- Make recommendations based on identification of incongruencies.

This group collected documents that reflect the education, practice and regulation of LPN/VNs in the state of Minnesota. The group was concerned that the practice of LPN/VNs in that state wasn't congruent with their education and the state regulations. Therefore, a random sample of LPNs in Minnesota according to practice area and geographic area were surveyed. They had a 64.3% response rate with this survey. Their significant findings included:

- Confusion with the terms "observation" and "assessment;" these terms lacked congruency across education, practice and regulation. Therefore, they recommended that the nature of observation and assessment needs to be clarified and differentiated from assessment and observation in RN practice.
- Confusion with the terms "delegation" and "supervision" in LPN/VN practice because of incongruence among regulations, education and practice. They recommended that ongoing education on the use of supervisory positions is needed, with clear examples of how to communicate the role differentiation between the LPN/VN and RN.
- No consistent statewide trends with urban or rural settings and long-term care and acute care. Therefore, the Committee recommended that scope of practice be state specific, not geographic or practice specific. Further study of practical nursing practice in long-term care and rural acute care is warranted.

Appendices

I. PN Focus Group Members

II. Algorithm for Discussion

III. The Desired Evolution of Regulation

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Appendix I

PN Focus Group Members

Marcia Hobbs, DSN, RN
NCSBN Board Member Vice President (until August 2004), Kentucky Board of Nursing

Anita Ristau, MS, RN
Executive Director, Vermont Board of Nursing

Marjesta Jones, LPN
NCSBN Board Member Director-at-Large (until August 2004), Alabama Board of Nursing

Claire Glaviano, MN, RN
Executive Director, Louisiana State Board of Practical Nurse Examiners

Mariann Williams, BSN, MPH, MSN, RN
Washington Board of Nursing

Marianna Kern Gracheck
Executive Director, Joint Commission's Long Term Care Accreditation

Marilyn Smidt, MSN, RN
Director of Nursing Programs, National League of Nursing Accrediting Council (NLNAC)

Donna M. Herrin, NSN, RN, CNAA, CHE
Senior Vice President and Chief Nurse Executive, Methodist Healthcare

Casey Marks, PhD
NCSBN Associate Executive Director — Business Operations

Gregory Tyrone Howard, LPN
President, National Federation of Licensed Practical Nurses (NFLPN)

Patricia Shutt, LPN
President, Nevada State Board of Nursing

Susan C. Reinhard, RN, PhD
Rutgers, The State University of New Jersey

Richard R. Kerr, LPN
President, National Association for Practical Nurse Education and Service (NAPNES)

Mr. Richard English, LCGI
Group facilitator

Lanette Anderson, BSN, JD, RN
Executive Secretary, West Virginia-PN Board of Nursing

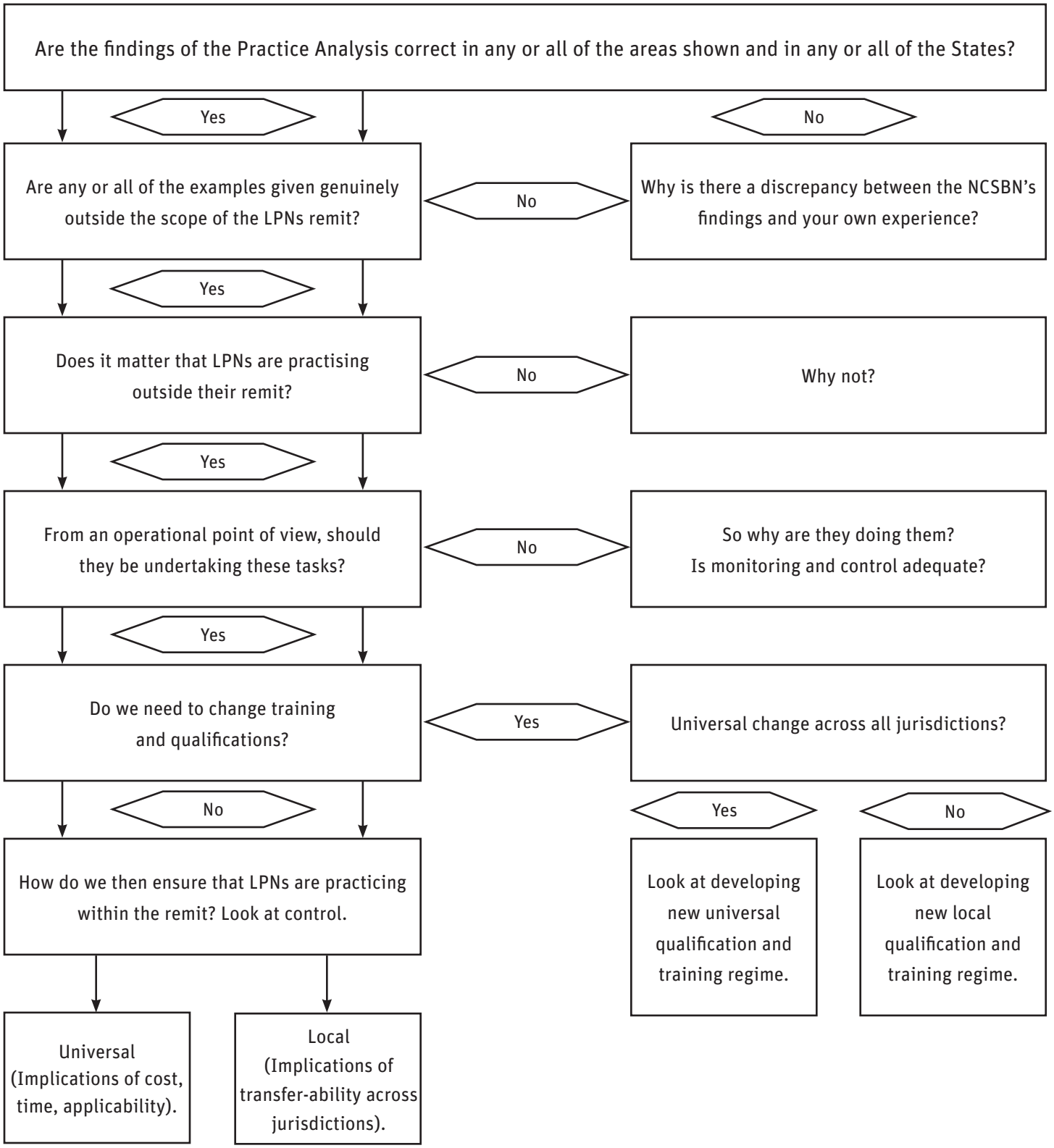
Kathy Apple, MS, RN, CAE
NCSBN Executive Director

Rose Kearney-Nunnery, PhD, RN
President, South Carolina Board of Nursing

June Smith, PhD, RN
NCSBN Associate Director of Research Services (until 2004)

Appendix II

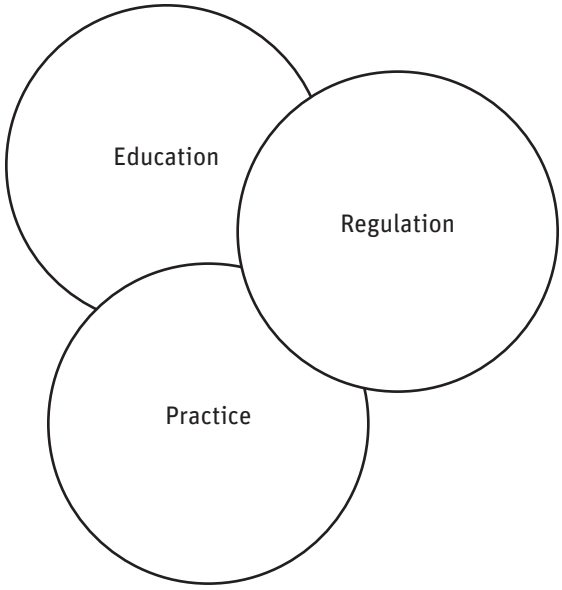
Algorithm for Discussion



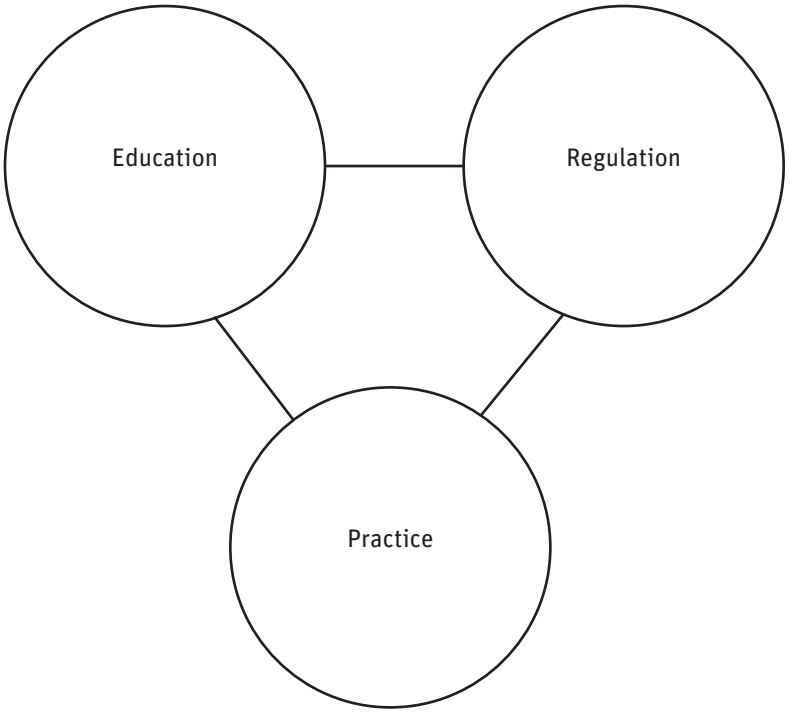
Appendix III

The Desired Evolution of Regulation

Now and/or Desired (Evolving)



Jurisdiction Specific NOW



Attachment D

Systematic Review of Studies of Nursing Education Outcomes: An Evolving Review

The systematic review is an integral part of evidence-based health care. One of the best definitions of evidence-based medicine (which can be applied to health care in general) is "…the integration of best research evidence with clinical expertise and patient values" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 1). This definition is a comprehensive definition that doesn't just include the results of the best studies, but it also considers clinical expertise and the patients' needs. When applying evidence-based health care to nursing education, we should employ the best studies available, integrated with the expertise of qualified and experienced nursing faculty and the values and needs of our students.

A systematic review is the ideal overview of several randomized trials of the same intervention or treatment for the same situation or condition; this overview systematically and critically reviews and combines all the studies, providing a better answer than the results from just one study (Sackett et al., 2000). Since there are not a lot of randomized trials available on nursing education, this systematic review is intended to be a critical analysis of evidence supporting, or not supporting, nursing education strategies and learning environments. It is important to note that this is an evolving review that will continually change as more research becomes available.

Systematic reviews consider the strength of the evidence for a particular strategy. Therefore, in this review the levels of evidence, or hierarchies of the studies, are identified. There are several ways that researchers classify research studies. One system is to grade the studies on a rating of I to V. Level I studies are large randomized control trials (RCTs); level II studies are RCTs with 50 subjects or fewer; level III are smaller cohort or case-control and cohort studies; level IV evidence come from case reports and low-level case-control and cohort studies; finally, level V is expert or consensus based on experience, physiology or biological principles. Another system uses the levels A through D to designate the strength of the evidence. Grade A is the strongest evidence, while grade D is the weakest (Mayer, 2004).

Many systematic reviews only use randomized controlled trials; however, that would limit the results in this review. Therefore, in this review, the level of evidence will be rated as adapted from Gallagher (2003) and Polit & Beck (2004). Gallagher (2003), while writing a clinical article, used a meaningful, easily understood method of rating studies. To avoid confusion, Polit and Beck's description of Level II nonexperimental studies was used to be more in line with nursing studies.

It is important for nurses to strongly consider the level of evidence when making decisions to use research in their practice. Level II or III evidence should not be discounted. If those studies are done well, they can begin to identify relationships, obtain information about populations and help us to understand the viewpoints and realities of those under study (Polit & Beck, 2004). Further studies can corroborate these findings or study the variables in a more controlled design. For the purposes of this review, the levels of the studies will be identified as:

- **Level I.** A properly conducted randomized controlled trial, systematic review or meta-analysis.
- **Level II.** Other studies, such as quasi-experimental, correlational, descriptive, survey, evaluation, and qualitative.
- **Level III.** Expert opinions or consensus statements

The databases used to retrieve these studies were CINAHL, Medline and ERIC. Keywords used were: *education, nursing, teaching, education research, learning methods, learning strategies, research-based education,* and *outcomes of education*. The Reference Librarian at Rush Medical

Center School of Nursing assisted in identifying appropriate articles. All issues not available at the Rush University School of Nursing were ordered.

The following criteria were used to select the studies:

- Study of educational outcomes.
- Identification of a design.
- Sample description.
- Comparison being studied or objective of the study (for noncomparison studies).
- Reporting of results.
- English-only studies (including countries outside the United States).

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Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Angel, B.F., Duffy, M. & Belyea, M. (2000). An evidence-based project for evaluating strategies to improve knowledge acquisition and critical-thinking performance in nursing students. *Journal of Nursing Education*, 39, 219-228. **Level II**	N = 142 undergraduate junior nursing students, during the Fall of 1996. 93% female 86% white Average age 24 ±5.5	Structured format for Health Pattern Assessment versus unstructured format.	Outcomes were acquisition of knowledge and development of critical thinking skills. Longitudinal, quasi-experimental study, utilizing a pre-/post-test design. A Case Study Questionnaire was developed to measure knowledge and to elicit characteristics of critical thinking.	■ Learning characteristics (e.g., age or previous degree) affected which teaching strategy was effective. ■ Older students and those without a previous degree tended to benefit more from the unstructured approach; younger students tended to benefit more from a structured approach. ■ Knowledge and critical thinking improved after a semester of faculty supervised clinical experiences.	■ One of very few studies that measured critical thinking during clinical experiences. ■ Psychometrics of the measurement tools needed to be cited. ■ Students assigned to groups by a stratified random procedure.	■ Evidence supporting that supervised clinical experiences with qualified faculty can improve the critical thinking of students. ■ Teaching strategies may be affected by student characteristics.
Armstrong, S., & Muller, M. (2002). A value clarification on quality within nursing colleges in Gauteng. *Curationis*, February, 52-68. **Level II**	Stratified sampling was used to obtain student and employer samples. Lecturers were selected by purposive sampling. Funders were selected by purposive sampling.	They developed a quality audit system and conducted a study to describe a value clarification on quality within the Nursing Colleges in Gauteng.	Data collection included interviews, naïve sketches and document analysis. Data analysis was done using a modification of Tesch's content analysis procedure. Guba's model of trustworthiness was used to ensure truth-value, applicability, consistency and neutrality.	Three themes were identified: ■ Structure – human resources, technology, theoretical learning facilities, practical learning facilities and strategy. ■ Process – leadership, educational program, relationship and research. ■ Results/Outcomes – community outreach, products of the college, organizational development and recognition.	■ Methodology to ensure reliability of the data was strong. ■ Data were collected from multiple sources. ■ Data collection might have been more consistent across all subjects. ■ Tape recordings might have been used on all subjects.	This study was able to validate that structure, process, and results/outcomes are important areas to evaluate for board approval surveys.
Babenko-Mould, Y., Andrusyszyn, M., & Goldenberg, D. (2004). Effects of computer-based clinical conferencing on nursing students' self-efficacy, *Journal of Nursing Education*, *43*(4), 149-155. **Level II**	Convenience sample = 42 fourth-year nursing students at an Ontario University. Control group = 27 Online intervention group = 15. 95% female; average age of 24 ± 5.	Examination of the differences in fourth-year baccalaureate nursing students' self-efficacy (or confidence) in carrying out nursing competencies, when using the addition of computer conference discussions, versus using only traditional conference discussions. Examination of strengths and challenges of computer-mediated learning (CML).	Design — Pre-/post-test, quasi-experimental, nonequivalent group. Theoretical framework — Bandura's theory of self-efficacy. Descriptive analysis was also used to explore themes regarding strengths and challenges of online learning.	■ Self-efficacy for students in the intervention group was not found to be significantly different from that of students in the control group. ■ In both groups, students' Self-Efficacy for Professional Nursing Competences Instrument (SEPNCI) scores increased from pretest to posttest. ■ All students agreed (some strongly) that computer conferencing enhanced learning. ■ Four strengths associated with computer conferencing were connection, support, learning and sharing. ■ Two challenges of CML were time and Internet access.	■ Content validity only was established. ■ Cronbach's alpha reliability coefficients were calculated for both instruments and were acceptable. ■ While online evaluations were rated positively by the students, there were no differences between the groups (traditional and traditional with CML) regarding self efficacy for nursing competencies; the study, therefore, really cannot conclude that CML can contribute to increased confidence levels, though authors conclude this.	■ This supports the idea that clinical practicum experiences, with qualified faculty, increases nursing students' level of confidence in all nursing competence domains. ■ Online learning need not be geographically oriented. ■ Online learning can be a positive experience for nursing students, though further testing must be done to determine if it is as effective as traditional methods.

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Benner, P. (2004). Using the Dreyfus Model of skill acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education. *Bulletin of Science, Technology & Society*, *24*(3), 188-199. **Level II**	Three studies: ■ 1978–1981 — 21 paired new graduates & their preceptors; 51 experienced nurse clinicians; 11 new graduates; 5 senior nursing students ■ 1988–1994 — 130 practicing ICU and general unit nurses ■ 1996–1997 — 75 critical care nurses	■ 1978–1981 — Delineate and describe characteristics of nurse performance at different levels of education and experience. ■ 1988–1994 — (1) describe nature of skill acquisition in critical-care nursing practice (2) delineate the practical knowledge embedded in expert practice. ■ 1996–1997 — Extension of above study, with inclusion of other critical-care areas.	Qualitative design (narratives, interviews & observations) ■ 1978–1981 — interviews with paired samples; interviews and/or participant observations with the rest of the sample. ■ 1988–1994, 1996–1997 — Small group narrative interviews, individual interviews, and participant observation.	■ Demonstrated that the Dreyfus Model is useful for understanding learning needs of students and nurses. ■ Novice or first year of education — operates from the perspective of inflexible, rule-governed behavior. ■ Advanced Beginner or new graduate — heightened awareness of feedback and frequently experience anxiety and fatigue. ■ Competent or one to two years in practice — decides what is important based on past experiences. ■ Proficiency or transitional stage to Expert — develop the ability to let the situation guide the nurses' responses. ■ Expert or phronesis (practical wisdom) — the integrated rapid response is the hallmark of expertise.	This study is a 21-year review of Dr. Benner's studies on the Dreyfus Model. Because of that, the methodologies weren't described in much detail, and establishing reliability and validity in this qualitative study weren't addressed. These may have been addressed in the prior published studies.	■ Students learn best when qualified faculty provides coaching, feedback and reflection throughout nursing education. ■ During the Novice stage, learning is best fostered by providing safe, clear directions first with simulations, followed by situated learning experiences.
Bjørk, I.T. & Kirkevold, M. (1999). Issues in nurses' practical skill development in the clinical setting. *Journal of Nursing Care Quality*, *14*(1), 72-84. **Level II**	Four nurses employed in different surgical units of two Norwegian Hospitals.	Development of practical skills of postoperative ambulation and dressing wounds.	■ Longitudinal qualitative study. ■ Videotaped the nurses during the skill performance and interviewed nurses and patients afterwards; observations done three times with three to five month intervals. ■ Videotaped actions were described impressionistically and coded.	■ Many omissions and faults with their performances were seen even on the third videotape, after eight to 14 months experience and 25 experiences with skills. ■ The nurses associated learning with efficiency and motor aspects of performance. ■ The nurses did not have much guided experience, and the units did not encourage collaboration.	■ Patient conditions could vary from one videotape to the next; thus, affecting the complexity of the skill performance. ■ The authors didn't address inter-rater reliability or their coding system. ■ The selection of the nurses wasn't discussed.	■ The general assumption that experience leads to mastery was challenged by this study. ■ Active reflection of one's own experience is a premise for experiential learning. If reflection is not fostered, improvement will not occur. ■ Similarly, guided experience or feedback from qualified practitioners is essential for improvement.
Buckley, K. M. (2003). Evaluation of classroom-based, Web-enhanced, and Web-based distance learning nutrition courses for undergraduate nursing. *Journal of Nursing Education*, *42*(8), 367-370. **Level II**	■ Convenience sample of 58 students enrolled in three consecutive nutrition and health courses. ■ N=24 in traditional lecture format; N=23 in Web-enhanced format; and N=11 in Web-based format. ■ Traditional four-year baccalaureate degree program, second-degree students, and RN BSN students.	■ Investigated differences between the same course content being delivered by traditional, Web enhanced, and Web-based formats. ■ Investigated differences regarding student perceptions of experiencing content via these three different formats.	■ A descriptive comparative study method was used. ■ Outcomes measured were exam scores, overall course grades and standard course evaluations.	■ Students' qualitative comments revealed both positive and negative aspects of online instruction. ■ No differences were found in student learning outcomes. ■ Web-enhanced courses were most popular. ■ Comments showed that possible sources of student satisfaction are student profiles, learner characteristics, student motivation and the communication process.	■ While instructors weren't blinded to the format, all exams were multiple choice which limited the bias. ■ Groups were not equal in size. ■ Students had no choice in the instructional format, though assignment to groups was not specified. ■ Because of small number of cases in each group, it would take a large effect size to find significant differences. ■ Administration of the computer exams and the paper and pencil exams was starkly different. ■ Authors attested to adequate reliability and validity of the course evaluation tool, though no statistics were provided; exam psychometrics weren't cited.	■ Students' needs for structure, instructor interaction and a feeling of belonging must be addressed in the development of distance learning courses. ■ Information concerning students' preferred learning styles and motivations for learning should be solicited before selecting the form and extent of technology used in a course. ■ Online nursing courses can be just as effective as traditional lecture courses.

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Epstein, R. M. & Hundert, E. M. (2002). Defining and assessing professional competence. *JAMA*, *287*(2), 226-235. **Level I**	195 relevant citations.	■ Propose a definition of professional competence. ■ Review current means for assessing it and to suggest new approaches of assessment.	■ Used the MEDLINE database from 1966 to 2001 and referenced lists of relevant articles for English-language studies. ■ Excluded articles that are purely descriptive, duplicate reports, reviews, and opinions and position statements.	■ Definition of "professional competence:" *the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served*. ■ Common methods: subjective assessment by supervisors, multiple-choice exams evaluating factual knowledge and abstract problem solving, and standardized patient assessments of physical exams and technical communication skills. ■ Few assessments use participatory decision-making measures; few reliably assess clinical reasoning, systems-based care, technology and the patient-doctor relationship; and few incorporate the perspectives of peers and patients.	■ Data retrieval was done by one researcher. ■ Use of MEDLINE only negates use of unpublished studies and dissertations and studies in other professional disciplines. ■ Criteria for selecting the studies allowed for a variety of types of studies to be included. ■ Can it be generalized to nursing? ■ Future directions in comprehensive assessments were provided.	■ Might provide good grounding for continued competence study. ■ Provides the boards with information about comprehensively assessing professional competence in health care workers.
Girot, E.A. (1995). Preparing the practitioner for advanced academic study: The development of critical thinking. *Journal of Advanced Nursing*, *21*,387-394. **Level II**	■ Convenience sample. ■ Setting: England. ■ 25 undergraduate nursing students in the control group; 15 in intervention group.	Compared the students' perceptions of their critical thinking development in a traditional university setting and in a short course setting.	■ Comparative quantitative study with a qualitative component. ■ Semistructured questionnaires.	■ Nonuniversity students defined "critical thinking" as the ability to analyze the written text, whereas the university students viewed it as having a direct relationship with their own practice. ■ The university-educated students reported that they were more confident in their critical thinking skills, questioned their practice more; receptive to new ideas, express themselves better, and were more flexible and less ritualistic in practice.	■ Psychometrics on questionnaires not supplied. ■ Essence of questionnaires needed to be shared. ■ Self-reports can be biased, and need to have corroborating evidence.	■ Beginning evidence that developing critical thinking skills requires time and exposure to others who are seeking similar goals. ■ Critical thinking should be integrated throughout the educational process, rather than to be taught in one short course, and should be taught collaboratively with education and service.
Greenhalgh, T. (2001). Computer assisted learning in undergraduate medical education. [Electronic Version]. *British Medical Journal*, 322(7277), 40-44. **Level I**	12 prospective randomized studies of medical students with objective, predefined outcome criteria.	Outcomes of learning with computer assistance.	■ Systematic review of published studies, with 200 potentially relevant studies. ■ All 12 had comparison groups.	■ A failure of student engagement can occur because of online glitches and "dead" hypertext links. ■ Evaluation of unsupervised students attempting to gain access from remote sites should include observation. ■ Adequately train these teachers, and they should be the senior teachers. ■ Barrier to computer-assisted learning is poor integration with other forms of learning. ■ Sharing of templates within, and even outside of universities, should be considered.	■ Many of the studies had methodological problems, lacked statistical power, had possible contamination between the intervention and control groups, and had sample attrition ■ Systematic review rigorously reviewed 12 randomized controlled trials, using a standard retrieval method and objective selective criteria. ■ Can it be generalized to nursing students?	■ When evaluating computer-assisted learning, the schools of nursing should observe unsupervised students from remote sites. ■ Aim to use a variety of teaching strategies, including traditional methods, along with computer assisted learning products.

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Ironside, P. M. (2003). New pedagogies for teaching thinking: The lived experiences of students and teachers enacting narrative pedagogy. *Journal of Nursing Education*, *42*(11), 509-516. **Level II**	■ 18 students and 15 teachers were interviewed, to date. ■ Includes teachers and students from all levels and types of nursing schools.	Explored how teachers and students experience enacting a new pedagogy, Narrative Pedagogy, and this article explains how enacting this pedagogy offers new possibilities for teaching and learning thinking.	■ Audio-taped, unstructured interviews face-to-face or by telephone. ■ Participants were asked to "tell about a time that stands out for you because it shows what it meant to you to teach a class using Narrative Pedagogy." ■ Further probing: "What did that mean to you?" or "Can you give an example?" ■ Questions were intended to keep participants engaged in their stories without directing them to particular aspects or events. ■ Verbatim transcriptions. ■ Data analyzed using Heideggerian hermeneutical phenomenology.	**Themes** *Thinking as Questioning: Preserving Perspectival Openness.* *Practicing Thinking: Preserving Fallibility and Uncertainty.* ■ These themes describe how the teachers and students experienced thinking in the context of Narrative Pedagogy and how Narrative Pedagogy influenced their thinking. ■ Thinking as questioning involved persistently questioning the meanings and significance of learning experiences and making visible that which had "not been thought of before." ■ The shift is to bring complexity and uncertainty into the classrooms and clinical situations, inviting students to think about nursing practice. ■ The emphasis shifts from the student acquiring the teacher's perspective to the student exploring multiple perspectives.	■ Vague, unclear or conflicting interpretations arising during analysis were clarified by referring back to the interview texts. ■ The research team analyzed the texts and the interpretations for coherence, comprehensiveness and thoroughness.	■ In outcomes education students are taught that they are safe if they know what the teacher told them to know; with this pedagogy thinking is necessary for knowledge and theory application. ■ In the future being safe in practice might require nurses to think in ways that persistently question practice. ■ With this pedagogy to keep students and patients safe in nursing practice, teachers ask the necessary questions, and content and knowledge is extended and enhanced. ■ Research shows that nursing faculty often tell students there is "no one right answer" and that it "all depends," although their pedagogical practices often reflect and reinforce the opposite. ■ In this pedagogy clear and concise test items are constructed that focus on analytical thinking.
Issenberg, S.B., McGaghie, W. C., Petrusa, E. R., Gordon, D. L., & Scalese, R. J. (2005). Features and uses of high-fidelity medical simulations that lead to effective learning: A BEME systematic review. *Medical Teacher, 27*, 10-28. **Level I**	Initial pool of 670 studies, reduced to 109.	Reviewed and synthesized existing evidence in educational science to answer what features and uses of high-fidelity medical simulations lead to the most effective learning.	■ Databases included ERIC, MEDLINE, PsychINFO, Web of Science and Timelit ■ 91 search terms and concepts in their Boolean combinations. ■ Hand searching ■ Internet searching ■ Attention to "gray" literature ■ Use of stringent criteria for inclusion of studies. ■ Qualitative data synthesis and tabular presentation of methods and outcomes.	Medical simulations facilitate learning under the right conditions by: ■ Providing feedback ■ Repetitive practice ■ Curriculum integration ■ Range of difficulty ■ Multiple learning strategies ■ Capture clinical variation ■ Controlled environment ■ Individualized learning ■ Defined outcomes ■ Simulator validity and effective learning correlate	■ Rigorous systematic review with an eight-step pilot project; methodological issues were attended to; then the six-step study phase was undertaken. ■ All coding decisions were unanimous, and each rater was blind to the coding decisions of his/her partner. ■ Much variation in the strength of the findings in the peer-reviewed publications. ■ Limits on the published body of evidence ruled out formal meta-analysis.	Simulations are valuable learning experiences when carried out under the right conditions.

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Joubert, A., Viljoen, M. J., Venter, J. A., & Bester, C. J. (2002). Evaluation of the effect of a computer-based teaching programme (CBTP) on knowledge, problem-solving and learning approach. *Health Sa Gesondheid*, *7*(4), 80-97. **Level II**	Convenience sample of 120 generic nursing students in two educational institutions in South Africa.	Evaluated the effect of the computer-based teaching program on knowledge, problem-solving skills and learning approach in relation to oncology content.	■ A quasi-experimental design, using a pre-test/post-test control group ■ Research was conducted in a nursing practice setting (control) and under strictly controlled circumstances in a multimedia computer center and in a practice and multimedia center (experimental groups). ■ They used six instruments; the reliability and validity of each were addressed.	■ Computer teaching made no difference in respondents' knowledge of problem solving. ■ Computer teaching had a better effect in controlled circumstances. ■ The students were weak at identifying potential problems, and the computer-based teaching did not promote this ability. ■ Recommended that computer-based teaching not be used in isolation.	■ Report was disorganized and hard to read. ■ Reliability and validity done on the instruments was relatively weak. ■ Some results weren't included because partner data was incomplete. ■ There were basic differences in the time spent using computer-based teaching between the intervention groups and the control group. ■ Unclear how assignment to groups was made. ■ Sample size was calculated using multiple factors. ■ Assessments were comprehensive.	■ When used appropriately, computer-based teaching can increase knowledge. ■ Computer-based teaching should not be used alone, but it should be used with actual clinical experiences.
Kyrkjebø, J. M., & Hanestad, B.R. (2003). Personal improvement project in nursing education: learning methods and tools for continuous quality improvement in nursing practice. [Electronic Version]. *Journal of Advanced Nursing*, *41*(1), 88-98. **Level II**	44 first-year nursing students, sample selection methodology was not documented.	Objective was to describe the use of a personal improvement project for teaching nursing students about continuous quality improvement.	Students participated in a two-hour session introducing them to the personal improvement project. They then participated in counseling sessions in week three and seven, which lasted for one hour. At eight weeks the students gave a 10-minute presentation of their projects. Data were collected using a questionnaire.	■ Personal improvement project seems to be an effective way of introducing continuous quality improvement knowledge to nursing students. ■ Even those who did not succeed in achieving a personal improvement felt they had a positive learning outcome. ■ Teachers' involvement in the program is important.	■ Self-reports can be biased. ■ Important to develop instruments that can measure change in knowledge. ■ Excellent review and integration of the literature. ■ No reports of psychometrics on their questionnaire.	Possible method of teaching continuous quality improvement.
Maag, M. (2004). The effectiveness of an interactive multimedia learning tool on nursing students' math knowledge and self-efficacy. *CIN: Computers, Informatics, Nursing, 22*(1), 26-33. **Level II**	A convenience sample of ninety-six undergraduate nursing students, attending two west coast universities participated in the study. The students were mixed gender, ethnically diverse and their ages ranged from 19 to 42 years.	Nursing students were randomly assigned to one of four treatment groups, all with computer-based learning methods: text only, text and image, multimedia and interactive multimedia.	Described as experimental multifactorial study, though the sample wasn't randomly selected. Instruments: three investigator designed criterion-based tests involving basic math problems and drug calculations; the Mathematical Self Efficacy Scale (MSES); Student Satisfaction Survey, which was investigator designed. The scales were given at intervals, as described. The results were analyzed with descriptive statistics, one-way analysis of covariance and one-way analysis of variance.	■ Interactive media presentation of remedial math and calculation concepts did not render statistically significant increases in mean math-test scores or math efficacy at the post treatment and follow-up treatment periods. ■ Results indicated that a one-hour intervention is not sufficient to correct the deep-seated math problem that has been documented by educators for many years. ■ The study showed that the computer-based learning modules did not impede the students' learning. ■ Interactive multimedia group students were more satisfied with this method of learning, though this difference was not significant.	■ Further research is needed to determine if increased learning can be achieved by providing multimodal online learning modules that nursing students can use at their convenience for longer periods of time. ■ The investigators acknowledge that their results are limited because of the short treatment time, a lack of strong student motivation, and the use of a small convenience sample. ■ Reliability and validity was established on all the instruments they used. ■ It would have been instructive were they to have had a fifth comparison group with face-face learning. ■ Extraneous variables, such as motivation, test anxiety, and computer attitudes might be the focus in future studies.	■ No significant differences were shown, either with math scores, math efficacy, or satisfaction with the teaching strategy, with four different computer-based methods of instruction. ■ While there was no comparison with face-to-face learning, these methods should continue to be explored as useful adjunctive teaching methodologies.

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
MacIntosh, J., MacKay, E., Mallet-Boucher, M., & Wiggins, N. (2002). Discovering colearning with students in distance education sites. *Nurse Educator*, *27*(4), 182-186. **Level II**	Four faculty members, one at each distance site and two at the main site, in Canada. Approximately 90 learners participated yearly from three sites.	They studied the first class of students that entered an expanded program in 1995 and 1999 when they graduated. They focused on understanding the phenomenon of becoming nurses within the context of a curriculum that is oriented toward caring and co-learning and that is delivered across three geographically distant sites.	Longitudinal, phenomenological study. Data collection involved open-ended questionnaires, interviews, and focus groups. Common themes were generated by clustering similar codes. There were approximately 12 to 18 audiotaped interviews across the sites.	■ Overall theme of colearning: Main strength of colearning was "having a small class where you really get to know and work with everyone. It's really close-knit and everyone encourages you to do your best". ■ Being able to study in relatively small centers, with small numbers of learners and faculty, created a family-like atmosphere that tended to support learning. ■ Findings indicate that orientation to a multisite program must include familiarization with distance technologies for both students and teachers. ■ Interaction with professors was important for colearning.	■ Some distant professors teaching by teleconference had less effective contact with learners; participants indicated that this did influence development of colearning relationships. ■ Learners came to like computers because e-mail provided a link to, and interaction with, others, including professors. ■ Some nonnursing courses are more difficult to teleconference and teachers accustomed to lecturing content on campus made learners question the effectiveness of this teaching strategy. ■ The required group projects to build colearning contributed to a sense of work overload. ■ Reliability of transcriptions wasn't addressed.	■ There may be benefits of dividing students in larger sites into smaller groups to foster supportive interactions present in smaller groups. ■ Interactions with professors remain an important part of learning.
McDonald, D. D., Wiczorek, M., & Walker, C. (2004). Factors affecting learning during health education sessions. *Clinical Nursing Research*, *13*(2), 156-167. **Level II**	The sample size started with 78 college students. The final sample size was 48 (see strengths and weaknesses; third bullet). Average age – 21.4 (± 6.21) White – 79.5% Female – 83.3% Nursing major – 71.8%	They tested how background noise and being interrupted affect learning health information.	■ A pre-/post-test, double-blind, two-by-two factorial experiment comparing interruption (interruption/no interruption) by noise (noise/no noise) was used. ■ Instruments included a demographic data record and the Antibiotic Resistance Test, where content validity and reliability were established. ■ The teaching intervention was a five-minute videotape on antibiotic-resistance teaching, and content validity was established. ■ Participants were randomly assigned to one of the four groups. ■ A data recall task was presented immediately after the videotape, which required the information learned while watching the videotape to be transferred into long-term memory to be recalled. ■ Analysis of covariance was used in analysis.	■ The results suggest that noise and interruption during health teaching adversely affects the ability to learn health information. ■ The difference in the mean scores was small, but a lack of understanding in any one of the areas could place a person at risk.	■ The study took place in a university rather than in a health care setting. Health care and university environments might introduce vastly different intrapersonal factors that encourage or inhibit learning. ■ The study controlled for confounding factors, such as different teachers, content, frequency, and magnitude of disruption. ■ The groups, though formed with random selection, were uneven regarding having taken a microbiology course; therefore, the original findings showed no differences. They found differences when they omitted those students who had taken a microbiology course. However, that decreased their sample size from 78 to 48. ■ The distractions and noise were realistic. ■ The teaching was only done by videotape, thereby negating teacher/student interaction, which could clarify misperceptions.	■ Greater effort should be made to create environments with minimal distraction, especially when understanding the health information, is critical. ■ People teaching health information should assess the environmental distractions present, develop plans to decrease the factors, complete a cost-benefit analysis for each option, implement changes, and evaluate the effectiveness of the changes for health-learning outcomes.

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Miller, S. K. (2003). A comparison of student outcomes following problem-based learning instruction versus traditional lecture learning in a graduate pharmacology course. *Journal of the American Academy of Nurse Practitioners*, *15*(12), 550-556. **Level II**	Convenience sample of 12 APRN students in the control group and 10 APRN students in the intervention group.	The medical literature has studied problem-based learning more comprehensively than nursing. Therefore, this study compared student performance and satisfaction in problem-based learning to a traditional lecture format in pharmacology.	■ The study design was experimental, post-test only, though the sample wasn't randomly selected. ■ They cite that they didn't need a pretest because it was a homogenous sample. ■ The same faculty member taught each class. ■ The students were blinded to the fact that another teaching method was being used, and the groups were 50 miles apart from each other. ■ The Student Satisfaction with Learning Tool had respectable content validity and test-retest reliability. ■ No psychometrics were supplied for the midterm exam and final exams. ■ The Students' t tests for independent samples were used for analyzing differences. ■ The teacher did not know whether she was grading a control or experimental exam.	■ Student satisfaction scores showed no significant differences between the groups. ■ Midterm exams showed no significant differences between the groups. ■ Final exam grades showed no significant differences between the groups.	■ Caution is advised using such a small sample size. The effect size would have had to have been large to have shown significance. ■ One intervening variable that the researchers acknowledged was that the intervention group were not only learning new material, but a new learning method at the same time. This could have affected the results. ■ Since problem-based learning is thought to improve critical thinking, the difference might be seen in practice, rather than with the exams. ■ The psychometrics of the exams were not provided. ■ Can the results be generalized to undergraduate nursing students?	■ This pilot study suggests that problem-based learning may be at least as effective as traditional lecture and should be explored in larger studies. ■ The evidence did not support problem-based teaching methodologies over traditional methodologies.
Murphy, M. (1995). Open learning: the managers' and educationalists' perspective. [Electronic Version]. *Journal of Advanced Nursing*, *21*(5), 1016-1023. **Level II**	Participants for this study were from a college of nursing and its clinical links. Setting was England.	Describe the feelings and motivations of nurse educators and managers toward open-learning programs. The definition they used was that open learning relates to an educational philosophy where the learners have access not just to educational products, but to the means of shaping their own learning.	■ Qualitative study using guided, standardized interviews with an open-ended, in-depth interview technique. ■ Tape-recorded interviews were transcribed verbatim. ■ Situation analysis was used, requiring detailed, searching and concrete analysis of the data collected to 'get inside the information." ■ A theoretical framework was devised that combines the philosophies of humanistic education and Knowles' andragogical assumptions for learning with concepts of student empowerment and increasing clinical competence.	■ Both practice and educators valued open-learning as a mode of program delivery appropriate for a practice profession. ■ Both groups confused the concepts of open and distance learning. ■ All interviewees agreed that open learning would help to close the theory-practice gap. ■ The interviewees saw open learning as a way of empowering the learner. ■ The findings showed that practice and education aren't working collaboratively, but each are functioning with their own competitive market in mind.	■ Lack of clarity of definition within both groups as to what exactly open-learning is. ■ Sample selection process was not made clear. ■ Line-by-line coding of interview transcripts allowed for comprehensive results. ■ Researcher acknowledged that some would use the survey method, and yet she cogently argued that the survey method hands over the data collection from the researcher to the informant. ■ Researcher acknowledged the lack of rigor with open interviews, and yet she argued that a rigid interview could be dominated by the researcher's agenda.	■ Educators and practitioners saw clinical experiences as vital in the education of nurses, and open-learning would only be a part of teaching nursing students. ■ Open-learning is often confused by nurse educators and managers as being distance-learning.

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Platzer, H. Blake, D., & Ashford, D. (2000). An evaluation of process and outcomes from learning through reflective practice groups on a post-registration nursing course. [Electronic Version]. *Journal of Advanced Nursing*, 31(3), 689-695. **Level II**	30 students were followed for two years in England.	Develop a better understanding of the use of groups and discussions to facilitate reflective practice.	■ Groups were qualitatively evaluated by the use of in-depth, semistructured interviews. ■ Interviews were audio-recorded and transcribed. They were analyzed using a qualitative software analysis package (QST NUD-IST version 3). ■ The data were coded and categorized as themes emerged.	■ The students reported significant development in their critical thinking abilities. ■ The reported greater autonomy to question the *status quo*. ■ The participants reported a less rule-bound approach to their practice (relates to Benner's work). ■ Their learning in the reflective practice groups can best be understood in terms of an increase in professionalism.	■ Self reports can be biased. ■ No measurements of critical thinking were made. ■ The reliability of the coding and categorization was not discussed.	■ Excellent qualitative evidence to support the need for students to reflect in groups and discussions about their practice.
Schaefer, K. M. & Zygmont, D. (2003). Analyzing the teaching style of nursing faculty: Does it promote a student-centered or teacher-centered learning environment? *Nursing Education Perspectives*, *24*(5), 238-245 **Level II**	Sample consisted of 178 females and nine males. Mean age of 50.	■ Describe the predominate teaching styles of nursing faculty as either teacher-centered or student-centered. ■ Compare faculty teaching styles to their instructional methods and to their stated philosophies.	■ Descriptive correlation design with triangulation of methods was used. ■ Principles of Adult Learning scale (PALS) was used to measure teacher or student centeredness; good reliability and validity have been reported for this tool. ■ Questionnaires were sent to 100 randomly selected baccalaureate programs accredited by NLNAC to be given by the dean to five faculty members.	■ Participants were more teacher than student centered; their written philosophies revealed both teacher-centered and student-centered approaches. ■ Faculty used student-centered language in their philosophies, often in a teacher-centered context; therefore, they may have recognized the need for a student-centered environment but had difficulty with implementation. ■ A distinction was made between clinical and classroom teaching. The authors questioned whether the philosophy should change according to the teaching venue.	■ Nice literature review. ■ Investigators met to achieve consensus about themes with the narrative data. ■ Questionable generalizability beyond baccalaureate nursing programs accredited by the NLNAC.	■ Excellent suggestions were given for assisting faculty to move to a more student-centered environment, and perhaps the boards of nursing could support these. ■ It is helpful for faculty to regularly share effective teaching methods with their peers in formal and informal settings.
Simmons, B., Lanuza, D., Fonteyn, M., Hicks, F., & Holm, K. (2003). Clinical reasoning in experienced nurses. *Western Journal of Nursing Research*, *25*(6), 701-719. **Level II**	15 experienced nurses. Five adult med-surg units in a teaching community hospital outside a large Midwestern city. Convenience sample.	Explored cognitive strategies used by experienced nurses as they considered assessment findings of assigned patients. Experienced nurse was defined as practicing from two to 10 years, full-time, on a medical-surgical unit.	■ Qualitative, descriptive design. ■ The think-aloud method was used to assess cognitive processes. ■ Participants were tape recorded by an investigator to gather information. ■ Each audiotape was transcribed. The text was methodically reviewed using the three steps of protocol analysis: referring phrase analysis, assertional analysis, and script analysis.	■ The most common thinking strategies used to reason about assessment findings were recognizing a pattern, judging the value, providing explanations, forming relationships, and drawing conclusions. ■ Nurses made sense of assessment information by linking concepts together to form relationships. ■ These relationships indicated the specific information nurses were concentrating on and determined the direction that their reasoning would take next. ■ Years in practice is only one criterion to distinguish between nursing skill level.	■ Three nurses spoke English as a second language, which may have affected understanding and thinking aloud. ■ Few studies of nurses' clinical reasoning have been conducted in a practice setting during actual patient care. ■ The number of years in practice may not have been an appropriate indicator of skill level, and the authors acknowledge this.	■ While this sample was of experienced nurses, it provides insight for teaching strategies with clinical reasoning and critical thinking. ■ The think-aloud method is an effective way to access the cognitive processes used in clinical reasoning and might be used by faculty teaching nursing students. ■ Although previous research has shown that expert nurses chunk information and employ thinking strategies to speed the reasoning process, this study indicated that experienced nurses (who were not experts) employed similar techniques

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Smith, J. & Crawford, L. (2003). *Report of findings from the practice and professional issues survey spring 2002*. NCSBN Research Brief, 7, 1-46. **Level II**	Stratified random samples of 1,000 RNs and 1,000 LPN/VNs were selected from lists of successful candidates on the NCLEX-RN® and the NCLEX-PN®, between January 1 and March 31 of 2002, resulting in a sample of 601, with a return rate of 62.3%.	Examined demographic data and educational variables of newly licensed nurses. The educational variables were: participation in distance learning, the adequacy of their educational preparation for practice, the types of transition programs available, their involvement in errors, and they perceived difficulty with client assignments.	Survey methodology, and the full instrument is available for review in the publication.	■ Of the four methods of distance education (Internet-enhanced, full Internet, linked classrooms, and correspondence courses), the most frequently reported for both RNs and LPN/VNs was Internet-enhanced. ■ 49% of RNs and 41% of LPN/VNs reported being involved in errors. ■ The two most common reasons given for errors (for both RNs and LPN/VNs) were inadequate staffing and lack of adequate communication. ■ About 20% of all respondents reported that their current client assignments were too difficult. ■ The two most critical clinical competencies (significantly related to being involved with errors and not being comfortable with their current assignment) were when nurses reported that they don't know when and how to call a client's physician or to work effectively within a health care team. ■ Other results in Report.	■ Self report surveys can be biased. ■ Being involved in errors was defined as "incidents or occurrences that resulted in harm to clients or had the potential to place a client at risk for harm. You may have been involved as the one making the error, the supervisor of others making errors, or as the one discovering errors made by others." Therefore, a nurse could have chosen the error selection even when he/she didn't make the error. Yet, this data compares to national data on errors. ■ Large, representative sample.	■ Taken with the IOM recommendation that health educators should teach students how to work in interdisciplinary teams, this study supports how important working with interdisciplinary teams is. Not being able to collaborate with other members of the health care team can put patients at risk.
Thiele, J. E. (2003). Learning patterns of online students. *Journal of Nursing Education*, *42*(8), 364-366. **Level II**	■ The sample consisted of 64 students in a baccalaureate program for RN students that completed a three-credit research and informatics course. ■ Learning outcomes were compared to 42 generic students.	■ The objective was to learn how online courses affect learners. ■ The researcher also compared students' learning in a traditional course to those in an online course.	■ The study was conducted during two sequential semesters. ■ During each semester, three face-to-face class meetings were conducted. The remaining 12 classes were conducted in an asynchronous format (via e-mail, group discussion board or telephone). ■ All assignments were posted online and required use of Web resources for completion. ■ Learning outcomes were measured with online exams. ■ Generic students were taught the same content with a traditional methodology and took an "almost identical" exam.	These results indicate that the learned information component was higher for the online students than for the traditional students.	■ Methodology poorly described. ■ The comparison of an RN-BSN group to a generic group is inherently flawed. ■ The exam procedures were starkly different: The RN-BSN students took the exam online at home, with no time period; no controls were placed on the students, except for personal integrity. Meanwhile the generic students took a 50-minute proctored exam. ■ K-R reliability for the exam was acceptable; no validity data were provided.	■ Additional research with controlled comparisons between traditional and online courses is needed to expand the knowledge of the effects of Web-based education on learners and learning outcomes. ■ Results of this study should be used very cautiously because of the methodological concerns.

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Tiwari, A. & Tang, C. (2003). From process to outcome: the effect of portfolio assessment on student learning. *Nurse Education Today*, *23*, 269-277. **Level II**	The sample consisted of 70 nursing students in the Department of Nursing Studies in The University of Hong Kong. ■ 21 second year students were assigned to the treatment group. ■ 49 third year students were assigned to the comparison group.	The purpose was to evaluate the effectiveness of portfolio assessment in enhancing student learning. This Paper mainly addressed the qualitative data.	■ The study involved the use of a nonequivalent control group design, as well as a qualitative component. ■ Data collection consisted of the Study Process Questionnaire (SPQ) to measure students' approaches to learning; the Assessment Preparation Strategy Questionnaire (APSQ) to find out how students prepare for their assessments; and semi-structured interviews with selected students (12) to explore their experience and perceptions of the assessment process. ■ The audio-recordings were transcribed verbatim to improve trustworthiness.	Three themes emerged from the analysis of the interview transcriptions: ■ The students favored the use of portfolio assessment. ■ The process of preparing portfolios yielded positive academic and affective outcomes. ■ Unexpected findings in the form of spontaneous collaborative learning during the process of preparing portfolios for those students who lacked motivation. The positive academic outcomes were (supported by qualitative comments): ■ Gaining a much better understanding. ■ Applying what they learn to their professional practice. ■ Learning deeply and meaningfully. ■ Conceptualizing at a high cognitive level. ■ Gain in confidence. ■ Pleasure, appreciation and freedom to choose.	■ Self report data can be biased. ■ Intervention was only one semester. ■ Other incidental variables could have been a factor, as the authors acknowledge. ■ This was only the report of the qualitative results; the quantitative results can be found: Tiwari, A. & Tang, C. (2001). The power of partnership: Enhancing student learning through assessment by portfolio. In: Conway, J. (ed). Research & Development in Higher Education: Vol. 24. Learning Partnerships. The Higher Education Research and Development Society of Australasia, Inc., ACT, pp. 188-194.	■ Backwash was discussed, and it implies that what the students learn and how they learn depends very much on what they think they will be assessed on; this seems to be very appropriate for those nurse educators who "teach to" the NCLEX. ■ The positive academic and affective outcomes suggest that the use of portfolios can have a positive effect on learning.
White, A. H. (2003). Clinical decision making among fourth-year nursing students: an interpretive study. *Journal of Nursing Education*, *42*(3), 113-120. **Level II**	Seventeen senior nursing students (16 women, one man) participated in the study. No students had any type of previous degree in nursing. All students were completing their last semester of coursework in a baccalaureate program.	They studied the essential components of learning clinical decisionmaking among nursing students.	■ A qualitative methodology was used, Heideggerian phenomenology, with hermeneutical analysis. ■ The identification of themes was accomplished through the accepted constant comparative method.	Five themes were identified as components associated with nursing students' clinical decision making: ■ Gaining confidence in their skills. ■ Building relationships with staff. ■ Connecting with patients. ■ Gaining comfort in self as a nurse. ■ Understanding the clinical picture. The results of the study indicate that until students are able to understand the clinical picture, their clinical decision making capabilities are limited. The researcher questions whether traditional clinical rotations are as effective as a consistent clinical experience.	■ Besides using the constant comparison method to identify themes, the investigators asked three students to verify the themes. ■ A model was presented to encourage further dialogue. ■ A more diverse student sample would have made the study more generalizable. This should be considered for future research.	■ The importance of students working with staff was paramount. ■ When students gained confidence, they were able to shift their focus from themselves to the clinical environment. ■ When students worked in the clinical area with patients and mentors, they gained in confidence. ■ When students became more comfortable in the clinical environment, they began to assume the nursing role. ■ Until students understand the clinical picture, their clinical decision-making capabilities are limited. Yet, they need knowledge, experience and self-confidence to understand the clinical picture.

Article	Sample	Comparison Studied	Study Procedures	Key Results	Strengths & Weaknesses	Implications for Boards
Yates, P. Jackie, C. Moyle, W. & Wollin, J. (1997). Peer mentorship in clinical education: outcomes of a pilot programme for first year students. *Nurse Education Today*, *17*, 508-514. **Level II**	55 of 323 first year students enrolled in the Bachelor of Nursing program agreed to participate. Eight peer mentors were selected from students in the second year of the program to facilitate the sessions. The setting was Australia. 55 randomly selected non-participants served as the controls.	Examine the potential of peer mentorship to assist students to improve their clinical learning outcomes.	■ Five sessions of one to two hours' duration were held every two to three weeks during the 14-week semester. ■ Sessions focused specifically on strategies for negotiating the clinical environment, promoting learning from clinical experience, and debriefing of events and experiences during clinical practicums. ■ Measurement included pre- and post-program questionnaires, a focus group interview, review of mentor journals, and a statistical analysis of the differences in clinical ratings between the participants and non-participants.	■ The program was perceived to provide a considerable amount of help to participating students, particularly in reducing anxiety and increasing confidence. ■ There were no differences between the groups related to clinical instructor ratings. ■ Mentors felt the program had assisted students with increasing confidence and reduced anxiety. ■ Students were less satisfied with issues such as timing and organization of the sessions. ■ Students spoke of their concerns about the need for practice of clinical skills to improve their confidence and reduce anxiety.	■ Evaluations were comprehensive. ■ Because the protégés were volunteers, there may have been a systematic bias.	■ Students feel it is important to integrate both theory and practice. ■ Most clinical teachers agree that lack of confidence and anxiety can have detrimental effects on student learning, and the strategy of using peer mentors may assist with this. ■ Support strategies, which reduce stress for beginning students are important in nursing programs, since they are likely to contribute to an improvement in student performance and a decrease in student attrition.

Conclusion

This is an ongoing project where we are continuing to search for studies that meet the specified criteria. A limitation of any systematic review is that it is only good as the quality of research that it covers. As discussed in strengths and weaknesses, oftentimes sample sizes were small and controls were lacking. The study criteria for this systematic review were not as stringent as some reviews so that the breadth of the literature could be reviewed. The review identifies strengths and weaknesses of the studies so that the reader can decide how to use these findings.

Three Level I systematic reviews were identified. Epstein & Hundert (2002) defined "professional competence" and provided some guidance for boards for assessing the competence of health care workers. Greenhalgh (2001) identified 12 prospective randomized studies of medical students for the purpose of evaluating computer-assisted learning. They suggest that computer-based learning can be effective, though the aim should be to use a variety of teaching strategies. Issenberg et al. (2005) conducted a systematic review of high-fidelity medical simulations for learning and found them to be valuable adjuncts to learning when carried out under the right conditions.

Five of the studies provided evidence that qualified faculty were important for teaching nursing students, though there was no literature about specific qualifications. Two studies specifically identified the need to improve students' confidence levels before they can effectively think critically when caring for patients. Five studies provided evidence that clinical experiences improve students' abilities to think critically when caring for patients, though there were no studies found that investigated specific numbers of clinical hours. Likewise, there were no studies that evaluated those programs that do not have, or have very limited, clinical experiences. Two studies found that reflective practice was a very important strategy for teaching nursing students to critically think. There were four studies that showed no differences in learning outcomes with online courses versus traditional courses, and one found online courses had significantly better student outcomes, though that particular study was not well controlled and should be replicated. Other research investigated some very specific issues, including:

- Validating the need to evaluate structure, process and results/outcomes when evaluating programs.
- Validating personal improvement courses for teaching continuous quality improvement.
- Decreasing environmental noises and distractions in order to enhance learning.
- Problem-based learning, compared to traditional learning, was investigated.
- Provided good guidelines for assisting the faculty members in moving towards a more student-centered way of teaching.
- Supported the IOM's recommendation for the importance of interdisciplinary teams in health care.
- Supported the use of portfolios for student learning assessment.
- Recommended the "think aloud" strategy for clinical reasoning.
- Supported peer mentors as a way to increase student confidence levels in clinical situations.

Report of the PR&E Subcommittee on International Nurse Issues

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

In FY02, the PR&E Committee recommended the formation of a special subcommittee to study the effect of nurses educated outside of the United States on U.S. nursing regulation. The Foreign Nurse Issues Subcommittee was formed in February 2002 and, in FY03, developed a Resource Manual to meet the needs of Member Boards. In FY04, the International Nurse Issues Subcommittee (formerly known as the Foreign Nurse Issues Subcommittee) updated the Resource Manual, reviewed the services of available credentialing evaluation agencies and developed a minimal data set as guidelines for the level of credential evaluations needed for regulatory purposes.

Subcommittee Process

The Subcommittee conducted a thorough review of the literature on the transition and assimilation of international nurses. Literature on transition and assimilation of nurses in general was also reviewed. Surveys of employers, universities, international nurse recruiters, boards of nursing and professional international nurse organizations were conducted. NCLEX licensure data regarding international nurses was also reviewed. Representatives from the Commission of Graduates of Schools of Foreign Nursing (CGFNS) and the Chicago Bilingual Nurse Consortium discussed specific topics of interest with the Subcommittee.

Subcommittee Findings

A review of the literature on the transition and assimilation of international nurses revealed a lack of information, though some useful information was obtained. A literature review on the transition and assimilation of nurses in general indicated some principles that would be useful with the international nurse cohort. Two separate surveys to employers were conducted. Initially, a survey to a random sample of 400 hospitals in the United States was done with a return of 94 (23.5%) (Attachment A). The results of this survey revealed that few of the hospital employers that completed the survey were recruiting international nurses. Those hospitals that were recruiting foreign nurses were only recruiting small numbers, sometimes only one or two nurses at a time. When asked about the challenges of hiring an international nurse, employers most frequently reported meeting the standards of the immigration process. Other challenges noted were language barriers, cultural differences, differences in competencies, setting up living arrangements and lack of recruitment dollars. The poor response rate and the infrequent use of international nurses by the majority of respondents of the first survey prompted a second survey. It was thought that possibly international nurses were utilized by the more heavily populated states. The second survey focused on the employers in the heavily populated states of Illinois, New York, Texas, California and Florida (Attachment B). For the second survey, a different methodology was employed. Instead of sending a survey to each employer, an introductory letter was sent to the employer with instructions to fill out a questionnaire over the Internet. The response rate was much lower than the first survey (7%). However, the responses of the second survey mirrored the first. The majority of respondents indicated that they were not using international nurses. The challenges of using international nurses identified by the second survey were identical to those in the first survey. Based on both surveys, it appears that there may not be large numbers or large cohorts of international nurses assimilating into U.S. health care system. Unfortunately, as the response rates were very small, the results may not be representative of the entire population of international nurse employers. Other findings of the employers' survey were: (1) Federal regulations are perceived to be major barriers for the immigration of international nurses due to the complexity of the process, the length of time of the process and the frequent changes

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Meeting Dates

- December 6–7, 2004
- January 31 – February 1, 2005
- April 4–5, 2005

Relationship to Strategic Plan

Strategic Initiative VI
Facilitate the mobility of safe and competent international nurses by influencing public policy.

occurring in the process and (2) It appears that hospitals bear the brunt of the assimilation and transitioning of international nurses.

Other groups surveyed included nurse recruiters, Member Boards and universities. For surveys sent to nurse recruiters, the response rate was too low for the results to be considered. Member Boards were also surveyed to determine (1) if they were tracking discipline data of international nurses (of the Boards responding, all said no) and (2) their perception of the public protection issues related to international nurses. The issues most frequently cited by Member Boards were language barriers, cultural diversity, knowledge of regulatory parameters, socialization issues and technology skills. Twenty-three Member Boards responded (38%). Universities were contacted regarding the services they provide to international students. Many provided international students with mentors and support groups as well as opportunities to improve English language skills. International nurse professional organizations were contacted to determine what services were provided to assist international nurses. Few of these organizations provided mentoring services to international nurses.

Although most of the hospital employers surveyed indicated that they are not hiring international nurses, NCLEX licensure data indicates an increasing number of international nurses are taking the NCLEX. In 2001, 8,612 first-time RN international nurses took the NCLEX. In 2004, 16,489 first-time RN international nurses took the NCLEX. This increase in the number of international nurses taking the NCLEX is not compatible with the results of the international nurse employers surveys conducted by the Subcommittee. Due to the low response rate of the employer survey, the results may not be valid. However, large numbers of international nurses may be in the 'pipeline' of the immigration process, many of whom could possibly become discouraged and drop out of the process. The likelihood of this being case was supported by a representative of a large nurse recruiting firm who reported that they usually can only complete the recruitment process for 200 international nurses per year.

Factors Influencing the Assimilation/Transition of the International Nurse

Based on the review of available resources and surveys, the Subcommittee identified factors that could influence the ease with which international nurses assimilated/transitioned into the U.S. workforce. They noted that three other transition groups: U.S. new graduate nurses, reentry U.S. nurses and new employee, were very similar to the international nurses in terms of the factors influencing assimilation/transition. They were:

- International nurses may work in a capacity other than nursing (e.g., ward clerk, nurse aide) prior to licensure. Some employers will hire international nurses who have not yet obtained U.S. licensure as unlicensed health care personnel. This will allow international nurses a chance to become comfortable with the health care environment and facilitate the assimilation process.
- Many changes in the immigration system, such as revisions in visa status and new requirements are challenging to international nurses who are attempting to complete the immigration process.
- If an international nurse's native language is English, the transition into the U.S. health care system is much easier. The majority of survey respondents and assimilation/transition articles referred to the language barrier as a major hindrance to the assimilation of international nurses.
- If the international nurses have a social support group, the transition is easier. Several journal articles described success stories regarding the use of support group for international nurses. With the support of their peers, they are more easily able to transition into the U.S. health care system.
- The ease of assimilation/transition can be influenced by employer expectations and willingness to provide support. Because all individuals are unique, the employer must

be aware of the needs of individual international nurses. An assessment followed by an individualized orientation program is preferred.

- Current nursing practice, if in an individual nurse's home country or other country, will give the individual an advantage in the assimilation/transition process. Whereas a nurse who has not practiced in some time may need additional competencies in order to assimilate or transition successfully.

Methods That Facilitate Assimilation/Transition

The Subcommittee determined that there are methods to assist with the assimilation/transition of international nurses. As noted above, the Subcommittee observed many similarities with the other transition groups: U.S. new graduate nurses, reentry U.S. nurses and new employees. The methods are:

- Language Classes — Communication barriers lead to frustration for international nurses, other staff members and patients. Communication skills include medical terminology, abbreviations (including JACHO abbreviations), colloquial terms, medication names, etc. Lack of communication skills hinder international nurses from assuming a nurse's role and responsibilities.
- Preceptors/Mentors — These programs provide support for international nurses. Employees volunteering to be mentors may initially contact international nurses while they are still in their home country, similar to pen pals, to answer any questions the international nurses may have. Upon arrival in the United States, mentors can provide assistance with adjusting to a new culture by assisting with life activities, and introducing international nurses to others from their homeland. Mentors need to be trained and when possible, be from the same country as the new international nurse. Of course, the program can only be successful if the new nurse is willing to participate. Mentoring is a continuous cycle of support created by individuals who recognize the difficulties of transitioning into a new venue.
- Support Groups — Upon arriving in the United States, international nurses enter into a different culture and environment. Support groups provide support and camaraderie for international nurses and allow opportunities to discuss common problems/concerns and to share information.
- Orientation Program — Employers of international nurses should provide an individualized orientation program. The components should include:
  - Skills Assessment
  - Pharmacology
  - Technology
  - Orientation to U.S. Health Care System, e.g., types of health care workers, delegation, etc.
  - Regulatory information, e.g., NPA, discipline process, etc.
  - Helpful hints, e.g., using eye contact, understanding some words used have several meanings, etc.
- Cultural Training for both international nurses and employees — Differing cultural norms are expressed through behaviors and attitudes which in turn influence communications and affect staff interactions and performance. Both international nurses and employers must be aware that each culture has a unique sets of beliefs that must be understood if communication is to be effective. Areas such as handling conflict, decision making and role expectations must be explored in cultural training sessions.
- Assistance with life activities such as getting a driver's license, finding living quarters — International nurses enter an entirely new system of living. They may be unfamiliar with

activities of daily living in the U.S. culture. Support with these activities can assist the international nurse as they adjust to the new culture.

Public Protection Issues

The International Nurse Issues Subcommittee identified the following as the major public protection issues:

- Assessment of Competencies — Health problems vary from country to country. International nurses may be trained in dealing with acute care illness, public environment and/or environmental concerns but may not be familiar with the chronic health problems they will encounter in the United States. Technology also varies from country to country. The international nurse may be familiar with the technology in their country but not technology found in the United States. These different sets of competencies and skills may affect public safety.
- Language Barriers — A challenge for international nurses is to develop effective communication skills. This is difficult because medical terminology is different. Technology and medications have different names. Problems may occur with abbreviations and words that sound similar, such as atrial and arterial. The inability to communicate a change in a patient's condition as well as the inability to communicate that change via writing could compromise patient safety.
- Lack of Familiarity with U.S. Health Care System — The home country of the international nurse may not have a similar health care system to the United States. They may not be familiar with the many types of health care workers present in the United States or the process of delegation. They may not have knowledge of a nurse practice act or board of nursing. When the international nurse practices in the United States, she/he must know what they can and can't do. It is important for the international nurse to be aware of the boundaries of their practice and their responsibilities to their patients.
- Cultural Differences — Each culture maintains different expectations. The difference in expectations can result in misunderstandings and misconceptions on both the part of the international nurse and other staff. For instance, international nurses from some cultures may be reluctant to ask questions, fearing that they would be perceived as rude or become embarrassed to let someone know she/he does not understand. This may compromise patient safety.

Highlights of FY05 Activities

- Reviewed current literature on assimilation and the transition of international nurses into the U.S. health care system.
- Surveyed Member Boards regarding the transition of international nurses and reviewed the results.
- Surveyed employers and nurse recruiters regarding their experiences with the transition of international nurses and reviewed the results.
- Reviewed activities of universities and professional associations regarding the transition of international nurses.
- Met with the Chicago Bilingual Nurse Consortium.
- Met with the Commission on Graduates of Foreign Nursing Schools.

Attachments

A. Employer (Hospitals) Survey

B. Survey to Illinois, California, New York, Texas and Florida Hospitals

Attachment A

Employers (Hospitals) Survey

400 Surveys Sent

94 Employer Surveys Returned as of March 11, 2005.

1. How many international nurses does your organization hire per year?

4 = 1 nurse hired

5 = 2 nurses hired

4 = 3 nurses hired

1 = 4 nurses hired

2 = 5 nurses hired

1 = 6 nurses hired

1 = 10 nurses hired

1 = 12 nurses hired

1 = 14 nurses hired

2 = 1-2 nurses hired

1 = 1-5 nurses hired

1 = 2-3 nurses hired

1 = Approximately 2–5 nurses hired

1 = 3–5 nurses hired

Comments:

- We are not hiring international nurses — 10.
- We have only hired Canadian nurses — 4.
- We have not had any applicants — 2.
- We have hired a total of 20 from Philippines.
- Attempted to hire 30 from Philippines but [they are] still not here.
- We recruited over 50 nurses and lab techs from the Philippines in 1992.
- An international nurse was hired in 2004.
- Very few, none last year. We currently have only seven on staff all Canadian.
- Few available.
- None, no shortage of available nursing staff for past two years.
- We are a small rural hospital.
- We are expecting our first international nurse in first quarter 2005.
- We have less than a 1% vacancy rate.
- We have been informed by our corporate recruiter that immigration regulations place a prohibitively long wait on foreign nurses entering the country which has discouraged us from trying to recruit them.
- Free standing psych hospital with only 30 acute in-patient beds.

- We have offered two jobs. We don't have an annual number for the hospital.
- One hired in last three years. Her husband is on staff as a physician now for last three years. We are a 25 bed critical access hospital in a village of 6,000 people. Service area 38,000.
- Need HI license first.
- Through school of nursing — F1 Visa.

2. What challenges do you find when hiring international nurses?

- Immigration and Naturalization Services has made delays exceptionally long. Getting nurses to pass all exams prior to arriving.
- Visa issues, Homeland Security issues.
- (1) Visa and work status, (2) Meeting standards.
- Immigration issues.
- Delay in processing requirements for the United States (passports, visa).
- Visa Screen — eligibility to practice. Unable to sit for NCLEX. Border issues.
- Acculturation issues including housing, transportation. VISA screen process, long and unreliable. Problems with border staff being inaccurate, for example: typos in a name spelling causing delay in getting social security numbers. INS not available by phone to public. Must go to Charlotte, NC (three-hour drive) and appear at office to ask questions/ seek assistance.
- Long processing times with BCIS. Delays at State Department and embassy levels to have Visa issued. Nurse's difficulty in passing required exams, particularly Test of Spoken English (TSE).
- They complete their requirements and are gone. Long wait to process application, Visa, etc. Expense (money and time).
- I can recruit Canadian Nurses, but the Immigration process is so multitiered and takes so long that many of the recruited nurses seek other employment.
- Language barrier: ability to understand individuals enunciation, clarity of speaking and use of vocabulary to mean very different things, frequently not communicating (though interaction suggests one is).
- Cultural differences, language barriers, knowledge-base differences.
- Language with dialect although speak English practice in foreign country does not necessarily match practice in the U.S. and acuity of patients especially for specialty units.
- Language barriers related to oral communication. Written skills are generally better.
- Cost, language barriers, housing, household.
- At a previous facility (VA in Syracuse, New York) we hired international nurses and language was a barrier at times.
- Getting them acclimated to U.S. nursing practices. Cultural changes.
- Competencies, language barriers, financial outstay to bring them on.
- (1) Staffing needs, (2) Communications, (3) Understanding/skill level regarding all areas.
- Occasionally in past have seen issues with cultural differences, language, understanding of slang by U.S. nurses.
- Language and different cultural issues.
- Language barriers; educational barriers — school programs; cultural barriers.

- Recruitment dollars.
- Never have hired any, but for us it would be the cost.
- Time and money: We investigating utilizing Philippine nurses and found this expensive and not cost efficient. We do not have any international applicants to date nor have we recruited.
- Setting up living arrangements; NCLEX; Length of time to process from initial contact to actual arrival; tend to leave to be with family in other parts of the United States; finding spouses employment.
- Poor communication with the company we worked with to recruit foreign nurses.
- Very difficult to recruit international nurses for a small nurse community.
- None, they were able to adjust, assimilate and process information, as they are also M.R. graduates in the Philippines.
- We are using none and have no plans to utilize.
- We have not had any since any nurse from a foreign country has already been licensed prior to employment. We have not recruited abroad.
- It takes so long to get them through their country's red tape as well as ours. It is difficult to predict needs two to three years in the future.
- I've hired international nurses in other facilities/other towns; they worked out great. We just don't do it here.
- Length of time of interview to arrival in country; knowledge deficit of specialized areas; terminology.
- Different skill level than in the United States. Medications have different names.
- State Department processes.
- We have not pursued hiring, but have found common challenges of working with employer's attorney and immigration for nursing students.
- We have begun to use "Nurse Immigration U.S.A.," which makes sure legal status/ paperwork is completed, communicates with RN, helps select appropriate placement (city vs. rural) etc.
- Meeting the standard of care.

3. Do international nurses differ from new U.S. graduates?

Yes — 29

No — 6

Unknown — 2

Comments:

- Cultural and language issues — 6.
- They have more, excellent clinical experience — 2.
- (1) Very eager and willing to work, (2) Not familiar with equipment.
- They seem more professional to me.
- Skills appeared to be comparable.
- Adaptation to system and practice.
- Require more orientation.

- Strengths and weaknesses differ.
- All Canadian nurses have had experience.
- Need work with medications and equipment as well as authority roles.
- Some have good and pertinent experiences and BSNs.
- Lack familiarity with cultural areas.
- Depending on country of origin, familiarity with terminology.
- Sometimes better trained.
- Two of our international nurses graduated from U.S. programs.

4. Do you permit international nurses to work in a capacity other than nursing (e.g., ward clerk) prior to licensure?

Yes — 13

No — 29

Comments:

- We would, but have not recruited yet — 3.
- Nurse Assistant.
- The International nurse has worked as a CAN and clerk roles.
- Patient Care Associate.
- We have an RN from Africa that is now a U.S. citizen, but not licensed, working as a PCT.
- Past experiences, not in Manchester.
- We have only hired those with license.
- If work eligibility verified/completed, usually occurs same time.

5. Do you prepare current staff to work with international nurses?

Yes — 19

No — 24

Comments:

- Preceptor programs. Cultural and diversity awareness programs.
- Staff was provided with cultural information.
- We will have education for our nurses.
- Our current Canadian staff has been "briefed" on Canadian recruitment efforts.
- We also had a large number of doctors from the Philippines that helped with this process.
- Incorporated additional transcultural education into preceptor program.
- We have a preceptor program to train all preceptors.
- Just informing. Some staff does not agree with international recruitment.
- Basic preparation for diversity.
- Unstructured guidelines.

6. If yes to number 5, what is included?

- Cultural diversity training — 3.
- Staff was provided with cultural information relevant to the new hire.
- Culture, nutrition, personal interest, religion, climate, language barriers.
- Understanding cultural differences, language differences. Inclusion of staff (new) into mainstream of community.
- Preceptor classes, cultural diversity, weekly sessions with clinical manager/director and educators.
- Culture issues. Retention tips.
- We currently do cultural training related to different areas, but much of this is currently N/A since we have not had any nurses apply and very few vacancies.
- Sensitivity and cultural training.
- Unstructured advisement, patience and tolerance, understanding other cultures.
- Basic diversity.
- Diversity Coordinator, Preceptor Education.
- Acculturation. How to mentor and precept. Diversity training.
- Transcultural workshops presented to nursing management, nursing education and preceptors. Transcultural educational content incorporated into preceptor educational programs.
- No special training regarding international nurses.
- Our RNs go through preceptor classes to be able to work with new RNs. All staff has mandatory competencies.
- We would work with the recruiting agency to provide central education to our staff. We would also plan to ask members of our medical staff to assist with this education.
- Orientation and in-services on the following: administrations rationale for hiring foreign graduates; background and competencies of the new hire; job description and job expectations.
- Review of customs and assimilation needs at staff meeting.

7. Do you have a transition/orientation program to assist international nurses?

Yes — 23

No — 25

Comments:

- Orientation program would be the same as for U.S. nurses — 5.
- Individualize unit orientation plan to meet needs of nurse — 2.
- We have recently started a “club” for Canadian nurses.
- Through our corporate facility.
- New graduate preceptorship.
- We also provided assistance in preparing them to take state boards.
- Complete a 22 and a half week residency after arrival.

- Orientation only, similar to new grads "Buddy" with other foreign RN as much as possible. Very individualized.

8. If yes, what is included?

Assistance language skills — 10

U.S. cultural transition — 15

Assistance ADLs — 19

Competency assessment — 24

Working Health care — 15

Knowledge regulation — 17

Nursing Education — 17

Clinical — 19

Classroom — 15

Comments:

- Classroom — 6 days.
- Classroom — 2 weeks.
- Clinical, Individualized, usually 4–6 weeks. Classroom — 8 days. Preceptor Model.
- Clinical — 6 weeks; Classroom — 2.5 days. Introduce nurse to other staff with similar cultural background.
- Clinical — 3 month orientation; Classroom — 1 week.
- Clinical — 12 weeks; Classroom — 2 weeks.
- Clinical — one month — 90 days.
- Clinical — 12 weeks; Classroom — 2 weeks.
- Clinical — One month with precept as needed; Classroom one to two weeks more if needed.
- Clinical — 6 weeks; Classroom — 1 week.
- Clinical — 6 weeks; Classroom — 3 weeks.
- Clinical — 6 weeks; Classroom — 2 weeks.
- Clinical — 6 months — 1 year; Classroom — 1 and a half weeks.
- Clinical — 22 and a half weeks.
- Clinical: 4–12 weeks; Classroom: 1–2 weeks.
- The length is individualized — 5.
- We are so close to Canada that these nurses are not viewed as "international."
- Don't remember how long for both classroom and education. They receive a follow-up at three months, six months and one year. In Texas I did the ones checked when we recruited about 60 Canadian nurses in the early 90s.

9. If you checked classroom education, what does it include?

Medical Terminology — 12

Pharmacology — 13

Delegation — 15

Priority Setting — 16

Other — 9

Comments:

- Same as new grads — 2.
- Pediatric skills.
- Regulations, patient safety, role of RN at Marshall.
- Entire orientation.
- Unit based population, specific knowledge requirements, unit based, p/p, etc.
- Roles and responsibilities.
- Mostly cultural acclimation.
- Critical thinking modules. Legal aspects. Policy/procedures.
- Cardiac monitoring, fetal monitoring.
- Planned.
- Videotapes, multiple competency test, skills, equipment training.
- State board exam preparation.

10. What other things have you done, in addition to those listed above, that have proven successful to retaining foreign nurses?

- Provide mentors for them — 4.
- Buddy with an RN of similar culture to assist with community and orientation. Also assists with facilitation for housing needs — 3.
- 12 hour shifts, little or no rotational schedules. A new project that we're implementing is "Friend at Work."
- Set up a welcoming network of other nurses, especially established nurses from the Philippines.
- In-services and support on how to work with a diverse team. Consistent assistance and support in the clinical area, in finishing their work on time. Support during high unit activity.
- Acculturation, forums with CWO/HR.
- Flexible scheduling.
- For our Canadian nurses we have completed a support group.
- Get them from close to home or close to family already here.
- Teach them about eating American food, very rich, some become ill. Many become home sick, called home frequently, increased phone bill.
- New to this — "Nurse Immigration USA" does a wonderful job of assistance and transition.
- Peer support.
- Have tried to provide individual assistance both educational and financial.
- Classes on critical thinking.

11. Does your orientation/transition program differ from the orientation program provided to new U.S.-educated nursing graduates?

Yes — 1

No — 15

Comments

- Individualized to meet unique individual requirements — 6.
- Slightly, covers areas we know.
- Federal/state laws and city information. Individual finance tutoring sometimes indicated.
- Value-added components.
- All nurses acting as preceptors for foreign graduates must have attended transcultural training.
- Pathway extended with fewer patients assigned with preceptor.
- Some residency to acquire pediatric specific skills.

12. Do international nurses stay at your organization as long as new U.S.-educated graduates?

Yes — 22

No — 7

Comments

- Some longer — 2.
- Shorter stay for U.S.-educated graduates.
- We hired RNs from UK in 1993. Several are still with us.
- 2004 is first time use of Philippines. Past experience with Canadian was good.
- Many are still here.

13. Would you be willing to share your successes?

Yes — 7

No — 1

Comments:

- Communication with staff as a whole as well as lessons learned from previous foreign trained nurses who came here 9-25 years ago.
- Our success is our welcoming staff and managers who take all new grads under their wing and make them feel safe and secure.
- Staff acceptance and willingness to assist both at work and in community.
- Connecting them within the organization.
- Adjusting or lengthening orientation/preceptorship until international nurse is competent to handle a team of patients with minimal assistance.
- Our mission, caring environment.

14. What would help you to transition international nurses into your organization?

- More interaction and communications.
- Transportation and housing, assistance with language skills.
- Assistance with language and computer skills.
- Best practice for overcoming language barriers given high fast-paced environment requiring quick decision making.
- I have not tapped into international resources outside of Canada. Our facility is on the border and would be an excellent resource if immigration weren't so difficult. I'm not sure how to go about recruiting in Europe/Asia, but I would be interested.
- Continue to look at successful retention programs. Possibly sponsorships. Marketing targeting these groups.
- Success stories from other organizations, what they have done and what has worked well for them.
- Reduction in legal obstacles.
- We have a county facility and have no money to recruit abroad.
- The nurses that were brought to this facility were very prepared and demonstrated good skills and medical knowledge. Housing to accommodate the desire to be together in large numbers and a yard for those with children to play.
- Information from successful hospitals.
- Resources (e.g., standardized programs, money, materials).
- Government assistance/streamline problems described in number 2 — *VisaScreen*, INS responsiveness, etc.
- Would need to know more about their culture and education.
- We would love to have additional nurses from the Philippines. They are excellent bedside nurses.
- Frequent updates regarding changes in immigration rules and regulation as occurs.
- Easier regulatory burdens.

Attachment B

Survey to Illinois, California, New York, Texas and Florida Hospitals

314 Letters were sent to hospitals. The results are as follows:

22 Employer Surveys Returned

1. How many international nurses does your organization hire per year?

1 = 1

1 = 4

1 = 5

1 = 10

2 = 1–2

1 = 3–4

1 = 15 to 20

1 = anywhere from 5–15

1 = approximately 10

One nurse in 2003, four nurses in 2004 and approximately five more in 2005.

Comments:

- We no longer use international nurses.
- I went to India and interviewed nurses making offers to 17.
- We have only hired 2 over the past several years.
- Never have needed any or tried to hire any.
- Usually attempt to gain employment, mostly from Canada.
- Has not been a purposeful recruiting strategy at this time. We are investigating the options. Historically, we have been involved from Canada, Philippines but limited.
- We work with several agencies to bring them in.

2. What challenges do you find when hiring international nurses?

Comments:

- We sometimes have language barriers. They do not always complete their contract. Gonzales is a small country Texas town; no movie theatres, only Mexican or fast food, about the only store is a run down Wal-Mart. The population is mostly black and Hispanic. The international nurses we got were mostly Filipino, were not accepted by the community. They were fine clinical nurses and nice people, but were not able to be comfortable in the community. Interestingly, our lab is all Filipino in the evening, night and weekend shifts. We introduce them and try to house them in the same area as other Filipino staff so they can get rides to work (The lab people do not live here, they commute in from cities near by).
- Some language issues. Acclimation to the American lifestyle.
- Language proficiency, Technology.
- Processing of immigration papers.

- The time between interview and actual arrival in the United States.
- The time delay in bringing these applicants through the immigration process.
- Licensure — Becoming accustomed to how things are done here — culture differences.
- Licensure, Language, Culture, Orientation and acclimation seem to be more complex.
- The biggest challenge is the NYS Education Department who takes three to five weeks even with multiple calls to issue a license once the exam has been passed. When inquiring with their office it is obvious the workers there are lacking education about the process. For example, one nurse waited a long time for the license; we sent the child abuse certificate five times as requested by the office when we called to inquire what the hold up was. On the next call I spoke with Liz who said fax me the Visa stamp from her passport and she will have a license number on the Web site in a few hours. The jobs were offered to our nurses two weeks prior to 9/11 and the green card process seemed to take forever. Once here, our biggest challenge is to reassure the nurses that the snow and cold weather is only a temporary pattern. They are very cold here.
- Difficulty in locating organizations who assist in providing international nurses.
- We have considered doing this in the past but our main stumbling blocks have been the increased cost and the time lag between need and start. We are a small hospital and luckily do not often have more than one or two openings at a time.
- Costs of transitioning to United States. It takes considerable time to obtain licensure and during this time we employ in a nonpatient care status, which means we cannot use as a nurse and they are not getting paid as a nurse. In our most recent experience, there were additional family members to support which makes it more of a financial challenge.
- Extreme difficulty assimilating them to American medicine. Very subservient, shy, will do whatever you ask, but no forethought or proactive nursing care. Extremely time consuming and frustrating for preceptors.
- The nurses are ready to be employed but the hiring offer usually falls through due to the length of time it takes for them to become licensed in NY State. Are often not successful in the NCLEX exam. The new Visa requirements are obstructive.
- Looked at this option once. Found it too expensive, had to wait one year or more for nurse to arrive, concerned about ability to be comfortable and happy in a small community.
- If they come from the Philippines they do rather well, as we have a large Filipino population. We have recently begun hiring nurses from India, and there is a relatively small population of this group; however, they are very well trained nurses. Some of the biggest challenges we see are the language barriers and differences in our processes. We tend to keep some of them on orientation longer than U.S.-trained nurses.
- Cultural differences. Linguistic and language differences. Knowledge of technology — specifically differences in equipment usually dependent on the country of origin.

3. Do international nurses differ from new U.S. graduates?

Yes — 13

No — 4

Comments:

- From the Philippines they are all BSN prepared, hence better skills and competency. They do need to adjust to the culture, both clinical and lifestyle, which is part of their orientation.
- Communication ability differs but in a short time is comparable. Our nurses from India are very hard workers, always smiling and are intelligent. They do not feel entitled.

- The nurses I have hired from the Philippines are experienced nurses with BSN degrees.
- The international nurses typically already have several years of experience in nursing.
- To a certain extent they do. We have not hired any new foreign graduates; all of them have worked in their country prior to arriving here. Some of the nurses that have come from Mexico have the biggest difficulties with the differences in medications.

4. Do you permit international nurses to work in a capacity other than nursing (e.g., ward clerk) prior to licensure?

Yes — 6

No — 11

Comments:

- No experience, but if we had a position available, we would.
- Central Processing Tech Support Aide on the floor. This is necessary due to the cumbersome NCLEX, NYS Education and processes.
- We allow them to work on a permit in the level of profession that they are in once they have a test date set for the exam for NY licensure. They could work in a lower capacity if the visa issue was taken care of.
- If there was an open position that would be appropriate.
- We have chosen not to do this because we had a significant failure rate, and some nurses decided they do not want to become licensed since they make more money here as a nonlicensed person than they made in their home country.
- If they are awaiting results of CGFNS or State Boards. It enhances their transitional process by allowing them to familiarize themselves to related policies, procedures, culture and staff.

5. Do you prepare current staff to work with international nurses?

Yes — 10

No — 6

Comments:

- They are just made aware of the plan.
- No experience, but we would.
- Have only hired two in the last five years. One is still here.
- For three years we waited for them to obtain their green cards and arrive in the United States. Much of the preparation was informal.
- No different than to work with any new nurse in the organization.
- Precepting and our 'On-Boarding' programs would individualize the match between new employee and the partners, to support the transition. Possibly another person who has experience with these issues to support the transition. Our program is individualized to meet the needs of the orientee, and then to concurrently monitor the process for any needed changes.
- If we were to have one, we would certainly have to provide staff education. Our current program is to assign all new staff to a preceptor.
- We have led classes in cultural diversity for the nurses on the units.
- All of our international nurses come to us from the Philippines and we have a very large

Filipino community in our city and many Filipino nurses.

- Attempts are made to buddy them with persons of similarly ethnicity and/or orientation. Additionally, one focus during the orientation and probationary period is cultural diversity.

6. If you answered yes to question 5 what type of preparation would the staff receive?

Comments:

- Background information, preceptor to orient them. No formal cultural training.
- If we did this, I would want the current staff to understand the culture of the nurses hired and how that affects behaviors and communication.
- Diversity programs, discussions with myself and the ICU Director who visited India and offered the jobs.
- Cultural awareness.
- Diversity training.
- Clearly defined parameters for their orientation. During the initial orientation in the classroom, areas are identified for the floor nurses to work with the new nurses on.
- In our current situation, we trained the nurse to work as a unit secretary and also used her with record reviews in preparation for JCAHO. We worked with both areas defining what the nurse was capable of doing and what was expected of her. We emphasized that she was to have no involvement with patient care.
- Preceptor course.

7. Do you have a transition/orientation program to assist international nurses?

Yes — 11

No — 7

Comments:

- They are assigned a preceptor. We try to get them comfortable with the lab staff, get them to church, invited to go to a movie or out to dinner, etc.
- They received the same nursing orientation that all RNs complete. In addition, the administration of the hospital assisted with some items below, which are not part of nurse orientation.
- No nurses, but we put together a support team for a Filipino Medical Technologist. The team helped her get from place to place and helped familiarize her with the community.
- Preceptor orientation program for all new nurses.
- It is our usual program. The difference would be the goal to find the right preceptor/ ambassador to facilitate the international challenges.
- Not specific for international nurses but they go through an extensive orientation to the facility with a clinical preceptorship which lasts approximately eight to 12 weeks.
- We tend to put them through an orientation that is similar to a new grad orientation.

8. If you answered yes to question 7 what are included?

Assistance with language skills — 1

U.S. cultural transition — 5

Assistance with ADLs, housing, etc. — 5

Assistance working within the U.S. nursing system — 5

Competency assessment (priority assessment, physical assessment, clinical skills, etc.) — 9

Working with health care team — 8

Knowledge about regulation/discipline — 7

Nursing Education — 9

Clinical — 10

Classroom — 8

Comments:

- The nurse we currently employ speaks English very well and comes with significant clinical experience and education. Although she has not obtained her license yet, she is very knowledgeable and competent.
- These are all in our orientation program, which is individualized to meet the needs of the orientee. Specific language, housing, etc. would depend on the need. In our association with contract agencies we outline these things as a part of our contracted service with them.
- We bring these nurses through international recruiting firms, so some of the items, like housing and language skills are conducted prior to their arrival.
- Topics and activities included are in a language bank made available for patients and staff. Competency assessment administered by the Department of Organizational Development. Individualized instruction and supervision in order to assess clinical competency and to assist the nurse in achieving competency.

8a. If you selected Clinical and Classroom please tell us how long the session is:

Clinical:

- 2 months or longer base on the needs of the new staff.
- 3-4 weeks.
- Up to 3 months.
- 6 weeks to 6 months.
- 4 to 8 weeks.
- 1 week core orientation, classroom setting. 1.5 days of HR/organization. The remainder is clinical, equipment, processes, documentation, etc.
- 6-10 weeks depending on the orientee's level of experience.
- 6 to 8 weeks.
- 4-6 weeks, or longer, if necessary.

Classroom:

- 2-3 weeks and longer if necessary.
- 16-20 hours.
- Two weeks.
- 4 weeks.
- 3 to 7 days.
- Orientation is unit or clinical area specific and based on competency, experiences.

Learning labs, Essentials of Critical Care Orientation, Intermediate care programs, ie, Cardiac specialty programs.

- 2 weeks.
- 1 week.

9. If you checked classroom education what does it include? Please check all that apply.

Medical terminology — 1

Pharmacology — 6

Delegation — 5

Priority Setting — 4

Other — 4

Comments:

- Computer system, e-mail system, equipment, policies, regulatory information. Various clinical classes held throughout the year.
- Computer documentation medication administration blood transfusion therapy glucose testing general hospital orientation.
- Policy and procedure review and basic skills for anyone new to the hospital.

10. What other things have you done that have proven successful to retaining foreign nurses?

Comments:

- Marry them to locals.
- I believe it has been very helpful that they were hooked up with other Filipino nurses in the hospital who became their guide so to speak and has been a tremendous help in their adjustment to the new area.
- Very little recruitment of foreign nurses.
- Probably not enough of a track record, but we have regular meetings and social events including our hospital network administrator who is from India, Professors from the local colleges who are from India, and hospital employees/administrators. We share food and stories. The hospital also tries to hire the husbands of the nurses into jobs they qualify for.
- We have provided other financial help such as providing transportation and reimbursing other expenses such as CGFNS exam, TOEFL, TSE, NCLEX prep exam and ICHP certificate. Additionally, nurses from her culture have been very supportive.
- Provided a packet to them regarding seeking licensure upon first contact.
- The most effective thing is bringing them into a setting with a large number of people from their home country. Many of our foreign nurses have family members that already reside in this community or work in our facility.
- Individualized orientation for all.
- Successful projects/programs with regards to retention of foreign nurses.

11. Does your orientation/transition program differ from the orientation program provided to new U.S.-educated nursing graduates?

Comments:

- No — 6.
- Yes, it is tailored to the new culture that these new nurses are facing.
- May be longer.
- Not significantly.
- Somewhat. If more education is needed in delegation skills, or understanding of medications, etc. the preceptor and director works with the new employee.
- Differences between orientation/transition programs for international nurses and new U.S. educated nursing graduates.

12. Do international nurses stay at your organization as long as new U.S.-educated graduates?

Yes — 7

No — 5

Comments:

- Longer — 2.
- Too early to tell, they have three-year contracts.
- Only two nurses in the past several years. One stayed about two years and the other just arrive this past October and are still in transition.
- Once they arrive, most are committed to us for a minimum of three years.

13. What do you think has proven most successful for you in acclimating international nurses into your organization?

Comments:

- We are not successful.
- The kind of orientation that they go through, the personal interview that is done by our HR Director in person accompanied by a tenured Filipino RN at our hospital.
- Taking an interest in them as humans, including the nurses in outside activities/dinners, supporting them as they cook occasionally at the local restaurant. Assuring they have good housing and being an advocate for them in negotiating the American systems: specifically Social Security Administration and the NYS Education Departments.
- Financial support and treatment with professional respect during transition.
- We change preceptors and units until we find a fit.
- Peer support.
- Proximity to the Canadian border, 12 hour shift availability, organized labor contracts, salaries.
- Individualization for the preceptor and clinical match.
- The extensive individualized orientation and connection with other international nurses.
- The staff who works with them initially. We have just really begun the process of bringing nurses from places other than the Philippines.

- Success in acclimating international nurses.

14. What would help you to transition international nurses into your organization?

Comments:

- So, far everything we are doing has resulted in a very positive experience for both the hospital and the nurses. We can improve in sharing our recruiting plans with our current nurses on staff.
- If they had a 'buddy' or mentor here. Living with a sponsoring family may help them acclimate.
- We are in a rural upstate location and previously, the nursing department was made up of female, middle-aged, white, U.S.-born nurses. The RNs are unionized and initially NYSNA had offered help with a transitional program that they had used in the NYC area. Although NYSNA does not want nurses to do mandatory overtime, neither do they want to welcome foreigners upstate. I believe it may be somewhat isolated to the current representative; it is sad that they are so unsupportive of attempts to hire adequate numbers of qualified staff. Everyone may have benefited from a more formal transition program.
- A more expeditious process for obtaining licensure.
- Addressing cultural issues is a challenge, not sure what the answer is. Language is a barrier as well. English courses and medical terminology courses prior to coming to work.
- More time for assessment and training.
- Hearing what they have to say their needs are.
- If we were to get an international nurse, I believe the primary issue would be language. We would verify skills to assure competency and then assign preceptor to help assimilate to our culture.
- Programs/behaviors that would be helpful in the transition of international nurses.

Report of the PR&E Delegation and Assistive Personnel Subcommittee

Recommendations to the Delegate Assembly

1. *Adopt the proposed Model Act and Rules for Delegation and Nursing Assistant Regulatory Model*

   Rationale

   Providers of health care must maximize the use of every health care worker to meet the public's increasing need for accessible, affordable, quality health care. There is a place for appropriately trained and supervised assistive personnel. Nurses coordinate and supervise the delivery of nursing care in many settings. Nurses typically have the broadest interface with patients in acute care, long-term care and many community settings, and work with a variety of assistive personnel who may be delegated nursing tasks. The regulation of assistive personnel to promote uniform training and oversight is a logical activity of boards of nursing. The regulation of nursing should include nursing practice by licensed nurses and the selected nursing functions performed by nursing assistive personnel.

2. *Adopt the proposed Delegation Position Paper.*

   Rationale

   Nurses work with and through others, resulting in multiple interactions and relationships with a variety of health team members, clients and families. The Subcommittee has described the means by which such an interaction and communication is achieved as an interface (Webster, p. 610). One important type of nursing interface with others is delegation. This Paper discusses the elements that need to be in place for delegation to be used, including the authority. Many of the interfaces in traditional practice settings, such as hospitals and nursing homes, involve delegation. In other settings, there may not be clear lines of authority. It is important that the nurse understand the type of interface that is expected in a role and setting, because this has significant consequences for how he or she may approach the role as well as the accountability of the nurse. This Paper identifies the elements a nurse should consider in using delegation and other types of interfaces.

Background

The critical nature of the regulatory issues raised by the use of nursing assistive personnel has been long recognized by the National Council of State Boards of Nursing (NCSBN). The NCSBN Nursing Practice & Education Committee developed a concept paper on delegation in 1990. Since then, a number of committees and projects have focused on related topics. In 1997, the Unlicensed Assistive Personnel Task Force developed strategies to support Member Boards in addressing unlicensed assistive personnel (UAP) issues including an updated Position Paper and several resource documents related to delegation and unlicensed assistive personnel.

NCSBN research findings that a variety of methodologies are being used to prepare assistive personnel, that 10-20% of assistive personnel are performing activities considered outside the range of assistive personnel practice and that adequacy of preparation for supervision of care was the lowest rated of all activities by both newly licensed nurses and employers raised the concerns with the NCSBN Practice & Regulation Committee in 2003. The PR&E Models Revision Subcommittee also identified the need to revisit the issues of delegation and assistive personnel and recommended to the Board of Directors that a NCSBN group explore the broader topic of how nurses work with and through others. And at the 2003 NCSBN Annual Meeting, the delegates adopted a resolution proposed by the Kentucky Board of Nursing that NCSBN develop a Position Paper on the regulation of nursing assistive personnel which includes model act and rule/regulations with a report to the 2004 Delegate Assembly.

In September 2003, the NCSBN Board of Directors charged a new PR&E Delegation Subcommittee

Members

Cheryl Koski, MN, RN, CS, Chair
Wyoming, Area I

Sue Deroen, RN, BSN
Kentucky, Area III

Julia George, RN, MSN
North Carolina, Area III

Judith Hiner, RN, CNA, BC
Kansas, Area II

George Herbert, MA, RN, APN, C
New Jersey, Area IV

Janette E. Wackerly, RN, MBA
California-RN, Area I

Board Liaison

Mary Bubaugh, MSN, RN
Kansas, Area II

Staff

Vickie Sheets, JD, RN, CAE
Director of Practice and Regulation

Relationship to Strategic Plan

Strategic Initiative II
Promote evidence-based regulation that provides for public protection.

Strategic Objective 2
Support Member Board adaptation of best practices.

Meeting Dates

- November 17–18, 2004
- January 31 – February 2, 2005
- March 29–31, 2005
- April 25–27, 2005

to collect information about how nurses work with assistive personnel, study how delegation is currently being implemented, and analyze the congruence between education, practice and regulation in the use of delegation. The Subcommittee was also directed to develop content related to delegation for the NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules and suggest ways to reconnect education to practice in terms of delegation.

At its first meeting, the PR&E Delegation Subcommittee developed a plan to meet this charge. Given the breadth of the project, the Subcommittee recommended a two-year process, with an update report to the 2004 Delegate Assembly. In FY05, the Subcommittee completed its final Position Paper and regulatory model for assistive personnel (presented as an additional article and a chapter for the NCSBN Models).

Highlights of FY05 Activities

- Developed Paper, Working with Others: Delegation and Other Health Care Interfaces — A Concept Paper.
- Developed a regulatory model for nursing assistants, presented in a new article for the NCSBN Model Nursing Practice Act and a chapter for the NCSBN Model Nursing Administrative Rules.
- Distributed documents for external review and feedback.
- Invited external groups to attend in person or via conference call, a meeting day with the Subcommittee to dialogue about its work.
- Review and incorporated selected comments in final documents.
- The PR&E Delegation Subcommittee met April 25-26, 2005, which was after the board mailing.
- Reviewed comments about the delegation Paper from Member Boards and external stakeholders.
- Reviewed comments about the model for the regulation of nursing assistive personnel from Member Boards.
- Held two conference calls to provide opportunity for stakeholders to call in comments.
- Met with guests from the American Association of Medical Assistants.
- Incorporated comments as deemed appropriate in the paper and model.
- Developed two templates
  - Decision tree for delegating to nursing assistive personnel
  - Decision tree for accepting assignment to supervise

Future Activities

- None — Subcommittee has completed its charge.

Attachments

A. Delegation: Working with Others — A Position Paper
   Appendix A — Review of Member Boards Statutes and Rules/Regulations
   Appendix B — Summary of Position Statements Regarding Assistive Personnel and Delegation
   Appendix C — Literature Review
   Appendix D — Case Law Review

Appendix E — Individuals Who Provided Comments on Working with Others: A Position Paper

Appendix F — Definitions

B. Proposed Model Act and Rules for Delegation and Nursing Assistant Regulatory Model

C. Delegation Decision Tree

D. Accepting Assignment to Supervise

Attachment A

Working with Others: A Position Paper

Executive Summary

KEY CONCEPTS

1. Boards of Nursing regulate nursing practice.
2. State Nurse Practice Acts determine what level of licensed nurse is authorized to delegate.
3. Delegation is a complex skill requiring sophisticated clinical judgment and final accountability for client care. Nursing education should include delegation theory and opportunities for case studies and simulated exercises. However, the application of delegation theory to practice must occur in a practice setting, where the nurse has clinical experience to support decision-making and the authority to enforce the delegation.
4. There is both individual accountability and organizational accountability for delegation. Organizational accountability relates to providing sufficient resources, staffing, appropriate staff mix, implementation of policies and role descriptions, opportunity for continuing staff development and creating an environment conducive to teamwork, collaboration and client-centered care.
5. To delegate is to transfer authority to a competent individual for completing selected nursing tasks/activities/functions. To assign is to direct an individual to do activities within an authorized scope of practice. Assignment (noun) describes the distribution of work that each staff member is to accomplish in a given work period.
6. The practice pervasive functions of assessment, planning, evaluation and nursing judgment cannot be delegated.
7. The steps of the delegation process include assessment of the client, the staff and the context of the situation; communication to provide direction and opportunity for interaction during the completion of the delegated task; surveillance and monitoring to assure compliance with standards of practice, policies and procedures; and evaluation to consider the effectiveness of the delegation and whether the desired client outcome was attained.
8. The variation in the preparation, regulation and use of nursing assistive personnel presents a challenge to nurses and assistants alike. Consistent education and training requirements that prepare nursing assistive personnel to perform a range of functions will allow delegating nurses to know the preparation and skill level of assistive personnel, and will prepare nursing assistants to do this work.
9. Delegation is one type of interface between nurses and other health care personnel. There are other types of interfaces, and nurses need to assess other types of interactions to identify the nursing role and the responsibility for the particular type of interface.

THE POSITION OF NCSBN

- State Boards of Nursing should regulate nursing assistive personnel across multiple settings.
- There are other types of interfaces with health care providers and workers in settings where there is not a structured nursing organization. In some settings, health care plays a secondary role. Nurses need to assess other types of interactions to identify the nursing role and responsibility for the particular type of interface.
- Delegation is the act of transferring to a competent individual the authority to perform a selected nursing task in a selected situation, the process for doing the work. Assignment describes the distribution of work that each staff member is to accomplish in a given time period.
- Nursing assistive personnel, regardless of title, should receive adequate basic training as well as training customized to the specific work setting. Basic education should include how the nursing assistant functions as part of the health care team, with an emphasis on receiving delegation. Individuals who successfully complete comprehensive educational and training requirements, including passing a competency examination, will be certified as nursing assistive personnel.

Working with Others: A Position Paper

But in both [hospitals and private houses], let whoever is in charge keep this simple question in her head, (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?

- Florence Nightingale

I. Introduction

The importance of working with and through others and the abilities to delegate, assign, manage and supervise have never been as critical and challenging as in the complex and complicated world of 21st century health care. Recent decades have seen an upheaval in health care triggered by an escalation of new knowledge and technology. There has never been a greater demand for nursing. At the same time, the numbers of nurses is not keeping pace with the growing needs for nursing services.

Nurses are present most continuously with clients and hold a tradition of using a variety of nursing assistive personnel in order to meet the needs of more clients than one nurse can care for alone. Today the world is facing a critical nursing shortage. Unlike the cyclic shortages that occurred periodically throughout the 20th century, this shortage is compounded by an aging nurse population, an increased need for nursing services due to changing demographics (e.g., the increased survival rate of people with chronic diseases as well as people generally living longer), more nursing care being delivered in nonhealth care settings, and a "war for talent" with other health and service professions. The profession of nursing **must** determine how to continue providing safe, effective nursing care with decreased numbers of nurses caring for increased numbers of clients.

Working with others has always been a fundamental aspect of nursing, and traditionally the major type of interaction has been the nurse delegating to competent others. This Paper provides an analysis of the complex concepts related to delegation, and is intended as a resource for boards of nursing in the regulation of nursing. It provides nurses and employers with information that will assist them in making informed decisions about using nursing assistive personnel to provide safe, competent nursing care. The Paper builds upon historical and conceptual NCSBN papers on delegation by reaffirming the delegation decision-making process while adapting it to the realities of the current nursing workplace. It discusses issues impacting the preparation of nurses to delegate as well as the use of delegation in the management of nursing care.

The Paper, and its companion piece, the draft article and chapter for the *NCSBN Model Nursing Practice Act and Model Administrative Rules*, propose a regulatory model for the oversight of nursing assistive personnel in agencies and facilities with structured nursing organizations (i.e., settings which have designated chief nursing officer). This Paper refers to individuals working with nurses in these settings as Nursing Assistive Personnel (NAP).

This Paper also addresses nurses working in settings that do not have organized nursing structures, where nurses have struggled to determine the appropriate nursing role. It provides guidance to nurses working in non-acute health settings, social support agencies and other settings where there is not a structured nursing organization. While delegation has been the traditional type of interface with assistive personnel, this Paper provides a template for nurses to evaluate other types of interfaces with health team members and other workers, referred to in this Paper as Unlicensed Assistive Personnel (UAP). Working with UAP in these settings is a source of confusion and frustration for nurses, and the subject of many calls to boards of nursing. This Paper proposes a template to guide nurses in these situations.

Boards of nursing have jurisdiction over licensed nurses and the nursing care they provide. In facilities with a structured nursing organization, there are multiple nurses (including the chief nursing officer) who all are accountable to their licensing board. The board of nursing is the logical

agency to regulate assistants to nurses in these settings. Distinction is made between nursing assistive personnel who work in settings with structured nursing organizations (hospitals, long-term care/nursing homes, hospice and home care) and unlicensed assistive personnel who work in other types of settings. This is related to the recommendation that boards of nursing should regulate nursing assistive personnel. The roles, titles and settings of all unlicensed assistive personnel are varied, and while the board would have jurisdiction over the licensed nurse working in those environments, the board would not have jurisdiction over non-nurse program providers and personnel. It is important to assist nurses in understanding the nature of nursing roles and accountabilities in these settings.

The Paper concludes with position statements and recommendations for continued work needed to develop and promote approaches to effectively working with others. The Paper, the regulatory model and the templates look to the future. The objective is to protect the public through licensing of individual nurses and through the regulation of a continuum of nursing care.

II. Background

Nursing home reform was initiated by the Omnibus Budget Reconciliation Act of 1987 (OBRA), OBRA provided amendments to the Social Security Act (SSA) for Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) that established requirements for the training and competency assessment of nursing aides working in long term care facilities. These requirements included that all nurse aides who work in Medicare and Medicaid funded nursing homes complete a State-approved training program that are a minimum of 75 hours (that includes 16 hours of supervised clinical training), pass a competency examination, and receive certification from the State where they are employed. State aide registries reside in different agencies in different states. Currently, there are thirteen (13) boards of nursing managing the registries. Home health aides are also included in the state registries, but there is no regulation of nurse aides working in acute care as well as other settings (OIG, 2002).The first NCSBN resource to address delegation was a concept paper written in 1990 by the Nursing Practice & Education Committee that discussed concepts and presented a delegation process. In 1996, a special subcommittee was convened to revisit the topic and update the Paper. In 1998, the Subcommittee produced a *Delegation Folder* that included a curriculum outline for teaching delegation to both nurses and assistive personnel (who receive the delegation). Other tools included a decision tree, a summary of the *Five Rights of Delegation*, glossary and bibliography. These widely cited documents provided a firm base for advancing concepts about working with others in the 21st century (NCSBN, 1998).

The Office of Inspector General published a Report, *Nurse Aide Training,* in November 2002. Its findings included the following:

- *Nurse aide training has not kept pace with nursing home industry needs.*
- *Teaching methods are often ineffective, clinical exposure too short and unrealistic.*
- *In-service training may not be meeting federal requirements.*

The OIG recommended that the Centers for Medicare & Medicaid Services (CMS) improve nurse aide training and competency evaluation program requirements. CMS reviewed a draft of this Report and concurred with the recommendations and indicated CMS would consider appropriate vehicles to implement a response (OIG, 2002). NCSBN concurs with this recommendation.

In September 2003, the NCSBN Board of Directors charged the Practice, Regulation & Education (PR&E) Delegation Subcommittee to develop a Position Paper, model legislative and administrative rule language pertaining to delegation and the regulation of nursing assistive personnel. This board action was in response to the increasing use of nursing assistive personnel, a resolution adopted by the 2003 NCSBN Delegate Assembly[1] and concerns brought to the board by the NCSBN

Practice, Regulation & Education Committee and the PR&E Models Revision Subcommittee. Given the breadth and scope of the project, the Subcommittee recommended a two-year process, with an update report to the 2004 Delegate Assembly and a final Position Paper and resources for consideration by the 2005 Delegate Assembly. This work is the culmination of that effort.

III. Premises

The following premises guided the Subcommittee deliberations:

A. Consumers have a right to health care that meets legal standards of care regardless of the setting. The safety and well-being of the client/client group must be the central focus of all decisions regarding delegation of nursing tasks and functions to nursing assistive personnel (NCSBN, 1997).

B. State Nurse Practice Acts and Nursing Administrative Rules/Regulations define the legal parameters for nursing delegation (ANA 1994). Most states authorize registered nurses to delegate. Many states also authorize licensed practical/vocational nurses to delegate in specified settings and/or circumstances (NCSBN, 1997). Provision of any care that constitutes nursing or any activity represented as nursing is a regulatory responsibility of boards of nursing.

C. Nursing is an outcome driven, knowledge-based, process discipline that is context dependent and requires critical thinking. Nursing cannot be reduced solely to a list of tasks. The licensed nurse's specialized education, professional judgment and discretion are essential for quality nursing care (NCSBN, 1997).

D. There is a need and a place for competent, appropriately supervised nursing assistive personnel in the delivery of affordable, quality health care (NCSBN, 1997).

E. All decisions related to delegation of nursing tasks must be based on the fundamental principle of protection of the health, safety and welfare of the public that is the underlying principle of nursing regulation. Decisions to delegate nursing tasks/functions/activities are based on the needs of clients, the stability of client conditions, the complexity of the task, the predictability of the outcome, the available resources to meet those needs and the judgment of the nurse (NCSBN, 1997).

F. It is imperative for the delegating nurse to have an understanding of what the NAP's credential represents in terms of education and demonstration of skill. The supervising nurse also needs to be informed regarding the nursing assistive personnel's education and competency.

G. The skill and art of delegation need to be developed, with both didactic content and opportunity to apply theory in a simulated context. The effective use of delegation requires a nurse to have a body of practice experience and the authority to implement the delegation.

H. Nursing employers need to recognize that a newly licensed nurse is a novice who is still acquiring foundational knowledge and skills. In addition, many nurses lack the knowledge, skill and the confidence to delegate effectively, so ongoing opportunities to enforce the theory and apply the principles of delegation is an essential part of employment orientation and staff development as well as a topic for continuing education offerings, mentoring opportunities and other continued competence strategies.

I. The practice pervasive functions of assessment, planning, evaluation and nursing judgment cannot be delegated (NCSBN, 1997).

J. While a licensed nurse must be actively involved in and be accountable for all managerial

[1]The 2003 Kentucky Board of Nursing resolution was that NCSBN develops a Position Paper on the regulation of nursing assistive personnel which includes model act and rule/regulations with a report to the 2004 Delegate Assembly.

decisions, policymaking and practices related to the delegation of nursing care, there is both individual accountability and organizational accountability for delegation (JONA, 1999; ANA 2005). Organizational accountability for delegation relates to providing sufficient resources, staffing, appropriate staff mix, implementation of policies and role description, opportunity for continuing staff development and creating an environment conducive to teamwork, collaboration and client-centered care.

IV. Data Collection

SURVEY OF BOARDS OF NURSING

NCSBN Member Boards were surveyed regarding needs and concerns pertaining to delegation and nursing assistive personnel. An electronic survey was distributed by e-mail in November 2003 asking for input regarding delegation and nursing assistive personnel. The critical challenges identified by respondents included:

- Evolving work settings, with expanded use of nursing assistive personnel, fragmentation in regulation, the use of untrained personnel in some settings (e.g., schools, jails, community homes), and nursing assistive personnel in physician offices.
- Variation in terminology and titles.
- Lack of standardized training and competency assessment issues.
- Accountability and responsibility issues.
- Lack of understanding by employers regarding the scope of issues and problems.
- RN discomfort with the delegation process and lack of both authority and time to appropriately delegate and provide adequate supervision.

The survey respondents suggested a variety of resources that would be helpful to address these challenges, ranging from an updated Position Paper to standardized curriculums to standards for use and training across all settings.

REVIEW OF CURRENT STATE NURSE PRACTICE ACTS AND RULES/REGULATIONS

Member Board Nurse Practice Acts and Nursing Administrative Rules/Regulations documents were reviewed for the terms *delegation*, *direction*, *assignment*, *supervision*, *management* and *nursing assistive personnel* (*nursing assistants*, *nurse aides* and *unlicensed nursing assistive personnel*) (see Appendix A — *Analysis of Nurse Practice Acts* and *Administrative Rules Regarding Nursing Assistive Personnel and Delegation*).

Forty-eight (48) boards have some reference to delegation in either the nurse practice act or rules; of these, 35 boards references appear in nurse practice acts and 43 boards references appear in the rules. Forty-four (44) boards included a definition of delegation in either the practice act or rules. Thirty-nine (39) boards authorized delegation by RNs; 23 boards authorized delegation by LPN/VNs. Fifteen (15) boards addressed delegation in standards of nursing practice. Thirty-two (32) boards addressed delegation or supervision in the grounds for discipline. Five boards specifically addressed delegation in the curriculum portion of education rules. Six boards inferred delegation when no specific language exists. One state advised that nurses do not delegate in that jurisdiction.

Thirty (30) boards have separate portions of the act or rules that address delegation, often providing criteria for delegation. Twelve boards provide lists of nursing functions that may be delegated or lists of nursing tasks that should not be delegated. Some states are silent regarding delegation in Nurse Practice Act, but have lengthy rules about the topic. Currently, 13 nursing boards manage the nurse aide registry in their respective states. Twenty-five (25) address nurse aide/nursing assistant training, 20 boards medication aides, and 23 boards have sections of the

law or rules regulating some aspect of nurse aide/nursing assistant activities.

There is much variation in the titles of nursing assistive personnel (e.g., unlicensed nursing personnel, nursing assistant, nurse aide, patient care attendant, patient care aide, etc). At least two states license nursing assistive personnel and three states have a second level of nursing assistive personnel. Ten boards have one or more advisory opinions addressing delegation, supervision or nurse aides/nursing assistants. Other resources include guidelines (eight boards), and decision trees (eight boards).

There was no clear consensus as to the best regulatory approach. A quagmire of semantics permeates delegation and the use of assistive personnel. Some states' use of delegation reflects how that term is defined in this Paper. Other states define delegation as what a nurse can direct another licensed nurse to do. In one state, nurses never delegate; in others only RNs may delegate. There are nursing assistants, certified nurse assistants, nurse aides, nurse techs, nurse extenders, medication aides, medication assistants, and the list of titles goes on and on. It is no wonder that nurses and other members of the health care team are confused, to say nothing of the public. But is nursing practice really that different from state-to-state? Do the nursing assistive personnel in one state really work that differently than the nursing assistive personnel in a neighboring state?

OTHER RESOURCES

A number of nursing organizations have developed position statements and guidelines regarding delegation and nursing assistive personnel. The Subcommittee reviewed and analyzed various organization position statements regarding delegation and nursing assistive personnel. See Appendix B, Analysis of Position Statements Regarding Nursing assistive personnel and Delegation. In addition, other professions were contacted regarding other approaches for working with unlicensed personnel

Surprisingly, an extensive literature search did not identify many recent articles published on delegation. The main concepts addressed in the literature included the implementation of delegation, staff mix, education and training, and regulation. The results of the literature review are available in Appendix C.

A legal case review was conducted. There were not a great number of cases on point, none involving nurses. The cases tended to vary by different fact patterns and courts. In some, the person receiving the delegation was perceived to have been practicing a profession without a license. In others, the professional was held accountable for aiding and abetting unlicensed practice. There were also cases that found it appropriate for unlicensed personnel to perform tasks or functions under the direct supervision and responsibility of a professional (see Appendix D).

STAKEHOLDER PERSPECTIVES

The Subcommittee identified numerous stakeholders including recipients of care, families, nurses, other members of the health care team, employers, nurse liability insurers, legislators and other policy makers as well as nursing assistive personnel themselves. As part of its external outreach, comments and feedback on a draft of this Paper were requested of stakeholders (see Appendix E).

In addition, the Subcommittee members and staff conducted focus groups of nurses, nursing assistants and nurse managers to get input from nurses working in a variety of clinical settings regarding delegation. The common themes were that nursing assistants feel prepared to provide routine cares effectively. Student nurses may receive theory regarding delegation in nursing education programs but not opportunities to apply the theory in clinical settings. New nurses are not prepared to delegate — this is a skill that must be developed post graduation, e.g., by working with a mentor. Many participants in the focus groups believed that nursing assistants

need more training. Another theme was that communication was identified as being a critical factor in successful delegation.

Stakeholders were also offered the opportunity to meet with the Subcommittee, either in person or via telephone conference call. Comments from those interactions are also summarized in Appendix E.

V. Delegation Decision-Making Process

A. PREPARATION

> *Delegation is a complex skill requiring sophisticated clinical judgment and final accountability for patient care. Delegation and supervision content can be presented in a didactic educational setting through theory and through case studies and exercises. It is part of the curriculum for all RN educational programs. However effective delegation cannot be practiced in a limited clinical learning experience. Delegation is best learned through actual work with colleagues. Effective delegation requires experience as a practicing nurse* (Grumet, 2005).

An ongoing nursing delegation process allows for the nurse to accomplish nursing care for more clients than one individual could provide alone. The first consideration is the authority to delegate that comes from the jurisdiction's Nurse Practice Act and Nursing Administrative Rules.

Secondly, both the delegating nurse and the nursing assistive personnel receiving delegation should be prepared to enter the nursing delegation process. The nurse is prepared to delegate through appropriate education, skills and experience, which include the following:

- Understanding of the delegation process.
- Understanding of the role and scope of functions of the nursing assistive personnel.
- Being in a line of authority that allows the nurse to enforce the delegation.
- Necessary knowledge, skill and professional judgment to perform the nursing tasks/functions/activities to be delegated.
- Access to pertinent client information.
- Access to pertinent staff information as well as relevant agency policies, procedures and guidelines.
- Opportunity to provide communication, surveillance and supervision.
- Consistent availability of the nurse to the nursing assistive personnel for consultation and procedural direction.

The nursing assistive personnel should also be prepared to receive delegation. This includes the following:

- Appropriate education, skills and experience, including:
  - The assistant's role and scope of functions.
  - The relationship between the assistant, the nurse and the health care team.

Once there is documented/demonstrated evidence of the nurse's current competency in the use of delegation and the nursing assistant's current competency in receiving delegation, it is appropriate to begin the steps of the delegation process.

B. PROCESS

The steps of the delegation process used by the nurse are outlined below.

Step One — Assess and Plan

An understanding of client needs is a critical aspect of determining appropriate nursing tasks/functions/activities to delegate to nursing assistive personnel. Assessment includes:

- The nature, complexity, variability and urgency of care.
- Priority of long and short term client care needs.
- Level of clinical decision making.
- Level of predictability of client's health care status and patterns of response to health care interventions.
- Range and severity of potential adverse outcomes associated with the performance of the task/activity/function.
- Range and complexity of actions required to intervene if adverse outcomes occur.
- Nature and likelihood of any emergency or risk management responses.
- Active client/family involvement in decision making.
- Therapeutic benefits and risks associated with delegating task/function/activity.

Similarly, the delegating nurse needs to have information about the staff members' knowledge, skills and abilities. Assessment includes:

- The cognitive and technical abilities needed to perform the task/function/activity.
- Information as to the level of responsibility and scope of the assistive person's role.
- Context in which the nursing task/function/activity is to be performed.
- Expected outcomes of the nursing care task/function/activity.
- Potential adverse effects of both delegated task and client condition (so assistant can be eyes and ears for nurse).

The nurse should have an appreciation of the client care context as well as the resources available for support of the provision of nursing care. Using all this information, the nurse plans for the episode of care, specifying each task and the knowledge and skills required to perform the task. If the nurse determines that client needs can be met while maintaining safety for both the client and nursing staff, the nurse proceeds to step two.

Step Two — Communication

The nurse provides directions and addresses any unique client requirements and characteristics, and clear expectations of:

- How the task is to be accomplished .
- When and what information is to be reported, including:
  - Expected observations to report and record.
  - Specific client concerns that would require prompt reporting.
  - Priorities for accomplishing tasks, while acknowledging the need for flexibility should client conditions or needs change.

The nurse individualizes the communication to the nursing assistive personnel and client situation and assesses the assistant's understanding of expectations, providing clarification if needed. The nurse's communication should be *clear*, *concise*, *correct* and *complete* (Hansten & Jackson, 2004, p.174). The nurse should verify comprehension with the nursing assistive personnel (Zimmerman, 27), and communicate his or her willingness and availability to guide and support assistant.

Finally, the nurse assures appropriate accountability by verifying the person receiving the delegation accepts the delegation and the responsibility that accompanies it.

Communication must be a two-way process. Nursing assistive personnel should have the opportunity to:

- Ask questions regarding the delegation and seek clarification of expectations if needed
- Inform the nurse if the assistant has not done a task/function/activity before, or has only done infrequently.
- Ask for additional training or supervision.
- Affirm understanding of expectations, including those regarding communication of specific client concerns as well as progress toward completion of the delegation.
- Determine the communication method between the nurse and the assistive personnel when the two are located at different sites.
- Determine the communication and plan of action in emergency situations.

The final aspect of communication is that of documentation. Timely, complete and accurate documentation of provided care facilitates communication with other members of the health care team and records the nursing care provided.

Step Three — Surveillance and Supervision

The purpose of surveillance and monitoring is related to nurse's responsibility for client care within the context of a client population. The frequency of observations varies with needs of client and experience of assistant. In determining the level and nature of appropriate supervision, the nurse considers the:

- Client's health care status and stability of condition
- Predictability of responses and risks
- Setting where care occurs
- Availability of resources and support infrastructure.
- Complexity of the task being performed.

The nurse supervises the delegation by monitoring the performance of the task or function and assures compliance with standards of practice, policies and procedures. The nurse determines frequency of onsite supervision and assessment based on the needs of the client, the complexity of the delegated function/task/activity and the proximity of location and needs of the nurse's location.

The nurse is responsible for:

- Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include:
  - A task not completed in a timely manner.
  - The implementation of a task/function/activity not meeting expectations.
  - Unexpected change in a client's condition.
- Alertness to subtle signs and symptoms (which allows nurse and assistant to be proactive, before a client's condition deteriorates significantly).
- Awareness of assistant's difficulties in completing delegated activities early rather than later (which facilitates addressing problems and allowing completion of delegation).

Providing adequate follow-up to problems and/or changing situations is a critical aspect of delegation.

Step Four — Evaluation and Feedback

In considering the effectiveness of delegation, the nurse addresses the following questions:

- Was the delegation successful?
  - Was the task/function/activity performed correctly?
  - Was the client's desired and/or expected outcome achieved?
  - Was the outcome optimal, satisfactory or unsatisfactory?
  - Was communication timely and effective?
  - What went well; what was challenging?
  - Were any problems or concerns; if so, how were they addressed?
- Is there a better way to meet the client needs?
- Is there a need to adjust the overall plan of care, or should this approach be continued?
- Were there any "learning moments" for the assistant and/or the nurse?
- Was appropriate feedback provided to the assistant regarding the performance of the delegation?
- Was the assistant acknowledged for accomplishing the task/activity/function?

C. ADAPTATION OF THE DELEGATION DECISION-MAKING PROCESS

For a model process to be useful, it has to be realistic. When one considers the hundreds of decisions made by a nurse in daily practice, going through all these steps for each is impossible. Therefore, the Subcommittee members offer the following:

- The *assignment*, typically developed by a nurse manager or charge nurse from the previous shift, is used in many work settings. Assignments are based on the client needs, available staff and resources, job descriptions, scope of practice for licensed nurses and scope of functions for nursing assistants. The assessment of staff resources for assignments is based largely on the organization's evaluation of an employee's credentials upon hire and periodic performance evaluations.
- The nurse must determine the level of supervision, monitoring and accessibility she or he must provide for assistive personnel. There is a difference in the level of supervision related to the different roles of licensed nurses and assistive personnel as well as routine tasks versus delegated tasks and the proximity of the supervising nurse. The nurse continues to have responsibility for the overall nursing care.
- To delegate effectively, nurses need to be able to rely on knowing nursing assistive personnel's credentials and job descriptions, especially for a first time assignment. Nursing administration (typically through human services/personnel) has responsibility for validating credentials and qualifications of employees. This is especially important in work settings where nurses frequently work with temporary staff or with other facility employees on an irregular basis.
- Effective nurses are selective, identifying those situations that require thoughtful application of the delegation process.
- Traditionally, one nurse has done all the steps in the delegation process for him/herself. In today's fast paced health care environment different nurses may do different steps (all steps need to be accomplished).

D. IMPORTANT CAVEATS

- The art and science of nursing is complex and knowledge based, thus the nursing process in its entirety cannot be delegated. **The practice-pervasive functions of assessment, planning, evaluation and nursing judgment cannot be delegated.**
- Discrete health care tasks/functions/activities may be delegated if it is within the nurse's scope of practice. The nurse cannot delegate functions and activities not in the nurse's scope of practice.
- Delegation is client specific. Having done a task for one client does not automatically mean an assistive person can do the task for all clients. In addition, delegation is also situation specific: doing a task for one client in one situation does not mean the nursing assistive personnel may perform the task for this client in all situations.
- The more complex or unpredictable the care and the care environment, the more likely nursing care should be provided by a licensed nurse.
- A task delegated to an assistive person cannot be redelegated by the assistive person
- A huge challenge for the delegating nurse is the current variation in nursing assistant preparation and training — frequently, a nurse cannot assume one assistant's training is the same as another assistant's training.
- Trust is central to the working relationships between nurses and assistive personnel. Good relationships have two-way communication, initiative, appreciation and willingness to help each other. Breakdown in communication may occur when assistive personnel work with more than one nurse. Many assistive personnel are task-oriented and are not trained to prioritize orders from nurses, so need guidance as to how to order activities (Potter & Grant, 2004).
- The nursing assistant has responsibility not to accept a delegation that he/she knows is beyond his/her knowledge and skills. The nursing assistant is expected speak up, and ask for training and assistance in performing the delegation, or request not to be delegated a particular task/function/activity.
- Nurses who were educated under a primary care model may not realize what they do not know about delegation. "In a 1995 nationwide survey of more than 40 EDs, 78% of the RNs indicated their delegation skills as good or excellent, yet 35% scored poorly on an accompanying test that evaluated their related knowledge" (Zimmerman, 10).
- Both nurses and nursing assistants need the appropriate interpersonal and communication skills and organizational support to successfully resolve delegation issues.
- An effective delegator recognizes that "an assistant is a resource for achieving results" (Linney, 1998).
- "Nurses have come to realize that doing tasks is not the essence of nursing… The profession is entering another phase of evaluation. It is learning to work with others, with new technologies, and in new settings in new ways" (Hansten & Jackson, 2004, p. 23).

VI. OTHER TYPES OF INTERFACES

Nurses work with and through others, resulting in multiple interactions and relationships. The means by which such an interaction and communication is achieved is an *interface* (Webster, p. 653). It is important that the nurse determine the type of interface that is expected in a nursing role because this has significance for how he or she may approach the role as well as the accountability of the nurse. Many interfaces include delegation in settings with structured nursing organization. But more and more nursing is provided in settings where there is not a structured nursing organization. Sometimes, the nurse working in a setting without structured nursing organization has a position with both the opportunity and authority to delegate and supervise unlicensed assistive personnel. In other settings, however, the nurse's position does

not provide the opportunity to supervise or the authority to enforce delegations. These latter situations can cause confusion of role, responsibility and accountability for the nurses working in these situations with unlicensed assistive personnel.

Teaching — The nurse whose only interface with staff members is a teaching function is accountable for the content and the methods used in teaching. A nurse brought in for this special function does not have the opportunity to enforce the learning. Looking at how staff members apply what they have learned to their practice and functions is an important outcome that can be used to evaluate the teaching effectiveness, but this type of teaching usually does not provide an opportunity to be involved in staff follow-up.[2] Examples of this type of episodic teaching are: teaching staff selected procedures in an assistive living facility; adult day care setting where the primary focus of the setting is not health care; and a nurse working for an equipment company who trains staff to use a new technology.

Accepting an assignment to supervise — There are situations when a nurse may be assigned to supervise a staff member who has been delegated tasks by another licensed provider (e.g., in a physician's office). There are other situations where the authority to provide tasks or procedures (that would be considered nursing in a health care environment) has been granted by a statute or rule/regulation separate from the Nurse Practice Act or rules/regulations (e.g., a school secretary being directed by the school principal to give medications to a student). Situations where a nurse is responsible for supervising unlicensed assistive personnel who have been delegated tasks by another licensed provider can be professionally uncomfortable as well as challenging. There may be a lack of clarity on how the nurse is expected to be involved. These situations fall outside of traditional delegation and assignment. These situations require a reasoned analysis to determine the nurse's role and responsibility. They have much to do with the culture and working relationships that have developed.

The nurse is responsible for the decision whether to accept an assignment to supervise. The nurse should verify that he or she has the authority to supervise. The nurse should determine that the supervised activity is within the nurse's scope of practice, that the nurse is appropriately educated and competent to perform and supervise the activity. The nurse should have the opportunity and proximity to provide the appropriate level of monitoring. The nurse should decline an assignment to supervise if the nurse:

- Does not have to the authority to intervene and take corrective action if needed
- Has never performed that activity to be supervised
- Does not have the opportunity and/or proximity to provide effective monitoring
- Would not be able to intervene if there were a problem.

Real life situations may involve a nurse caught in the ethical dilemma of knowing that she/he should not accept an assignment to supervise but also knowing that to refuse could cause a threat to her/his employment. On one hand, the nurse could be disciplined for accepting an assignment beyond the nurse's personal scope of practice and/or accepting an assignment that presents a risk to the client. On the other hand, the nurse could experience the loss of livelihood with resultant implications for the nurse and her/his family's economic security. Nurses should be aware of different options and strategies in dealing with these situations and make informed decisions.

If there were client harm, the nurse's accountability would focus on the elements of supervision. One example of situations where the nurse may be supervising staff performing activities delegated by others is the nurse working with medical assistants in a physician's office. Here, the physician has delegated procedures and tasks to a medical assistant and assigns supervision to the nurse. The school nurse is another example of a nurse providing nursing services in a setting where health care is secondary to the primary purpose of providing education. A school

[2]The episodic teaching referenced above should not be confused with the teaching provided in formal nursing education programs that involve student clinical and require ongoing instructor supervision and interaction.

nurse might determine it necessary to decline supervision of an individual whose authority to do a procedure comes from the principal and statutes/rules governing education. One example of negotiating the expected interface would be that the nurse suggests providing instruction to perform a task with a return demonstration rather than supervise.

Another concern is regarding individuals with functional disabilities who need interventions that enable a client to remain in an independent living environment. Tasks and functions that go beyond the typical activities of daily living and would be considered nursing interventions in health care settings may be considered health maintenance functions[3] (HMF) or tasks in assisted living settings. The Texas Board of Nurse Examiners has developed rules to address this type of interface, where the nurse is required to do the initial assessment and then unlicensed assistive personnel do the HMF as well as activities of daily living (ADL). The Oregon Board of Nursing enacted rules specifically to provide guidance for nurses who teach noninjectable medication administration to unlicensed personnel as well as standards for the delegation of specific tasks of nursing care to unlicensed persons.[4]

In summary, to determine the nature of an interface with another health care provider, the nurse should consider:

- What is the nurse's scope of practice and role?
- What is the nurse's experience and education related to the proposed activity?
- Is there a line of authority and where is the nurse in it?
- What aspect of care is being implemented?
- Does the nurse have the power to enforce decision-making?
- Does the nurse have the necessary resources, access to monitoring and ability to follow-up?
- Is it a limited contact or an ongoing relationship?

VI. DISCUSSION

Many nurses are reluctant to delegate. This is reflected in NCSBN research findings and the literature review as well as in anecdotal accounts from nursing students and practicing nurses. There are many contributing factors, ranging from not having educational opportunities to learn how to work with others effectively to not knowing the skill level and abilities of nursing assistive personnel to simply the work pace and turnover of clients. At the same time, NCSBN research shows an increase in the complexity of the nursing tasks/functions/actions performed by assistive personnel. With the demographic changes and resultant increase in the need for nursing services plus the nursing shortage, nurses cannot provide the needed care without assistive support.

VII. CONCLUSIONS

The topic of delegation has never been timelier. Delegation is a management tool. Used effectively, it can result in safe and effective nursing care, free the nurse for attending to more complex client care needs, develop the skills of nursing assistive personnel and promote cost containment for the organization. There is no clear consensus as to the best regulatory approach for the regulation

[3]Texas Rules Chapter 225 provide for an RN assessment for determining whether clients living in an independent living environment have requirements for activities of daily living, health maintenance activities or nursing tasks. If a client requires ADH or HMF, delegation by the nurse is not required. If a client requires nursing tasks, then RN involvement in the ongoing care is required.

[4]The regulatory approach in Oregon Rule 851-047-0000 addresses delegation to unlicensed persons in settings where an RN is not regularly scheduled and not available to provide direct supervision. In the Oregon rules, the RN is responsible for assessing a client situation to determine whether or not delegation of a task of nursing can be safely done, safely implementing the delegation process by following the Oregon Board's process for delegation, and for reporting unsafe practices to the facility owner, administrator and/or the appropriate state authorities.

of nursing assistive personnel and delegation at this time. However, facing a shortage of epic proportions, the nursing community needs to plan how we can continue to accomplish nursing care while assuring the public access to safe, competent nursing care. This Paper and the proposed model language provide a first step.

VIII. POSITION OF THE NATIONAL COUNCIL OF STATE BOARDS OF NURSING

A. **It is the position of the National Council of State Boards of Nursing (NCSBN) that the state boards of nursing should regulate nursing assistive personnel across multiple settings, as set forth in proposed Article XVIII, Chapter Eighteen of the NCSBN Model Nursing Practice Act and Nursing Administrative Rules.**

Rationale:

Many licensed nurses work with nursing assistive personnel in facilities and agencies where there is a nursing organization that comprises a major portion of the institutional infrastructure. The board of nursing is responsible for the regulation of nursing care, thus the board of nursing is the logical entity to regulate assistants to nurses in these environments. The proposed regulatory framework for nursing assistive personnel will enhance public protection by supporting the delegating/supervising nurse and nursing assistive personnel in these health care settings. Developing national standards for basic training and competency testing for nursing assistive working in these settings will promote consistency and safety among nursing assistive personnel.

B. **There are other types of interface with health care providers and workers in settings where there is not a structured nursing organization and where health care plays a secondary role, e.g., group homes, adult day care and assisted living facilities. In these settings, the nurse's role is typically not one of delegation. Nurses need to assess other types of interactions to identify the nursing role and responsibility for the particular type of interface.**

Rationale:

These are challenging settings for nurses and nursing regulation. Boards of nursing do not have authority over the personnel in charge of these programs, but they do have jurisdiction over the licensed nurses who work in these settings. The nurse's role is often episodic, often one of teaching or consulting. The nurse is not in a position of authority to delegate or enforce the delegation, more often the nurse advises. There is an interaction between the nurse and the agency workers — but it is a different sort of interface than delegation. The focus of these homes and facilities is the support of daily living by providing meals, offering opportunities for social interaction and meeting housekeeping, laundry and other personal needs in a "homelike" setting. There are other types of settings where there is not a nursing structure but there is a nurse role to provide nursing services. This Paper offers a template to assist nurses to evaluate a role, the type of interface and articulate the nurse's responsibility in a particular setting.

One of the competencies identified by the Institute of Medicine (IOM) for all health care professionals is working within the health care team. Knowing the characteristics and roles of different providers and identifying how they relate to the nursing role is an important step toward mastering this competency. For nurses working in other types of settings, where the emphasis is on support of living and health care is secondary, knowing the characteristics and roles of different workers is also an important step toward effective teamwork.

C. **Delegation is the act of transferring to a competent individual the authority to perform a selected nursing task in a selected situation, the process for doing the work. Assignment describes the distribution of work that each staff member is to accomplish on a given shift or work period.**

Rationale:

The management strategy of delegation is a tool nurses use to direct others in the provision of nursing care and is defined as transferring authority to a competent person to perform a

selected task in a selected situation. In previous NCSBN papers, "assigning" the verb, was defined as the act of designating nursing activities to be performed by another nurse consistent with that nurse's scope of practice. Using the verb assign in this manner is a variation of delegation. Since the process for both is the same, this Paper uses the verb "delegate" to describe the process of working through others and the noun "assignment" to describe what a person is directed to do, (reflecting the common usage of language among nurses working in clinical settings.

D. **Nursing assistive personnel, regardless of title, should receive adequate basic training as well as training customized to the specific work setting. Basic education should include how the nursing assistant functions as part of the health care team, with an emphasis on how to receive delegation. Nursing assistive personnel Individuals who successfully complete comprehensive educational and training requirements, including passing a competency examination, will be certified as nursing assistive personnel.**

Rationale:

Nursing assistive personnel provide services to vulnerable clients, often of an intimate nature. It is difficult work. Better education and training will better prepare nursing assistants to do this work. Individuals who complete the education, training and competency evaluation discussed above earn the recognition of a title and the responsibility of a range of functions.

In addition, it is imperative for the delegating and supervising nurse to have an understanding of what a nursing assistant credential represents in respect to training and demonstration of skill, something that is currently difficult to do. The use of nursing assistive personnel is expected to increase. It is very important that nurses have an accurate estimation of at least their training, and ideally their experience, to be able to effectively direct the services nursing assistive personnel provide.

IX. RECOMMENDATIONS

The PR&E Delegation Subcommittee makes the following recommendations:

A. That the NCSBN Delegate Assembly adopts the following position statement that appears in Section VIII of this Paper.

B. That research is needed in the following areas:

1. Research to identify best practices for use of nursing assistive personnel.
2. Research to study the outcomes of delegation from:
    a. Perspective of client
    b. Perspective of nurse
    c. Perspective of nursing assistive personnel
    d. Perspective of employer.
3. Research to support staff mix, other staffing concerns.
4. Outcomes research to look at medication assistant errors (e.g., frequency, type and cause).
5. Quantify client outcomes — well-being, not having problems (what works)
    Rationale:
    Data is needed to identify the safest ways to work with assistive personnel to accomplish what nurses alone cannot do.

C. That the following resources be developed:

1. National discipline tracking

Rationale:

NCSBN includes tracking of discipline taken against nursing licenses as part of Nursys®. This is one of the benefits of NCSBN Membership for boards of nursing. NCSBN does not track assistive personnel actions. The only national reporting available is through the Healthcare Integrity and Protection Data Bank (HIPDB), but boards are charged a fee for each inquiry, which is cost prohibitive given the numbers of nursing assistants. Although NCSBN has previously explored the possibility of tracking assistive personnel discipline actions, the Board of Directors did not find this to be feasible at that time. The Subcommittee recommends revisiting this issue. More information available about this mobile population would support board of nursing review of applicants for nursing assistant certification.

2. Toolbox (includes updating of previous NCSBN delegation resources)
    a. How to delegate
    b. How to receive delegation
3. Information about how other states regulate (e.g., see Attachment A)
4. Models for monitoring and coaching nursing assistive personnel
    a. Curriculum content outlines
    b. Nursing students
    c. Practicing nurses
    d. Nurses returning to practice
    e. Nursing assistive personnel

    Rationale:

    Nurses are not born delegators — it is a skill that must be learned, practiced and mastered. Assistive personnel also need resources to support them in their work. Nurses and assistive personnel, as well as other health care personnel, need to learn teamwork and how to work together.

D. That boards of nursing and/or NCSBN pursue the following collaborations:

1. Work with stakeholders, state agencies and legislatures toward placement of nursing assistive personnel regulatory frameworks with the board of nursing.

    Rationale:

    Thirteen boards of nursing currently manage the nurse aide registries created by OBRA in the late 1980s. Some boards are involved in other aspects of regulating nursing assistive personnel. Adequate stakeholder buy-in and consensus is needed to make this happen.
2. Work with the Center for Medicare and Medicaid and other federal agencies to revisit OBRA regulations.
3. Work with state agencies that currently regulate nursing assistive personnel.
4. Work with the American Nurses Association, the American Association of Colleges of Nursing, the National League for Nursing, the American Organization of Nurse Executives and other nursing organizations to promote innovation in how nursing students learn how to work with assistants, including delegation, as well as theory application as part of clinical studies

    Rationale:

    The current regulatory system for assistive personnel is fragmented at best and absent at worse. It is time to revisit OBRA, to promote other approaches to develop comprehensive basic training and competency assessment for assistive personnel. CMS has acknowledged the need to upgrade the OBRA requirements, providing a window of opportunity for collaboration.

5. Educators of health professionals, allied health and paraprofessionals and assistive personnel need to collaborate to better prepare students to work as a health care team.

   Rationale:

   It is not conscionable to train practitioners and assistants in silos and then expect them to instantly work together effectively after graduation. Valuing the contributions of all health team members must begin when they are students.

Appendices

A. Review of Member Boards Statutes and Rules/Regulations

B. Summary of Position Statements Regarding Assistive Personnel and Delegation

C. Literature Review

D. Case Law Review

E. Individuals Who Provided Comments on Working With Others: A Position Paper

F. Definitions

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Appendix A

Review of Statutes and Rules/Regulations (Spring 2004)

Board	Delegation Definition	RN Scope	LPN/VN Scope	Delegation Section	Task Lists Can or Cannot	NA Section	NA Registry	NA Ed/Training	Cert or Lic NA	Med Asst	Discipline Grounds	Other Resources
AL	X											
AK	X	X	X	X		X		X	X		X	X
AS												
AZ	X	X	X			X	X	X				
AR	X	X	X	X							X	
CA-RN	X					X						X
CA-VN												
CO	X			X		X	X	X		X	X	
CT												
DE	X	X		X						X		
DC	X	X		X		X						
FL	X	X	X	X	X	X	X	X	X		X	
GA-PN												
GA-RN												
GU	X	X				X	X	X			X	
HI	X	X		X	X		X					
ID	X			X		X	X	X		X	X	
IL	X	X										
IN	X	X									X	
IA	X	X	X		X						X	
KS	X	X		X		X		X		X	X	
KY	X	X	X	X		X						
LA-PN												X
LA-RN	X	X		X							X	X
ME	X	X		X		X	X	X		X	X	
MD	X	X	X	X			X	X	X	X	X	
MA	X	X	X	X						X		X
MI	X	X		X								
MN		X				X		X		X	X	
MS	X	X										X
MO	X											X
MT	X	X		X	X					X	X	
NE	X	X	X		X			X		X	X	X
NV	X	X	X	X			X	X			X	X
NH	X		X			X	X	X	X	X	X	
NJ				X		X		X	X	X	X	X
NM	X	X						X		X	X	

Board	Delegation Definition	RN Scope	LPN/VN Scope	Delegation Section	Task Lists Can or Cannot	NA Section	NA Registry	NA Ed/Training	Cert or Lic NA	Med Asst	Discipline Grounds	Other Resources
NY											X	
NC	X	X	X	X	X	X	X	X	X	X	X	X
ND	X	X	X			X	X	X		X		
NMI												
OH	X	X	X	X	X			X		X	X	
OK	X	X	X			X		X	X		X	X
OR	X	X		X	X	X	X	X	X	X	X	
PA												
PR												
RI	X	X	X	X								
SC		X	X	X	X	X					X	
SD	X	X	X	X	X		X	X		X		
TN		X									X	
TX	X			X	X					X		X
UT	X	X	X	X							X	
VT	X	X	X	X		X	X	X	X		X	X
VI						X	X	X	X			X
VA				X		X	X	X	X		X	
WA	X	X	X	X						X		
WV-PN	X		X								X	X
WV-RN	X	X										X
WI	X	X									X	X
WY	X	X	X	X	X	X	X	X	X		X	X
Totals	44	39	23	30	12	23	18	25	13	20	32	19

KEY

Delegation definition — NPA or rules include a definition of delegation.

RN scope — RN authorized to delegate.

LPN/VN scope — LPN/VN authorized to delegate.

Delegation section — Entire section or chapter of statute and/or rules devoted to delegation.

Task lists can or cannot do — Statute and/or rules includes either a list of what tasks can be delegated or a list of what cannot be delegated.

NA section — Entire section or chapter of statute and/or rules devoted to assistive personnel.

NA registry — Board of nursing responsible for Nurse Aide Registry.

NA ed/training — Statute and/or rules addresses the education and training of assistive personnel.

Cert or Lic NA — Board either certifies or licenses nursing assistants.

Med Asst — Regulation of medication assistants by the board (interpreted broadly — if statute or rule addressed medication administration or reminding by assistive personnel, was included).

Discipline Grounds — Board's grounds for discipline in statute and/or rules specifically reference delegation/supervision.

Other Resources — Board has developed resources to support nurse delegation (e.g., decision trees).

Appendix B

Summary of Position Statements Regarding Assistive Personnel and Delegation (Fall 2003)

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
Academy of Medical-Surgical Nurses	Globalization of market forces and evolving health care reform provide opportunity to analyze nurses' traditional roles and assume responsibility for judicious delegation of nursing tasks to UAP. The RN uses professional judgment to determine what to delegate.	Redesign of traditional nursing roles does not replace RNs with UAP; it gives RN the opportunity for appropriate support for the delivery of nursing care.	Variety of job classifications	Must be commensurate with the activities that will be delegated. Competency of UAPs should be evaluated annually and provided ongoing education.		RNs are accountable for patient outcomes from nursing care. RNs must participate in decisions regarding UAP job descriptions and UAP job duties within the clinical setting, and be knowledgeable about the competency of each UAP and intervene when needed	Support the control and monitoring of UAP through the use of existing mechanisms that regulate nursing practice (state board of nursing), including the clarification of the delegation process and what may be delegated and restrictions.
American Association of Spinal Cord Injury nurses (AASCIN) 1995	Budgetary and resource considerations not valid reasons for wrongful delegation; RN does not have to teach UAP who do not demonstrate the ability to learn and perform care.	RNs asked to increase delegation and use of UAPs; UAP not substitute for RN; UAP should be under direct supervision of RN; UAP role varies by setting.	■ Nursing aides ■ Personal care attendants ■ Family members ■ Friends ■ Appointees of the client	At request of client or client's agent the RN may teach the client's care to UAP. The client or agent then accepts responsibility for the UAP supervision and the type and quality of UAP care; exception when UAP is from an agency		The RN has a legal scope of practice and a legal authority to perform nursing acts; UAPs do not	Employers and RNs who participate in wrongful delegation should be sanctioned
American Federation of Teachers (AFT), 1995	The RN must remain the single authority over delegation of nursing tasks and responsibilities to UAP based on the nurse's evaluation of the training and competencies of the unlicensed person and the nature of the tasks to be performed.	Performance of non-nursing duties such as environmental maintenance; clerical tasks; and directly assisting patients with ADL such as hygiene, feeding and ambulation. Increasingly licensed personnel are being pressured to inappropriately delegate.	Standardized job titles and job description are needed	Minimum education and training requirements needed at state level		The RN retains responsibility for all tasks he/she delegates	
American Nurses Association (ANA) 1997	Direct patient care activities are delegated by the RN and involve ADL; indirect patient care activities focus on environmental maintenance, such as housekeeping, transporting clerical, and stocking. In delegation the RN uses professional judgment to determine the appropriate activities to delegate.	UAP provide support services to the RN; in virtually all health care settings UAP are inappropriately performing functions within the legal scope of nursing.		The nursing profession should define and supervise the education, training and utilization of UAP		The RN is responsible and accountable for the provision of nursing practice. The RN supervises and determines the appropriate use of UAPs. Therefore, it is responsibility of the nursing profession to establish and the individual RN to implement standards for the practice and utilization of UAPs.	Definitions of nursing in state practice acts.

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
American Nephrology Nurses' Association (ANNA) 1983, revised and reaffirmed 2003	Never delegate a nursing care activity that requires the specialized skill, judgment and decision-making of an RN or the core nephrology principles needed to recognize and manage real or potential complications.	The RN shall have either instructed the UAP in the delegated activity or verified the UAP competency. Administration of medications is beyond the scope of practice of UAP, and shall be limited to those medications considered part of the routine hemodialysis treatment (e.g., normal saline and heparin via the extra corporeal circuit and intradermal lidocaine).	■ Dialysis technicians ■ Patient care technicians ■ Reuse technicians ■ Nephrology technologists (All under supervision of RN)	Assistive personnel in dialysis need not be licensed; but must complete a standard program of education and training for UAP in dialysis preferable in a junior college or vocational school with ongoing CE requirements.		The RN is accountable and responsible for all delegated nursing care activities and interventions — must be present in the patient care area for ongoing monitoring and evaluation of the patient's response to the therapy. The RN is legally accountable and clinically responsible for the complete documentation of the entire nursing process.	UAP must function under the state nurse practice act; ANNA prefers specific language referring to UAP in dialysis settings.
Arizona Nurses Association (ANA) 1992, renewed 2002	Delegation presumes the delegator has greater knowledge and a delegated task is only a subcomponent of a larger whole	Written job descriptions with clear parameters that define and limit the responsibilities of the position. RNs should never delegate to any member of the health team a function for which that person is not qualified.		Core curriculum developed and supervised by RN that includes but is not limited to: ■ Communication ■ Customer service ■ Safety ■ Clinical practice issues.		RN is originator of delegation and retains responsibility for outcomes. The employing organization has a responsibility to assure that the appropriate training, orientation and documented competencies are in place for the UAP so that the RN can be reasonably assured that the UAP can function safely.	
Association of periOperative Registered Nurses (AORN) 1995, reaffirmed 1999	Restructuring of traditional roles does not replace perioperative RNs, but provides opportunity to focus leadership skills on coordinating patient care and directing activities of the nursing team. The perioperative RN may delegate appropriate patient care activities.			Perioperative RNs define and supervise the training and utilization of UAP who provide direct and indirect care in the perioperative setting. UAP must receive appropriate training and demonstrate competency before assuming new and expanded responsibilities, and must be commensurate with the delegated activities.		Perioperative RNs are accountable for patient outcomes resulting from nursing care provided during the perioperative experience.	

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
Association of Rehabilitation Nurses (ARN) 1995, revised 2003	UAPs needed to "achieve the goal of assisting individuals in the restoration and maintenance of maximal physical, psychosocial and spiritual health."	Basic scope ADL tasks plus support of RN assessment; secondary scope consists of those tasks that require additional training and demonstration of competence prior to being performed by the UAP (includes insertion catheters, NG feedings, bowel programs, single dressing changes, glucose testing, ECGs and bladder scans).	Institutional, residential, outpatient and community settings under the supervision of RN.	Qualifications: ■ HS diploma or equivalent ■ Nurse aide training certificate or a minimum of documented four weeks on the job training ■ CPR training ■ Additional training prior to performing tasks in secondary scope of care ■ Demonstrated initial and ongoing competence in both categories.			Tasks delegated by RN shall not exceed any restrictions in the scope of care as set forth by the state.
Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) 1997, 2000	Clear written parameters for direct supervision by RNs; includes lengthy list of nursing activities that should not be delegated.	Need written job descriptions that clearly delineate the duties, responsibilities, qualifications, skills and supervision of UAPs.	UAP should be clearly identifiable to patients as unlicensed.	Orientation and training of UAPs, including didactic content, knowledge base evaluation and clinical skills verification consistent with performance expectations and role responsibilities.		UAPs work under supervision of and are accountable to RN. The RN remains responsible and accountable for the overall nursing care.	Need to evaluate state practice act to ensure that UAP job descriptions and delegated activities are consistent with rules and regulations.
Massachusetts Organization of Nurse Executives (MONE) 1994, 2002	Supervision of UAP remains with the licensed nurse.	Delegation must occur within the delegatee's job description, organizational policies and procedures. Individual health care facilities need flexibility in developing institution specific programs.		Should be determined by nursing leadership in individual facilities.		Differing concerns and debates have focused on primary area of accountability and decision making.	MA Board of Registration in Nursing has regulations on delegation and supervision.
National Association of Neonatal Nurses (NANN), 1999	RN may assign or delegate tasks to assistive personnel based on the assessed patient need, the potential for harm, the complexity of the care and the knowledge and skill of the UAP.	Tasks based on needs, potential for harm, complexity and UAP KSAs	■ Nursing assistants ■ Nursing Aides ■ Orderlies Also list as assistive personnel LPN/VNs, respiratory therapists (RTs) and emergency medical technicians (EMTs).	UAP in this area must have appropriate education in the care of the high-risk newborn and family, even when carrying out support services for the RN.		Neonatal RN responsible for the assessment, planning delivery and evaluation of newborn care.	
National Association of School Nurses (NASN)	Key factors for effective and competent use of assistive personnel are role definition, adequacy of training and appropriate delegation and supervision.	Assistive personnel can be used to supplement professional school nursing services but should not be used to supplant school nurses or be permitted to practice nursing without a license.	■ School staff ■ Clerical aides ■ Health/nursing assistants (HA) Also listed as paraprofessionals are: LPN/VNs, Certified Nurses Aides and RNs who do not meet requirements for school nurses.	The professional school nurse should take lead in helping school districts determine whether and how to use assistive health personnel.		The school nurse is the only one who can legally delegate nursing activities to assistive personnel.	State nursing practice acts determine scope of practice and what nursing activities may be delegated or given to assistive personnel.

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
New Jersey State Nurses Association (NJSNA) 1995, revised 1999	The RN may transfer responsibility for carrying out specified tasks to UAP to assist health care consumer through delegation of nursing tasks. RN in charge of delegating has confidence in the UAP and has adequate time allowed. Delegation may be direct or in-direct.	RNs must develop and implement standards, policies and procedures for UAPs to assist health care consumer in meeting basic needs. UAP does not practice nursing and does not provide total nursing care.	■ Nurse aides ■ Orderlies ■ Assistants ■ Technicians ■ Home health aides In hospitals, LTC, schools, prisons or community settings et al.	Require education developed, taught and evaluated by RNs. UAP preparation is skill-oriented to assist health care consumer in meeting basic human needs. UAP competency is evaluated by an RN and does not require a written examination.		The RN retains accountability for the outcomes of care.	NJ Board of Nursing, the same that governs nursing, should regulate UAPs.
New York State Nurses Association (NYSNA) 1996	Does not address delegation, speaks of RN assignment of tasks and care to other members of nursing staff, including UAP.	Concern regarding shift in use of UAPs to more complex tasks and patients with higher acuity. RNs must express concern when the inappropriate use of UAPs is suggested or employed.		Identification of tasks, patients, circumstances in which care can be assigned to UAPs is responsibility of the nursing profession — RNs need to be involved in establishing the parameters of care and in the standardization of preparation.	Forums should be established to prepare RNs to use UAPs appropriately.	RNs accountable for the delivery of safe, competent care to those patients entrusted to them.	
Oncology Nursing Society (ONS) 1997, revised 2000, 2002	RN validates UAP competency, completes ongoing client assessment, provides ongoing supervision of UAP, performs evaluation of client response to care and interprets and makes decisions regarding care.	Performance of repetitive, common tasks and procedures that do not require the professional judgment of an RN.				Nurse retains accountability for delegated tasks and decisions.	Use existing mechanisms for regulation of nursing practice to regulate UAPs.
Society of Gastroenterology Nurses and Associates (SGNA) 1996, 2001		Perform duties under direct, on-site supervision of delegated patient care.	■ GI assistants				
Society of Oto-rhionolaryngology and Head-Neck Nurses (SOHN), 1996, 2003	Lists criteria to be considered in decision to use UAPs.	Supports safe and appropriate use of UAP, supervised by RN who identifies tasks and [level of] supervision.		Promotes UAP education and training programs consistent with SOHN mission and vision.		RN accountable for patient safety, nursing care and maintains responsibility for patient assessment, care planning and evaluation.	
The American Association of Nurse Attorneys (TAANA)		Increased in recent years partially due to managed care and decreased Medicare reductions; used in more settings, doing more complex tasks; supervising nurses have increased responsibility.	■ Certified nurses aide ■ Home health aide ■ Personal care assistant ■ Personal care attendant ■ Certified phlebotomist ■ Clinical assistant ■ Nursing Assistant ■ Orderly	Recommend standardized curriculum and testing by state; similar to OBRA 1987 requirements for long term care assistants.	Recommend that nursing schools add team nursing to curriculum and/or supervision and delegation to assist working with UAPs.	Nurses ultimately responsible for the provision of nursing care.	Recommend Board provide guidance and direction, including criteria for determining what can be delegated, what cannot, and direction on the type of supervision needed.

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
Tri-Council(1995)	Must be made by RN based on the patient, the task, the preparation of the UAP and other factors.	Increased use due to economic pressures; increased concerns about role and use of UAP.				Nurses accountable for all nursing care provided including policies, procedures and standards.	Board of nursing

Appendix C

Literature Review

When "delegation" is entered as a keyword in search engines such as CINAL, MEDLINE, ABI-INFORM, LEXIS-NEXIS, EBSCO host, ERIC, and Psych INFOR, many articles come up until the search years are limited to 1998-2004. Surprisingly, an extensive literature review did not identify many recent articles published on delegation. The main concepts addressed in the available recent articles include:

Implementation

- Delegation "dos and don'ts" — protect your practice (MNA Online Publications)
- Moen (2001) references both ANA and NCSBN work in writing about how to make delegation work.
- Buppert (2004) writes from the APRN perspective of whether it is safe to delegate to UAP and the business implications.
- Clarke (2003) discusses several high-profile research studies linking nursing staffing and client safety.
- Parsons (1998) described increased confidence in RN delegation after training using a *Nursing Assessment Decision Grid*, as well as increasing job satisfaction experienced by RNs relative to autonomy and promotional opportunity.

Staff Mix

- Changes in staff mix (with increase numbers of nursing assistive personnel) causes role confusion for both RNs and assistants (Zimmerman, 2000; Potter& Grant, 2004; Hall, 1998); especially when job descriptions/level of training and expectation are unknown (Thomas & Hume, 1998; Barter, McLaughlin & Thomas, 1997).
- Thomas, et al, (2000) states that RNs do no feel confident with UAP skills.
- Unruh (2003) notes that the number of LPNs has decreased and may contribute to increased workload for RNs.
- Bernrueter & Cardona (1997) observed a dramatic rise in the number of UAP with mixed feelings from RNs about UAP value.
- Potter & Grant (2004) note that UAP working with multiple RNs can cause UAP confusion (because UAP are not taught to prioritize, they are task oriented).
- Kido (2001) suggests making staff mix public knowledge.
- Clarke (2003) observes more RNs equal less adverse outcomes.

Communication

- Good communication helps nurture the RN and UAP relationship (Thomas & Hume, 1998; Potter & Grant, 2004).
- Parsons, 1998, notes that lack of communication makes relationships poor (UAP not relaying information because they are not trained to recognize things that nurse are and RNs are not trained how to deal with less skilled workers).
- Emphasis on group function may help improve RN-UAP interactions (Anthony, Casey, Chau & Brennan, 2000).

Education/Training

- There is a lack of UAP education, or a lack of consistency of UAP education (Thomas, et al, 1998; Kido, 2001).
- Education of UAP recommended (Barter, McLaughlin and Thomas, 1997).
- Another barrier is the lack of RN educational preparation regarding delegation skills (Thomas & Hume, 1998; Hopkins, 2002; Anthony, Standing & Hertz, 2001).
- Recommend teaching delegation skills (Thomas & Hume, 1998; Parsons, 1998; Anthony, Standing & Hertz, 2001).
- Barter, McLaughlin & Thomas (1997) suggest that UAP have formal training with a defined scope.
- Hopkins (2002) developed a continuing education tool.
- Conger (1999) adjusted the Nursing Assessment Decision Grid NADG 1993/1994, to teach nursing students delegation tools.
- The U.S. Department of Labor's *Occupation Outlook Handbook* advises that minimum education and training is generally required for entry-level nursing, psychiatric and home health aides, that job prospects will be very good because of fast growth and high replacement needs, but that earnings are low.
- Kopishke (2002) provides a historical perspective on the use of nursing assistive personnel and how nurses must prepare themselves to head the team of caregivers found in today's acute care facilities.
- Numerous continuing education offerings address delegation and supervision.

Regulation

- There is a need to work with Boards of Nursing to assure regulatory language is clear to support delegation to UAP in OR setting (Habgood, 2000).
- Recommendations that states mandate minimal educational requirements and competency evaluation for UAP in acute care settings, with a movement to establish national regulation of educational requirements to ensure the competency of UAP in acute-care hospitals (Thomas, Barter & McLaughlin, 2000).
- The best foundation for teaching what can and cannot be delegated is the nursing practice act in the state (Hall, 1996).
- The National Council of State Boards of Nursing adopted its first delegation paper in 1990. The Paper was updated in 1997, and in 1998, a Delegation Resource folder was developed (included the Paper, curriculum outline for teaching delegation to both delegating nurses and the recipients of delegation, decision tree, decision grid and other resources). Delegation was also addressed in the NCSBN *Model Nursing Practice Act and Model Nursing Administrative Rules* in 2004.

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Appendix D

Review of Case Law

Tom Abram, attorney with Vedder, Price, Kaufman & Kaufman in Chicago, provided a legal case review in 2004 regarding delegation and nursing assistive personnel. A case law search found no cases holding a nurse accountable for actions performed by a UAP whether or not the activity was delegable according to the state statutes. Two Illinois cases, People v. Stults, 683 N.E.2d 521 (Ill. App. Ct. 1997) and People v. Cryns, 763 N.E. 2d 904 (Ill. Ct. 2002) discussed actions brought against unlicensed personnel for practicing nursing without a license (neither involved delegation). This review was updated with materials from the Federation of Associations of Regulatory Boards (FARB) in 2005.

Some cases were identified where courts have addressed the use of UAP in other professions.

- In State ex inf. Danforth v. Dale Curteman, Inc., 480 S.W.2d 848 (Mo.,1972) unlicensed individuals claiming to be technicians working under the supervision of ophthalmologists were found to have illegally engaged in the practice of optometry.
- The appellate court affirmed the trial court's decision to revoke the physician's license after he ordered an unlicensed person to administer injections to clients, holding that "when a doctor directs an unlicensed person to perform a medical act, the question is not whether the unlicensed person may be disciplined for the act, but whether the doctor's conduct is unprofessional…" Kolnick v. Board of Medical Quality Assurance, 161 Cal. Rptr. 289 (Cal. Ct. App. 1980).
- In the presence of conflicting evidence, a jury found that a client's injury was not caused by a flu shot administered by an unlicensed and untrained individual. The appellate court affirmed because it could not state the jury was clearly wrong. However, in its opinion, the court stated that the standard of care that nurses are subject to is the same as the standard applied to physicians. Novak v. Texada, et. al., 514 So.2d 524 (Ct. App. La. 1987).
- In Portable Embryonics, Inc. v. J.P. Genetics, Inc., 810 P.2d 1197 (Mont., 1991) unlicensed individuals claiming to be technicians who performed non-surgical bovine embryo transfers were found to have illegally engaged in the practice of veterinary medicine.
- A doctor was convicted of aiding and abetting unlicensed medical assistants in the illegal practice of medicine. People v. Gandotra, 14 Cal.Rptr.2d 896 (Cal.App.2 Dist., 1992)
- The Colorado Supreme Court found that an unlicensed lab technician was not a "health care professional," within the meaning of a statute designed to protect individuals from negligent acts of health professionals but that the statute still applied under the circumstances of the case. Scholtz v. Metropolitan Pathologists, P.C., 851 P.2d 901 (Colo. 1993).
- The appellate court affirmed the trial court decision that unauthorized dentistry took place when a dentist authorized the unlicensed assistant's acts, and inadequately supervised, was held to be unprofessional conduct by a dentist, Fotovatjah v. State of Washington, 1998 Wash. App. LEXIS 1689 (Wash. App. 1998).
- However in PM&R Associates v. Workers' Comp Appeals Board, 94 Cal.Rptr.2d 887 (Cal. App.5 Dist., 2000) doctors use of unlicensed medical assistants to assist physicians in performing physical therapy tasks was not illegal.
- And in State Farm Mut. Auto. Ins. Co. v. Universal Medical, 881 So.2d 557 (Fla.App. 3 Dist., 2004), unlicensed medical assistants authorized to administer physical modalities under the direct supervision and responsibility of a physician.
- A discipline of a veterinarian who had allowed an unlicensed veterinary technician to position a dog for x-ray and to operate an x-ray machine was upheld on appeal. Gilman v.

Nevada State Board of Veterinary Medical, 89 P.3d 1000 (Nev., 2004).

- In People v. Santi, 785 N.Y.S.2d 405 (N.Y., 2004), a doctor was convicted of aiding and abetting an unlicensed medical assistant in the illegal practice of medicine.

Appendix E

Individuals Who Provided Comments on Working with Others: A Position Paper

Submitted Written Comments:

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Met with the PR&E Delegation Subcommittee on April 26, 2005, at NCSBN offices:

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Appendix F

Definitions

- Accountability is being responsible and answerable for actions or inactions of self or others in the context of delegation (NCSBN, 1997). There are different levels of accountability:
  - Licensed nurse accountability involves compliance with legal requirements as set forth in the jurisdiction's law and rules governing nursing. The licensed nurse is also accountable for the quality of the nursing care provided, for recognizing limits of knowledge and experience and for planning for situations beyond the nurse's expertise (NCSBN, 2004). Licensed nurse accountability includes the preparedness and obligation to explain or justify to relevant others (including the regulatory authority) one's judgments, intentions, decisions, actions and omissions… and the consequences of those decisions, actions and behaviors (SA, 2004).
  - Nursing assistive personnel accountability relates to being answerable for the assistant's actions and behavior.
  - Organizational accountability relates to providing sufficient resources, staffing, appropriate staff mix, opportunity for continuing staff development and creating an environment conducive to teamwork, collaboration and patient-centered care.
- Assignment describes the distribution of work that each staff member is to accomplish on a given shift or work period.
- Competence is the ability of the nurse to act with and integrate the knowledge, skills, values, attitudes, abilities and professional judgment that underpin effective and quality nursing and is required to practice safely and ethically in a designated role and setting (SA, 2004).
  - Licensed nurse competence is built upon the knowledge gained in a nursing education program and the experiences of implementing nursing care. The nurse must know herself or himself first, including strengths and challenges, assess the match of her or his knowledge and experience within the requirements and context of a role and setting, and gain additional knowledge as needed and maintain all skills and abilities needed to provide safe nursing care. Competence requires the application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role (NCSBN, 1996).
  - Nursing assistive personnel competence is built upon formal training and assessment, orientation to specific settings and groups of patients, interpersonal and communication skills, and the experience of the nurse aide in assisting the nurse provide safe nursing care.
- Client directed care is a situation in which a client maintains all or most of self-care responsibilities, including direction of unlicensed nursing assistive personnel (NCSBN, 1997).
- Delegation is transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation (NCSBN, 2004).
- Education infers the transfer of generic information and skill, and includes components of information (teaching) and skill training and assessment (training).
- Nursing care tasks/functions/activities are those nursing interventions that may be delegated/assigned to nursing assistive personnel and are not restricted or prohibited by legislation, regulation and/or agency policy (adapted from SA, 2004).

- Medication assistant is an individual who receives specialized training preparing for a role in administering oral and topical medications and who works under the supervision of a licensed nurse.
- Nursing assessment is "the gathering of objective and subjective information relative to a client, confirmation of the data, and communication of the information" (*NCLEX-RN® Test Plan, 2004*).
- Nursing assistive personnel are unlicensed personnel to whom nursing tasks are delegated and who work in settings with structured nursing organizations.
- Professional judgment is the intellectual (educated, informed and experienced) process that a nurse exercises in forming an opinion and reaching a clinical decision based upon an analysis of the available evidence (SA, 2004).
- Rescission of delegation is the process of taking back a delegation, typically due to serious change in client condition (stable to unstable), nature of therapies or other situation requiring change in planning for a group of clients.
- Range of functions are the tasks and activities learned in an approved nursing assistant and competency evaluation program that are typically performed by nursing assistive personnel for clients who are stable and predictable, supervised by a licensed nurse who may need to limit the range of tasks based on client needs.
- Scope of practice is the parameters of the authority to practice granted to a nurse through licensure.
- Supervision is the provision of guidance or direction, oversight, evaluation and follow-up by the licensed nurse for the accomplishment of a nursing task delegated to nursing assistive personnel.
    - Direct Supervision involves the presence of the licensed nurse who is working with other nurses and/or nursing assistive personnel to observe and direct the assistant's activities. The proximity of this supervision is such that immediate intervention is possible if problems occur (SA, 2004).
    - Indirect supervision occurs when the licensed nurse is not present and supervision is provided by other than direct observation of the nurses and/ or nursing assistive personnel. The absence of proximity of the licensed nurse requires processes being in place for the direction, guidance, support and monitoring of the LPN or nursing assistive personnel activities (SA 2004).
- Surveillance and monitoring is the process of observing and staying attuned to client status and staff performance.
- Teaching/providing information is to impart knowledge, to cause to know something (Merriam Webster, p. 1281).

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Attachment B

Proposed Model Act and Rules for Delegation and Nursing Assistant Regulatory Model

Attached please find a proposed article for the NCSBN *Model Nursing Practice Act* and a proposed chapter for the *Model Nursing Administrative Rules*. This document is a companion piece to the Paper, *Working with Others: A Position Paper*, and presents a model approach for the regulation of nursing assistive personnel.

Draft Model Language: Nursing Assistive Personnel

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Section 1. *Delegation*. Delegation is a management technique used by licensed nurses to work with nursing assistive personnel in a variety of health care settings. a. The registered nurse may delegate nursing care tasks/functions/activities to nursing assistive personnel, regardless of title, that are appropriate to the level of knowledge and skill of the nursing assistive personnel and are within the range of functions as defined by the board for the level of nursing assistive personnel. b. The licensed practical/vocation nurse may, in limited settings, delegate nursing care tasks/functions/activities to nursing assistive personnel, regardless of title, that are appropriate to the level of knowledge and skill of the nursing assistive personnel and are within the range of functions as defined by the board for the level of nursing assistive personnel. ****States vary as to whether LPN/VNs are authorized to delegate. Because the review of board of nursing statutes showed that a majority of boards do allow LPN/VN delegation in specified settings, they are included in this section.* b. Those nursing care tasks/functions/activities that may be delegated to nursing assistive personnel are determined by criteria to be put forth in rule.	****Article XVIII of the Model Nursing Practice Act (MNPA) and Chapter Eighteen of the Model Nursing Administrative Rules (MNAR) address how licensed work with nursing assistive personnel and requirements for nursing assistive personnel.18.1 Criteria for determining nursing tasks/functions/activities that may be delegated:* a. Knowledge and skills of the nursing assistive personnel; b. Verification of the clinical competence of the nursing assistive personnel by the employing agency; c. Stability of the patient's condition that involves predictability, absence of risk of complication, and rate of change. d. The variables in each service setting that include but are not limited to: 1. The accessible resources and established policies, procedures, practices and channels of communication that lend support to the type of nursing tasks/functions/activities being delegated to nursing assistive personnel. 2. The complexity and frequency of care needed by a given patient population. 3. The proximity of patients to staff. 4. The number and qualifications of staff. 5. The accessibility of the licensed nurse. e. Nursing tasks/functions/activities that inherently involve ongoing assessment, interpretation or decision-making that cannot be logically separated from the procedure(s) are not to be delegated to nursing assistive personnel.
Section 2. *Nursing assistive personnel* — individuals employed within a health care, residential or community support context that includes a component of direct hands-on care and performing delegated nursing care tasks set forth by the board in administrative rules. Nursing assistive personnel work under the supervision of a registered nurse or, in limited settings, a licensed practical nurse. ****States currently vary as to what types of nursing assistive personnel are regulated.*	*This section identifies standards for nursing assistive personnel.* **18.2 Purpose of Standards** a. To communicate board expectations and provide guidance for nursing assistive personnel b. To articulate board criteria for evaluating nursing assistive personnel actions and behavior when providing nursing care under the supervision of a licensed nurse. ****Standards promulgated by boards of nursing provide a broad framework and provide notice to nursing assistive personnel, nurses, and employers as to board expectations regarding the use of assistive personnel.*

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Section 3. *Nursing Assistive Personnel Registry.* Each individual who successfully meets all requirements for certification shall be entitled to be listed on the Nursing Assistive Personnel Registry as a certified nursing assistant (CNA), certified nursing assistant II (CNA-II) or medication assistant — certified (MA-C). a. An applicant whose certificate or listing in another jurisdiction has been disciplined or who has had a criminal conviction may not be eligible for certification. b. Before listing nursing assistive personnel on the Nursing Assistive Personnel Registry, the board shall investigate and act upon each application for certification. c. The board shall require the periodic renewal of certifications and updating of listings in the registry on a biennial basis.	**18.3. Nursing Assistant Registry.** a. The board shall determine policies and procedures for the operation of the registry. Certified Nursing Assistants, Certified Nursing Assistants II, and Medication assistant — certified shall all be listed on the registry. ****States may choose to operate three separate registries or include all levels of nursing assistive personnel on one registry. The advantage of having one registry is that tracking of individuals with multiple certificates would be facilitated. However, this may not be possible if different agencies are responsible for managing different categories of nursing assistive personnel.* b. Duty to Report — nursing assistive personnel shall report to the board criminal convictions substantially related to the functions of their work.
Section 4. *Certified Nursing Assistant (CNA) Range of Functions*. Nursing assistive personnel function within a range of tasks and activities that are typically performed by nursing assistive personnel for patients and that are learned in basic certified nursing assistant education and training as set forth in rule. A licensed nurse may need to limit the range of tasks based on patient needs, situation or available resources and shall supervise all nursing tasks/functions/activities. ****The delegating/supervising nurse is accountable for decisions made and actions taken in the course of delegation and supervision.* ****Employers may choose to limit or restrict but cannot expand the range of functions articulated by the board.*	**18.4 Standards for Assistive Personnel** *The nursing assistant:* a. Performs nursing tasks and functions within the range of functions authorized in the Nurse Practice Act and rules governing nursing. b. Demonstrates honesty and integrity in performing nursing tasks/functions/activities c. Bases nursing tasks/functions/activities on education, training and the direction of the supervising nurse. d. Accepts accountability for one's behavior and actions while assisting the nurse and providing services to patients. e. Performs delegated aspects of patient's nursing care. f. Assists in observing patients and identifying patient needs. g. Communicates progress toward completing delegated nursing tasks/functions/abilities, as well as any problems or changes in a patient's status. h. Seeks clarification if unsure of expectations. i. Uses educational and training opportunities as available. j. Takes preventive measures to protect client, others and self. k. Respects client's rights, concerns, decisions and dignity. l. Functions as a member of the health care team, contributing to the implementation of an integrated health care plan. m. Respects client property and the property of others. n. Protects confidential information unless obligated by law to disclose the information.

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Section 5. *Certified Nursing Assistant II (CNAII) Range of Functions*. A certified nursing assistant with additional education and training as prescribed in rule may perform more complex nursing skills with emphasis on sterile technique, elimination, oxygenation, and nutrition that are learned in a certified nursing assistant II education and training program and are performed under the direct supervision of a licensed nurse.	
Section 6. *Medication Assistant – Certified (MA-C) Range of Functions*. A certified nursing assistant or certified nursing assistant II, with additional education and training as set forth in rule, may administer medications as prescribed by an authorized provider within the parameters set forth in rule. A licensed nurse shall supervise the medication assistant-certifed. ****Any state restrictions regarding the type and route of medications to be administered by a medication assistant-certifed should be placed here. Other state restrictions may address the licensure level required of supervising nurses.*	**18.6 Medication Administration by Medication Assistants – Certified (MA-C)** a. A medication assistant – certified may perform a task involving the administration of medications if: 1. The medication assistant – certified's assignment is to administer medications under the supervision of a licensed nurse in accordance with provisions of this act and rules; and 2. The delegation is not prohibited by any provision of this act and rules. ****Medication assistant – certified may work under the supervision of another professional in some limited settings. Most, however, work in facilities where licensed nurses provide supervision.* b. A medication assistant – certified shall not perform a task involving the administration of medication if: 1. The medication administration requires an assessment of the patient's need for medication, a calculation of the dosage of the medication or the conversion of the dosage; 2. The supervising nurse is unavailable to monitor the progress of the patient and the effect on the patient of the medication; or 3. The patient is not stable or has changing nursing needs. c. A medication assistant – certified who has any reason to believe that he or she has made an error in the administration of medication shall follow facility policy and procedure to report the possible or known error to the appropriate superior and shall assist in completing any required documentation of the medication error. ****The tracking of medication errors assists in the identification of any system issues that contributed to the error as well as identifying any need for retraining or remediation of the MA-C.* d. Medication Administration Policies 1. Medication assistant — certified shall report to the supervising nurse: (a) Signs or symptoms that appear life-threatening;

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	(b) Events that appear health threatening; and (c) Medications that produce no results or undesirable effects as reported by the patient. 2. A licensed nurse shall supervise medication assistant – certified. 3. A registered nurse shall review periodically the following: (a) Authorized provider orders; and (b) Patient medication records.
Section 7. *Certified Nursing Assistants (CNA), Certified Nursing Assistants-II (CNA-II), and Medication assistant – certified (MA-C)* a. The board of nursing shall regulate the preparation and competency assessment of nursing assistive personnel in this state. b. The board shall issue certification to qualified applicants. c. The board shall adopt rules regarding the certification of nursing assistive personnel, including educational, training, and other qualifications for certification that will ensure that the nursing assistive personnel are competent to perform safely within the range of functions. d. The board shall conduct state and federal criminal background checks on all applicants. e. The board will adopt an application process in rule. f. Upon meeting all requirements and successful completion of the basic certified nursing assistant education, training and competency assessment prescribed in rule, an applicant shall be certified as a certified nursing assistant. g. Upon meeting all requirements and successful completion of additional education, training and competency assessment prescribed in rule, an applicant shall be certified as a certified nursing assistant II. h. Upon meeting all requirements and successful completion of additional education, training and competency assessment prescribed in rule, an applicant shall be certified as a medication assistant certified. i. A person may not use the titles certified nursing assistant, certified nursing assistant II, medication assistant–certified or the abbreviations CNA, CNAII or MA-C unless the person has been duly certified under this section.	**18.7 Certified Nursing Assistants**. a. Basic Training Required of all Certified Nursing Assistants 1. Classroom Training. All nursing assistive personnel shall have instruction in the following areas: (a) Role of the nursing assistant (b) Client and resident rights (c) Legal and ethical duties (d) Culturally sensitive care (e) Range of functions (f) Interpersonal communication (g) Receiving delegation and working as a member of the health care team (h) Basic safety skills, including infection prevention (i) Basic nursing skills, including taking and recording vital signs, measuring and recording patient/resident height and weight, recording intake and output, recognizing and reporting abnormal changes in body functioning (j) Personal care skills, including feeding, hydration, skin care, dressing, grooming and toileting. (k) Caring for the client or resident environment. (l) Promotion of patient/resident independence (m) Basic restorative skills, including transfer, ambulation, maintaining range of motion and positioning (n) Characteristics that may put the patient or resident at risk include but are not limited to: i. Patient cognitive impairment ii. Patient sensory deficits or impairments

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	iii. Communication limitations iv. Altered level of consciousness v. Agitation or combativeness (o) Working with agitated or combative clients (p) Restraints (q) End of life care (r) Documentation of vital signs, weights, intake and output, and other routine observations (s) Mental health and social service skills (t) Caring for the cognitively impaired (u) Dealing with developmentally disabled (v) Dealing with behavior problems (w) Basic emergency procedures. 2. Clinical experience. All nursing assistive personnel shall have supervised practical training, with early, realistic exposure to the job requirements. The clinical experience shall include the full range of nursing assistive skills needed in the workplace. ****Additional clinical training in the assigned work setting is recommended as part of job orientation to assist the certified nursing assistant to adapt to the work setting. This training would focus on the type of setting, the health care team the certified nursing assistant is joining, the types of patient care typically provided, including information specific to disease processes or patient characteristics the assistant is likely to see.* b. Additional Education and Training for Certified Nursing Assistant II shall include: 1. Role of the certified nursing assistant II in providing nursing care as established routines for stable, predictable patients with limited risk of complication and change under the supervision of a licensed nurse. 2. Oxygen therapy 3. Sterile technique 4. Wound care 5. Suctioning 6. Trach care for patient with well established trachs 7. Assisting with peripheral IV fluids ****Assisting with peripheral IVs refers to the set-up of equipment and discontinuing IVs. It does not include venipuncture or hanging IVs.*

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	8. Urinary catheterization 9. Gastrostomy and other feeding 10. Elimination procedures c. There shall be supervised clinical experiences. d. Each applicant shall test out for each skill area. e. Additional Training for medication assistant – certified shall include: 1. Role of the medication assistant – certified, including medication administration as a delegated nursing function under nursing supervision and the following acts that cannot be delegated to medication assistant – certified: (a) Conversion or calculation of drug dosage. (b) Assessment of patient need for or response to medication. (c) Nursing judgment regarding the administration of PRN medications. 2. Rights of individuals 3. Legal and ethical issues 4. Agency policies and procedures related to medication administration. 5. Functions involved in the management of medications, including prescription, dispensing, administration and self-administration. 6. Principles of safe medication storage and disposal of medication. 7. Reasons for medication administration 8. Classes of drugs, their effects, common side effects and interactions 9. Reporting of symptoms or side effects. 10. Techniques to check, evaluate, and record vital signs as part of safe medication administration 11. The rights of administration, including right person, right drug, right dose, right time, right route and right documentation. 12. Documentation of medication administration 13. Prevention of medication errors 14. Incident reporting 15. Location of resources and references

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	16. Overview of the state agencies involved in the regulation of medication administration 17. Supervised clinical experience in administering medications.
Section 8. *Education and training program approval*. The board shall adopt rules governing the approval of education and training programs for certified nursing assistants (CNA), certified nursing assistant II (CNA-II) and medication assistive-certified (MA-C).	**18.8 Certified Nursing Assistant Education and Training Programs.** a. A certified nursing assistant training program shall be conducted in a manner to assure that clients receive safe and competent care. b. To be approved by the board, certified nursing assistant education and training programs shall provide: 1. Curriculum and clinical experience as described in rule 18.7a. 2. Documents each student's demonstration of skills by completion of the certified nursing assistant skills checklist required by rule 18.9. 3. Competency assessments for the level of program provided. c. To be approved by the board, certified nursing assistant II education and training programs shall provide: 1. Curriculum and clinical experience as described in rule 18.7b. 2. Documents each student's demonstration of skills by completion of the certified nursing assistant skills checklist required by rule 18.9. 3. Competency assessments for the level of program provided. d. To be approved by the board, a medication assistant – certified education and training programs shall provide: 1. Curriculum and clinical experience as described in rule 18.7c. 2. Documents each student's demonstration of skills by completion of the certified nursing assistant skills checklist required by rule 18.9. 3. Competency assessments for the level of program provided. e. All programs shall provide: 1. Instructors who meet the requirements of 18.h. 2. Classroom and clinical facilities that meet the requirements of 18f.

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	3. Maintenance of records to verify class completion and competency evaluation. Maintenance of records that record the disposition of any complaints regarding the training program. f. A basic certified nursing assistant education and training program preparing certified nursing assistants shall consist of a minimum of: 1. 120 hours of hours of classroom instruction that meet the requirement of 18.7a.1. 2. 80 hours of supervised clinical experience that meet the requirements of rule 18.7a.2. g. An education and training program preparing certified nursing assistant II shall consist of a minimum of: 1. 120 hours of hours of classroom instruction that meet the requirement of 18.7.b. 2. 80 hours of supervised clinical experience that meet the requirements of 18.7b. h. An education and training program preparing medication assistant – certified shall consist of: 1. 120 hours of hours of classroom instruction that meet the requirement of 18.7.c. 2. 80 hours of supervised clinical experience that meet the requirements of 18.c. i. Organization and Administration. Approved certified nursing assist, certified nursing assistant II and medication assistant – certified and a state approved educational institution, an independent contractor or a health care agency, may conduct competency evaluation programs. j. Program Coordinator. Certified nursing assistant, certified nursing assistant II, and medication assistant – certified education, training and competency evaluation programs coordinator shall: 1. Hold a current, unencumbered registered nurse license in the state. 2. Have at least two years of full time experience as a registered nurse in a health care agency or nursing education program. 3. Have at least two years experience relevant to areas of responsibility. k. Program Instructors. Certified nursing assistant, certified nursing assistant II and medication assistant – certified instructors shall:

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	1. Hold a current, unencumbered registered nurse license in the state 2. Have a minimum of two years practice experience in a health care facility. 3. Have at least one year clinical experience relevant to areas of responsibility. 4. Provide documented evidence of preparation for teaching adults. 5. Be listed on the state registry for certified nursing assistant, certified nursing assistant II and medication assistant – certified instructors. 6. Have completed periodic training updates. l. Classroom and Clinical Facilities 1. The resources, facilities and services of the education institutions or health care agency shall be available to the certified nursing assistant I and II, and medication assistant – certified training and competency evaluation programs in order to meet the purpose of the program. 2. The education and training programs shall receive adequate financial support for faculty, other support personnel, equipment, supplies and services. 3. The agencies and services used for clinical experiences shall be adequate in number and of the kind to meet the education and training program's curricular objectives. m. Application for certified nursing assistant, certified nursing assistant II and medication assistant – certified Education and Training Programs Approval. An applicant seeking to establish a certified nursing assistant, certified nursing assistant II, or a medication assistant – certified training program must submit, at least 90 days before the date the program is expected to begin: 1. A completed application on a form provided by the board for each type of program, that includes (a) Summary of the rationale, philosophy and purpose of the program (b) Faculty qualifications (c) Program outline, including program title, type of program, objectives, content and teaching methodology (d) A copy of the curriculum and other instructional materials.

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	(e) A copy of the certified nursing assistant skills, certified nursing assistant II and/or medication assistant – certified checklist to be used to measure student clinical skills (f) Program location (g) A description of the classroom and clinical facilities. (h) A schedule of classroom and clinical instruction hours (i) The fee prescribed in chapter 14 of these rules. 2. Within 90 days of receipt of the application, the board will advise the applicant whether additional information is needed to complete the application. Once the application is complete, the board will provisionally approve the program if it meets the requirements of the intended program type. A program that has received provisional approval is authorized to conduct training until the board's final decision on the application for approval. 3. The board will conduct a review of the training facilities and personnel of a provisionally approved program during the first education and training offered by that program. 4. If the program is determined to meet all the requirements of 18.8 the program will be granted full approval. 5. The board will notify the program of any deficiencies. (a) If there are deficiencies, the program will be allowed < > time for correction. The program will notify the board when the deficiencies have been corrected. (b) The board will conduct a follow-up site visit to verify that the program provider has corrected the deficiencies. (c) If after follow-up review, the program has not corrected the deficiencies, the board will deny approval of the program. (d) A program provider whose application has been denied may request a hearing under (state APA) to appeal the denial of training program approval. n. Program Changes. The board shall approve changes in an approved certified nursing assistant I, certified nursing assistant II, or medication assistant – certified training program. The program provider shall submit a description of the proposed change in curriculum or other substantive change to the board for review at least 60 days before the program provider plans to implement the changes. The board will base its approval on whether the proposed change meets the requirements of 18.8.

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	o. Periodic Training Program Evaluation. To insure compliance with the standards for certified nursing assistant, certified nursing assistant II and medication assistant – certified programs: 1. Each program coordinator shall submit a report every year regarding the program's operation and compliance with the board rules. 2. Each program shall be surveyed by representatives of the board and evaluated for ongoing approval every two years. 3. If a program is cited by [applicable state agencies] or by the Center for Medicare and Medicaid Services (CMS), a copy of all deficiencies relating to certified nursing assistant, certified nursing assistant II and medication assistant – certified shall be appended to the report. 4. A copy of the survey visit report will be made available to the education and training program. p. Withdrawal of Approval. The board shall withdraw approval of certified nursing assistant, certified nursing assistant II and medication assistant – certified education and training a programs when: 1. The board determines that there is not sufficient evidence that the program is meeting standards. 2. The program does not permit unannounced survey visits or if the education institution or health agency loses state approval or licensure 3. The board shall provide due process rights and adhere to the procedures of the State Administrative Procedures Act, providing notice, opportunity for hearing and correction of deficiencies. 4. The board may consider reinstatement or approval of a training and competency evaluation program upon submission of satisfactory evidence that the program meets the standards for the type of program. r. Closing of Education and Training Programs 1. Voluntary (a) Notification to the board, in writing, stating the reason and planned date of intended closing (b) Continue program until the committed class schedule for currently enrolled students is completed (c) Notify board of final closing date at least 30 days prior to final closing.

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	(d) The board shall be notified regarding custody and retention of records. 2. Other Closing — If the board denies or withdraws approval of any type of training and competency evaluation program, the educational institution or health agency shall: (a) Close the program after the graduation of all students currently enrolled or (b) Close the program after the transfer of students to approved programs. (c) Submit to the board a list of students transferred to approved program and date of transfer (d) Consider the date on which the last student was transferred the closing date of the program (e) Comply with the requirements of all applicable state and federal rules and notify the state that the requirements have been fulfilled and give date of final closing. (f) Comply with the requirements of 18.k.1d.
Section 9. *Certified Nursing Assistant, Certified Nursing Assistant II and Medication Assistant – Certified Competency Evaluation.* The board of nursing shall set forth in rule criteria for acceptable certified nursing assistant, certified nursing assistant II and medication assistant – certified competency evaluations.	**18.9 Certified Nursing Assistant, Certified Nursing Assistant II and Medication Assistant – Certified Competency Evaluation.** a. To be approved by the board, a certified nursing assistant competency evaluation shall: 1. Meet the following criteria: (a) Cover the topics addressed in rule 18.8.a. (b) Examination that is psychometrically sound and legally defensible (c) Based upon an incumbent job analysis conducted periodically (d) Include a practical examination demonstrating the applicant's clinical nursing assistant skills. 2. The competency evaluation will be administered by the board or by a person approved by the board. 3. Notification to the applicant of the applicant's performance on the competency evaluation, identifying those portions, if any, the applicant did not pass. b. To be approved by the board, a certified nursing assistant II competency evaluation shall: 1. Meet all the requirements of 18.9.a.1.b-d, 18.9.a.2 and 18.9.a.3. 2. Cover the topics addressed in rule 18.8.b.

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	c. To be approved by the board, a medication assistant – certified competency evaluation shall: 1. Meet all the requirements of 18.9.a.1.b-d, 18.9.a.2 and 18.9.a.3. 2. Cover the topics addressed in rule 18.8.c d. The board may contract with a test service for the development and administration of a competency evaluation. e. The board shall determine the minimum passing standard on the competency evaluation. f. Certified Nursing Assistant Skills Checklist 1. A certified nursing assistant training program shall maintain a nursing assistant skills checklist that records the performance of each student. The nursing assistant skills checklist shall include: (a) Each of the skills listed in 18.7. (b) The date each skill was practiced or demonstrated. (c) The student's satisfactory or unsatisfactory performance of a skill each time it was practiced or demonstrated. (d) The name and signature of the instructor who supervised the student's performance of a skill. 2. After a student has completed a certified nursing assistant education and training program, the program provider shall provide a copy of the certified nursing assistant skills checklist to the student. g. Certified Nursing Assistant II Skills Checklist 1. A certified nursing assistant II training program shall maintain a nursing assistant II skills checklist that records the performance of each student. The nursing assistant II skills checklist shall include: (a) Each of the skills listed in 18.7b. (b) The date each skill was practiced or demonstrated. (c) The student's satisfactory or unsatisfactory performance of a skill each time it was practiced or demonstrated. (d) The name and signature of the instructor who supervised the student's performance of a skill. 2. After a student has completed a certified nursing assistant II training program, the program provider shall provide a copy of the nursing assistant skills checklist to the student.

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	h. Medication Assistant – Certified Skills Checklist 1. A medication assistant – certified education and training program shall maintain a medication assistant – certified skills checklist that records the performance of each student. The medication assistant – certified skills checklist shall include: (a) Each of the skills listed in 18.7c (b) The date each skill was practiced or demonstrated (c) The student's satisfactory or unsatisfactory performance of a skill each time it was practiced or demonstrated (d) The name and signature of the instructor who supervised the student's performance of a skill. 2. After a student has completed a medication assistant – certified education and training program, the program provider shall provide a copy of the nursing assistant skills checklist to the student.
Section 10. *Certification.* The board of nursing shall develop a certification process in rule.	**18. 10. Application for Certification.** a. An applicant for certified nursing assistant shall submit to the board: 1. A completed application form 2. Successful completion of an approved certified nursing assistant education and training program 3. Successful completion of a certified nursing assistant competency evaluation 4. Applicable fees 5. Applicant's fingerprint information. ****Prepare educational materials for applicants that describe the purpose of fingerprinting, the procedures for screening, places to get fingerprinted, and that the applicant is responsible for any costs from local law enforcement, the state agency and the FBI.* b. An applicant for certified nursing assistant II shall submit to the board: 1. A completed application form 2. Successful completion of an approved certified nursing assistant II education and training program 3. Successful completion of a certified nursing assistant II competency evaluation 4. Applicable fees 5. Applicant's fingerprint information

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	c. An applicant for medication assistant – certified shall submit to the board: 1. A completed application form 2. Successful completion of an approved medication assistant – certified education and training program 3. Successful completion of a medication assistant – certified competency evaluation 4. Applicable fees 5. Applicant's fingerprint information. d. Temporary certification. 1. The board may issue a temporary certification to an applicant who has submitted all other requirements including state criminal background check, and is waiting for the federal criminal background report. 2. Temporary certification is valid for six months from the date of issuance or until a permanent certification is issued or denied, whichever occurs first. e. A certificate shall not be issued to an applicant who has been convicted the following most serious felonies which are a permanent bar to becoming a certified nursing assistant, certified nursing assistant II or medication assistant – certified in this state: 1. Murder 2. Felonious assault 3. Kidnapping 4. Rape/sexual assault 5. Aggravated robbery 6. Sexual crimes involving children 7. Criminal mistreatment of children or vulnerable adults 8. Exploitation of vulnerable individual (e.g., financial exploitation in an entrusted role). f. A certificate shall not be issued to an applicant who has who has been convicted of the following serious felonies who has not received an absolute discharge from the sentences for the following felony convictions < > years prior to the date of filing the application: 1. Drug trafficking 2. Embezzlement 3. Theft

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	4. Arson. g. The boards shall evaluate the behavior underlying plea bargains and lesser offenses on a case-by-case basis, considering any mitigating and/or aggravating factors in their decision making. ****These requirements are consistent with the recommendations in the proposed NCSBN Model Criminal Background Checks Paper.* h. Acceptance of Out of State Certificates 1. The board may issue a certificate to a nursing assistant who has a current certificate or an equivalent document issued by another state if the board receives an application pursuant to 18.10a. and determines that the applicant meets the requirements of this rule. 2. The board shall evaluate felony convictions according to Rule 18.10 e-g. i. Certification renewal. 1. The certified nursing assistant shall submit to the board: (a) A renewal application on a board form (b) The applicable fee (c) A verified statement that indicates whether the applicant has been convicted of a felony during the period of time since becoming certified or renewing the certification. (d) Evidence of completion of < > hours of continued education. ****Federal OBRA requirements are 12 hours per year. States may require additional hours.* (e) Evidence of completion of < > hours of work as a nursing assistant. ****Federal OBRA requirements are eight hours per year. States may require additional hours.* (f) Upon satisfactory review of the application, the board will renew the certification and update the Nursing Assistive Personnel Registry. 2. The certified nursing assistant II shall submit to the board: (a) A renewal application on a board form (b) The applicable fee

Article XVIII. Nursing Assistive Personnel	Chapter Eighteen — Nursing Assistive Personnel
	(c) A verified statement that indicates whether the applicant has been convicted of a felony during the period of time since becoming certified or renewing the certification. (d) Evidence of completion of < > hours of continued education. (e) Evidence of completion of < > hours of work as a nursing assistant. (f) Upon satisfactory review of the application, the board will renew the certification and update the Certified Nursing Assistant II Registry. j. Lapsed certification. A nursing assistant who has not maintained a current certification but wishes to be reinstated: 1. If the certification has been lapsed for less than < >, the nursing assistant may apply and meet the requirements of 18.10 e. 2. If the certification has been lapsed for more than < >, the nursing assistant shall be required to repeat training and competency evaluation for the desired level. 3. The Medication Assistant – Certified shall submit to the board: (a) A renewal application on a board form. (b) The applicable fee. (c) A verified statement that indicates whether the applicant has been convicted of a felony during the period of time since becoming certified or renewing the certification. (d) Evidence of completion of <>hours of continued education. (e) Evidence of completion of <> hours of work as a nursing assistant. (f) Upon satisfactory review of the application, the board will renew the certification and update the medication assistant – certified registry.
Section 11. *Disciplinary Procedures* a. Purpose 1. To protect the public from unsafe nursing assistants 2. To assure minimum competence of certified nursing assistants, certified nursing assistants II, and medication assistant – certified. 3. To provide a process to resolve complaints regarding nursing assistants.	

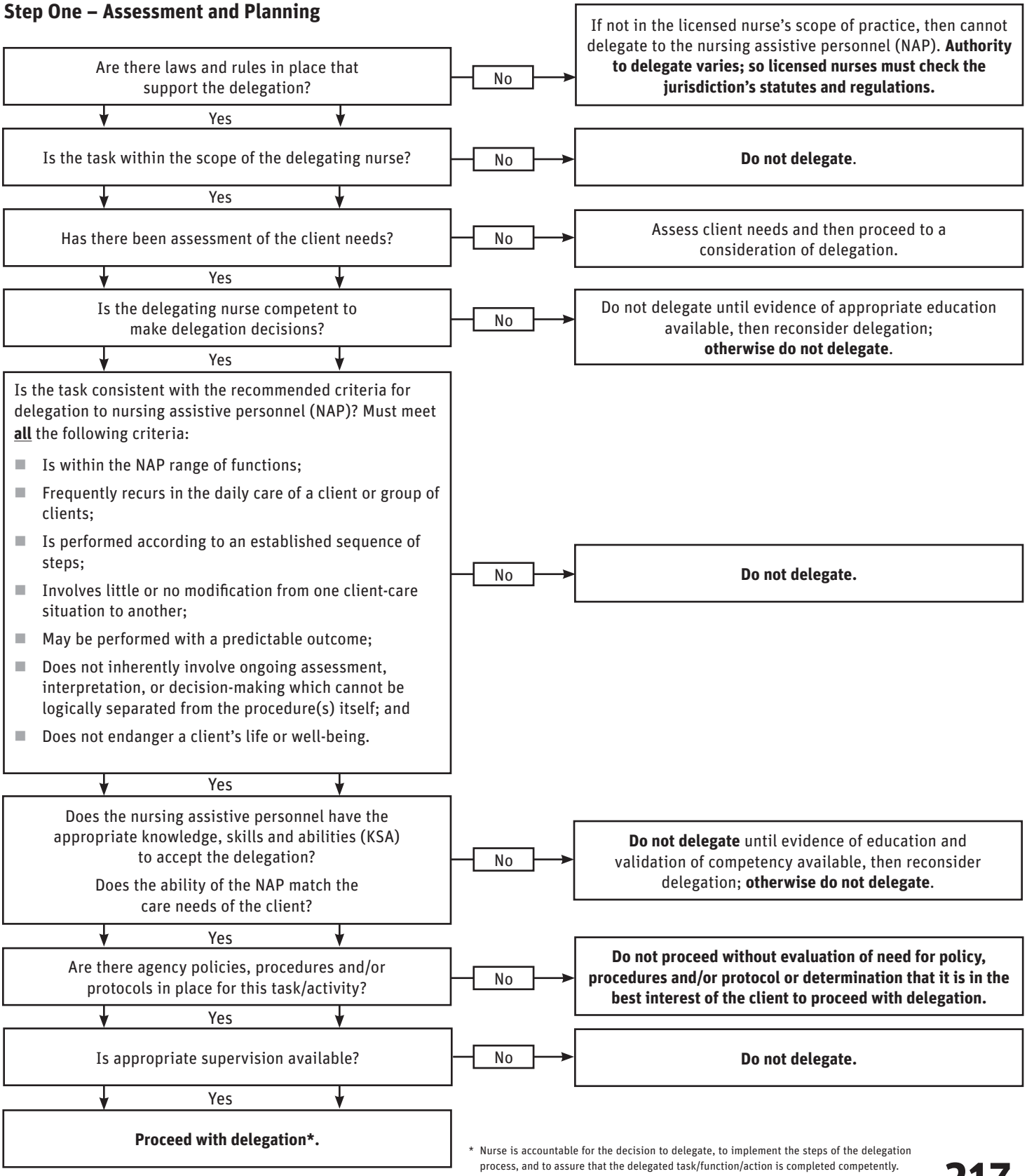
Article XVIII. Nursing Assistive Personnel	Chapter Eighteen — Nursing Assistive Personnel
b. Authority For any one or a combination grounds the board shall have the authority to: 1. File a letter of concern if the board believes there is insufficient evidence to support direct action against the certified nursing assistants, certified nursing assistants II, and medication assistant – certified. 2. Indicate on the certificate and registry the existence of any substantiated complaints against the certificate holder. 3. Deny certification or recertification, suspend, revoke or accept the voluntary surrender of a certificate if a certified nursing assistant, certified nursing assistant II or medication assistant – certified commits an act of unprofessional conduct. 4. Refer criminal violations of this article to the appropriate law enforcement agency. 5. Revoke the certificate or not issue a certificate or recertification to an applicant who has committed serious felonies as set forth in rule. 6. In addition to any other disciplinary action it may take, impose a civil penalty of not more than one thousand dollars per violation. 7. Recover costs of case prosecution. c. Grounds for denial, suspension, revocation or other discipline of nursing assistant include the inability to function with reasonable skill and safety for the following reasons: 1. Substance abuse/dependency 2. Client abandonment 3. Client abuse 4. Fraud or deceit, which may include but is not limited to: (a) Filing false credentials (b) Falsely representing facts on an application for initial certification, reinstatement or certificate renewal. (c) Giving or receiving assistance in taking the competency evaluation 5. Client neglect, abuse or abandonment 6. Boundary violations 7. Performance of unsafe client care.	

Article XVIII. Nursing Assistive Personnel	Chapter Eighteen — Nursing Assistive Personnel
8. Performing acts beyond the certified nursing assistant, certified nursing assistant II or a medication assistant – certified range of functions or beyond those tasks delegated under provision of Article XVIII, section 1 of this Act. 9. Misappropriation or misuse of property 10. Obtaining money or property of a client or resident by fraud, misrepresentation or duress 11. Criminal conviction 12. Failure to conform to the standards of nursing assistant. 13. Putting clients at risk of harm 14. Violating the privacy or failing to maintain the confidentiality of client or resident information. d. Disciplinary Process. The shall comply with the provisions of the <STATE> Administrative Procedures Act for taking disciplinary actions against certificates. e. Disciplinary Records. The board shall maintain records of disciplinary actions and make available all public findings of abuse, neglect or misappropriation of client property, or other disciplinary findings, and any statement disputing the finding by the nursing assistant listed on the registry. f. Disciplinary Notification. The board will notify the [relevant state and federal agencies] of the disciplinary action.	

Attachment C

Decision Tree — Delegation to Nursing Assistive Personnel

Step One – Assessment and Planning



* Nurse is accountable for the decision to delegate, to implement the steps of the delegation process, and to assure that the delegated task/function/action is completed competently.

The Delegation Decision Tree on the other side of this Paper represents the first step in the delegation process. The other three steps are summarized below.

Step Two – Communication

Communication must be a two-way process

The nurse:	The nursing assistive personnel	Documentation:

■ Assesses the assistant's understanding of
  ■ How the task is to be accomplished
  ■ When and what information is to be reported, including
  ❑ Expected observations to report and record
  ❑ Specific client concerns that would require prompt reporting.
■ Individualizes for the nursing assistive personnel and client situation
■ Addresses any unique client requirements and characteristics, and clear expectations of:
■ Assesses the assistant's understanding of expectations, providing clarification if needed.
■ Communicates his or her willingness and availability to guide and support assistant.
■ Assures appropriate accountability by verifying that the receiving person accepts the delegation and accompanying responsibility
	■ Ask questions regarding the delegation and seek clarification of expectations if needed
	■ Inform the nurse if the assistant has not done a task/function/activity before, or has only done infrequently
	■ Ask for additional training or supervision
	■ Affirm understanding of expectations
	■ Determine the communication method between the nurse and the assistive personnel
	■ Determine the communication and plan of action in emergency situations.
		Timely, complete and accurate documentation of provided care
		■ Facilitates communication with other members of the health care team
		■ Records the nursing care provided

Step Three – Surveillance and Supervision

The purpose of surveillance and monitoring is related to nurse's responsibility for client care within the context of a client population. The nurse supervises the delegation by monitoring the performance of the task or function and assures compliance with standards of practice, policies and procedures. Frequency, level and nature of monitoring vary with needs of client and experience of assistant.

The nurse considers the:	The nurse determines:	The nurse is responsible for:

■ Client's health care status and stability of condition.
■ Predictability of responses and risks.
■ Setting where care occurs.
■ Availability of resources and support infrastructure.
■ Complexity of the task being performed.
	■ The frequency of onsite supervision and assessment based on:
	  ■ Needs of the client.
	  ■ Complexity of the delegated function/task/activity.
	  ■ Proximity of nurse's location.
		■ Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include:
		  ■ Alertness to subtle signs and symptoms (which allows nurse and assistant to be proactive, before a client's condition deteriorates significantly).
		  ■ Awareness of assistant's difficulties in completing delegated activities.
		  ■ Providing adequate follow-up to problems and/or changing situations is a critical aspect of delegation.

Step Four – Evaluation and Feedback

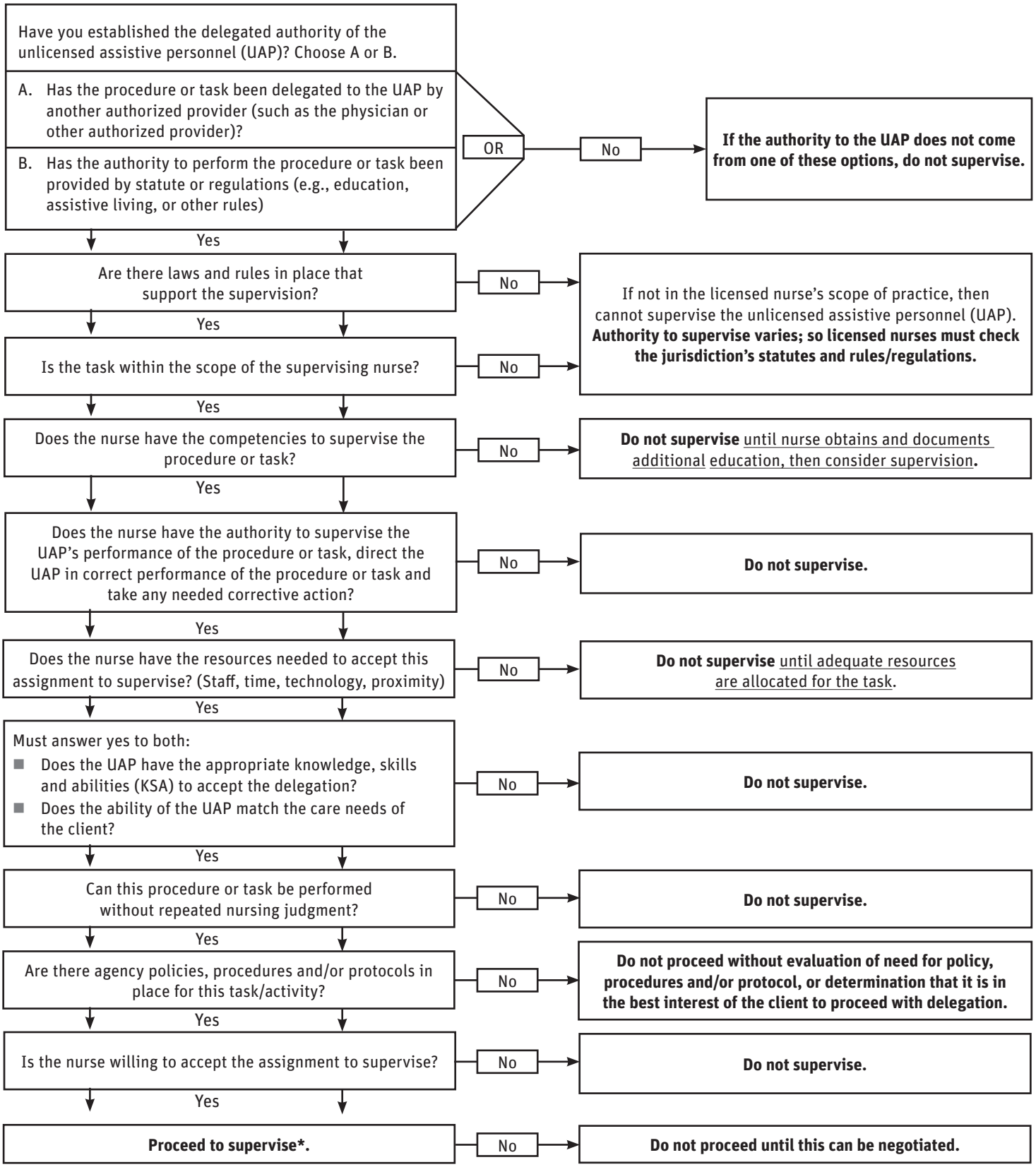
Evaluation is often the forgotten step in delegation.

In considering the effectiveness of delegation, the nurse addresses the following questions:

- Was the delegation successful?
  - Was the task/function/activity performed correctly?
  - Was the client's desired and/or expected outcome achieved?
  - Was the outcome optimal, satisfactory or unsatisfactory?
  - Was communication timely and effective?
  - What went well; what was challenging?
  - Were there any problems or concerns; if so, how were they addressed?
- Is there a better way to meet the client need?
- Is there a need to adjust the overall plan of care, or should this approach be continued?
- Were there any "learning moments" for the assistant and/or the nurse?
- Was appropriate feedback provided to the assistant regarding the performance of the delegation?
- Was the assistant acknowledged for accomplishing the task/activity/function?

Attachment D

Decision Tree — Accepting Assignment to Supervise Unlicensed Assistive Personnel



* Nurse is accountable for decision to accept the assignment to supervise, for monitoring so the task or procedure is performed correctly, and that there is appropriate follow-up on problems.

The Decision Tree on the other side of this Paper represents the first step in the accepting an assignment to supervise. The other steps are summarized below.

Accepting an Assignment to Supervise

The nurse supervises by monitoring the performance of the task or function and assures compliance with standards of practice, policies and procedures. Frequency, level and nature of monitoring vary with needs of client and experience of assistant.

The nurse considers the:	The nurse determines:	The nurse is responsible for:

■ Client's health care status and stability of condition
■ Predictability of responses and risks
■ Setting where care occurs
■ Availability of resources and support infrastructure.
■ Complexity of the task being performed.
	■ The frequency of onsite supervision and assessment based on:
	  ■ Needs of the client
	  ■ Complexity of the delegated function/task/activity
	  ■ Proximity of nurse's location
		■ Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include:
		  ■ Alertness to subtle signs and symptoms (which allows nurse and assistant to be proactive, before a client's condition deteriorates significantly).
		  ■ Awareness of assistant's difficulties in completing delegated activities
		  ■ Providing adequate follow-up to problems and/or changing situations is a critical aspect of delegation.

The nurse is responsible for the decision whether to accept an assignment to supervise. Nurses should be aware of different options and strategies in dealing with these situations and make informed decisions.

The nurse should be prepared to provide feedback to the delegating provider regarding the effectiveness of the task or procedure. This feedback may include whether:

- The task/function/activity was performed correctly.
- The client's desired and/or expected outcome was achieved.
- There were any problems or concerns; if so, how were they addressed.
- There are suggestions for adjusting the plan of care.

Report of the Advanced Practice (APRN) Advisory Panel

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

In January 2002, the Board of Directors approved the criteria and process for a new review process for APRN certification programs. The criteria represented required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses. Subsequently, the APRN Advisory Panel has worked with certification programs to ensure the legal defensibility of APRN certification examinations and to promote communication with all APRN stakeholders regarding APRN regulatory issues.

Highlights of FY05 Activities

- Updated the *APRN Comment Paper* and placed it on the Member Only side of NCSBN's Web site.
- Completed the *APRN Resource Manual* and placed it on the Member Only side of the NCSBN Web site.
- Conducted the annual survey of certification programs.
- Held the APRN Roundtable in Chicago on May 5, 2004.
- Determined that the new Acute Care Pediatric Nurse Practitioner Examination developed by the Pediatric Nursing Certification Board meets the NCSBN certification criteria.
- Provided feedback to the Model Rules Subcommittee regarding the draft *APRN Model Administrative Rules*.
- Developed and initiated implementation of the Board-approved Educational Plan for Member Boards regarding APRN regulatory issues.
- Met with the National Association of Clinical Nurse Specialists to discuss common issues and concerns.
- Developed a draft APRN Vision Paper on the future of APRN regulation.
- Developed an APRN Listserve to enhance communication among Member Boards regarding APRN regulatory issues.
- Reviewed and gave feedback regarding the NP and CNS Job Analysis Study.
- Reviewed the NONPF Acute Care Nurse Practitioner competencies and recommended that the Board of Directors endorse them.

Future Activities

- Complete the Vision Paper on APRN regulation.
- Continue the APRN Roundtable.
- Maintain and enhance communication among APRN stakeholders, Member Boards and NCSBN.

Attachments

None

Members

Katherine Thomas, MN, RN, Chair
Texas, Area III

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

Ann Forbes, RN, MSN
North Carolina, Area III

Marcia Hobbs DSN, RN
Kentucky, Area III

Randall Hudspeth, MS, APRN-BC
Idaho, Area I

Sheila Kaiser, RN, CRNA, MS
Massachusetts, Area IV

Laura Poe, MS, RN
Utah, Area I

Kim Powell, RN, MS, ACNP-C
Montana, Area I

Cristiana Rosa, RN, MSN
Rhode Island, Area IV

Cathy Williamson, RN, CNM, MSN
Mississippi, Area III

Janet Younger, PhD, RN, CPNP
Virginia, Area III

Charlene Hanson, EdD, RN, CS, FNP, FAAN; Georgia, Consultant

Board Liaison
Polly Johnson, MSN, RN
North Carolina, Area III

Staff

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

Carin Zuger, Credentialing and Education Coordinator

Relationship to Strategic Plan

Strategic Initiative I
Facilitate Member Board excellence through individual and collective development.

Strategic Objective 1
Conduct Regulatory Leadership and Governance Education in Accordance with Three-Year Plan.

Strategic Initiative II
Promote Evidence-Based Regulation that Provides for Public Protection.

Strategic Outcome B
Support Member Board adaptation of best practices.

Strategic Initiative III
Enhance the organizational Culture to Support Change and Innovation.

Strategic Outcome C
Enhance communication between Member Boards and external stakeholders.

Meeting Dates

- November 4–5, 2005
- January 4–5, 2005
- May 4–6, 2005

Report of the Awards Panel

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

In FYO1 the Board of Directors established the Awards Panel to review and evaluate the NCSBN Awards Program. The Panel was charged with developing an awards program that ensured consistency and fairness, and celebrated the contributions and accomplishments of the membership. The panel has continued to refine the award categories, objectives and eligibility criteria.

Highlights of FYO5 Activities

- Selected the 2005 Award recipients.
- Reported the Panel's selection for the 2005 Award recipients to the Board of Directors.
- Identified executive officers who are eligible to receive the Executive Officer Service Recognition Award.
- Collaborated with the Communications Department to redesign the Awards Brochure to be consistent with NCSBN branding efforts.
- Developed templates for each Award category to provide additional structure and create a standardized electronic nomination process.
- Facilitated two Awards Panel conference calls and one onsite meeting.
- Launched the Awards Program in February and promoted the program at the Midyear Meeting.
- Determined there were sufficient award categories to recognize Member Board staff and Board Members.
- Revised the criteria for the Regulatory Achievement Award to include "active participation in NCSBN activities."
- Changed the name of the Service Recognition Award to Executive Officer Recognition Award. Revised the award criteria to recognize years of service in the Executive Officer role, beginning at five years of service and at five-year increments thereafter.
- Determined the award symbol for the Executive Office 30 Year Award.
- Identified boards of nursing celebrating a centennial anniversary of nursing regulation.
- Completed minor revisions to the Awards templates and brochure.

Attachments

None

Members

Marty Alston
West Virginia-RN, Area II

Iva Boardman, RN, MSN
Delaware, Area IV

Joan Bouchard, MSN, RN
Oregon, Area I

Libby Lund, MSN, RN
Tennessee, Area III

Lori Scheidt, BS
Missouri, Area II

Staff

Alicia Byrd, BSN, RN
Member Relations Manager

Meeting Dates

- October 4, 2005 (Conference Call)
- November 4, 2005 (Conference Call)
- April 20, 2005

Report of the Bylaws Committee

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

The Bylaws Committee has been a standing committee since 2001 and is charged with reviewing and making recommendations on proposed bylaw amendments as directed by the Board of Directors or Delegate Assembly. For FY04, the Board of Directors directed the Committee to further articulate the language related to run-off balloting in the voting procedures. The Delegate Assembly for FY04 provided no direction to the Committee.

The Bylaws Committee did propose additional clarifying language related to run-off balloting to the Standing Rules of the Delegate Assembly that were approved by the Board of Directors for presentation at the 2005 Delegate Assembly.

Highlights of FY05 Activities

- Met via conference call on January 20, 2005.
- Reviewed the current run-off balloting procedure.
- Reviewed and discussed proposed additional language from the Parliamentarian.
- Draft revised language was presented to the Board of Directors in February 2005. The Board of Directors asked for further clarification.
- Final revision was reviewed by the Committee via e-mail and was presented to the Board of Directors for approval at their May 2005 meeting.

Future Activities

- None scheduled at this time.

Attachment

A. Revised Standing Rules of the Delegate Assembly

Members

Laura Rhodes, MSN, RN, Chair
West Virginia-RN, Area II

Laurette Keiser, RN, MN
Pennsylvania, Area IV

Charlene Kelly, PhD, RN
Nebraska, Area II

Patricia LeCroy, MSN, RN
Alabama, Area III

Nancy Smith, PhD, RN, BC, FAAN-P
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Board Liaison
Polly Johnson, MSN, RN
North Carolina, Area III

Staff

Kathy Apple, MS, RN, CAE
Executive Director

Chrissy Ward, Executive Office
Relations/Meeting Manager

Beth DeMars, Executive Office
Meeting Coordinator

Meeting Dates

- January 20, 2005, Conference Call

Attachment A

Revised 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. Meeting Conduct

1. Delegates must wear badges and sit in the section reserved for them.
2. All attendees shall be in their seats at least five minutes before the scheduled meeting time.
3. There shall be no smoking in the meeting room.
4. 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.
5. A delegate's conversations with nondelegates during a business meeting must take place outside the designated delegate area.
6. All attendees have a right to be treated respectfully.

3. Agenda

A. Business Agenda

1. The Business Agenda is prepared by the President in consultation with the Executive Director and approved by the Board of Directors.

B. Consent Agenda

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 NCSBN.

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 nonprocedural 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, August 3, 2005, at 4:00 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, August 3, 2005, at 4:00 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 nonprocedural main motion or resolution after the deadline of 4:00 pm on Wednesday, August 3, 2005, 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. Note: 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. Nondelegate 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 for 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.

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, August 3, 2005.

D. Election for officers, directors and members of the Committee on Nominations shall be held Thursday, August 4, 2005, from 7:45 to 8:45 am.

E. A majority vote is required for the election of an Officer or Director. 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. Run-off balloting shall proceed as follows:

- 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, on the first ballot, only 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.
- 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 only one candidate receives a majority on the third ballot, another run-off shall be limited to the remaining two candidates;
- Or, if one candidate receives a majority on the second ballot, a third run-off shall be limited to the two candidates receiving the highest numbers of votes.
- In case of a tie vote, a position shall be chosen by lot.

7. Forums

A. Scheduled Forums: 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, nondelegate members and employees of Member Boards have spoken.

B. Open Forum: 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 Commitment to Ongoing Regulatory Excellence (CORE)

Recommendations to the Delegate Assembly

None. This report is for information only.

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. Founded on an earlier project, the Commitment to Public Protection through Excellence in Nursing Regulation project, 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.

In 2004, boards of nursing were surveyed regarding the five functions of boards: (1) discipline, (2) practice, (3) education program approval, (4) licensure and (5) governance. Six groups of stakeholders that were directly affected by board actions were surveyed in 2003 and will be surveyed in 2005. These six groups include: (1) employers, (2) nursing programs, (3) associations, (4) nurses, (5) nurses who were the subjects of complaints and (6) 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.

Highlights of FY05 Activities

- Based on results from past surveys and the expert opinion of the Committee members, discussed and approved revisions by the CORE Committee to the six surveys of stakeholders. Revisions will be incorporated into the surveys of stakeholders that will be conducted in 2005.
- Discussed with NCSBN's Marketing & Communications Director ways to market CORE's best practices results as a means of encouraging all boards to participate in the project.
- Created a promotional handout describing CORE and its benefits.
- NCSBN staff contacted representatives from states who attended the 2005 Midyear Meeting and solicited their cooperation in providing lists of stakeholders for the 2005 survey.
- Committee members telephoned boards that did not participate in the 2003 survey to encourage participation in the CORE project.
- Began compiling a Best Practices Tool Kit. The Tool Kit is a collection of tools (i.e., examples from states) for identifying, assessing and applying relevant evidence for better decision making by nursing boards.
- Began process of identifying and recruiting new CORE Committee members to replace two members who can no longer participate on the Committee.

Future Activities

- Collect stakeholder lists from boards of nursing. Boards will be asked to provide samples of specific groups of stakeholders including nurses, employers and state associations. These sample groups will be surveyed to capture their perspectives about specific types of board of nursing performance.
- Collect stakeholder data in 2005.

Members

Cynthia Morris, MSN, RN, Chair
Louisiana-RN, Area III

Lanette Anderson, JD, BSN, RN
West Virginia-PN, Area II

Kay Buchanan, MN, RN
Minnesota, Area II

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

Lori Scheidt, BS
Missouri, Area II

Board Liaison
Constance Kalanek, PhD, RN
North Dakota, Area II

Staff

Kevin Kenward, PhD
Director of Research

Esther White
Research Project Coordinator

Richard Smiley, MS, MA
Research Statistician

Relationship to Strategic Plan

Strategic Initiative II
Regulatory Effectiveness. NCSBN will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Strategic Outcome A
Increase the number of Member Boards participating in CORE.

Strategic Outcome B
Support Member Board adaptation of best practices.

Strategic Outcome C
Identify linkages among regulatory functions, best practices, standards of excellence and outcomes.

Meeting Dates

- February 24–25, 2005
- May 5–6, 2005
- July 7–8, 2005

- Undertake a review of past CORE reports and responses to further identify possible questions that can be considered for deletion from the surveys.
- Develop promotional materials using quotes and interviews with CORE Committee members from NCSBN's 2004 Midyear Meeting.
- Modify and refine data collection tools for collection of board data in 2006.
- Provide both board and stakeholder surveys online.
- Review all CORE surveys and determine if some of the questions asked of boards should be asked as part of the Board Profiles survey or as part of the TERCAP questionnaire.
- Examine whether or not to conduct a survey of Consumers (e.g., patients and clients) as part of the set of stakeholder surveys.

Attachments

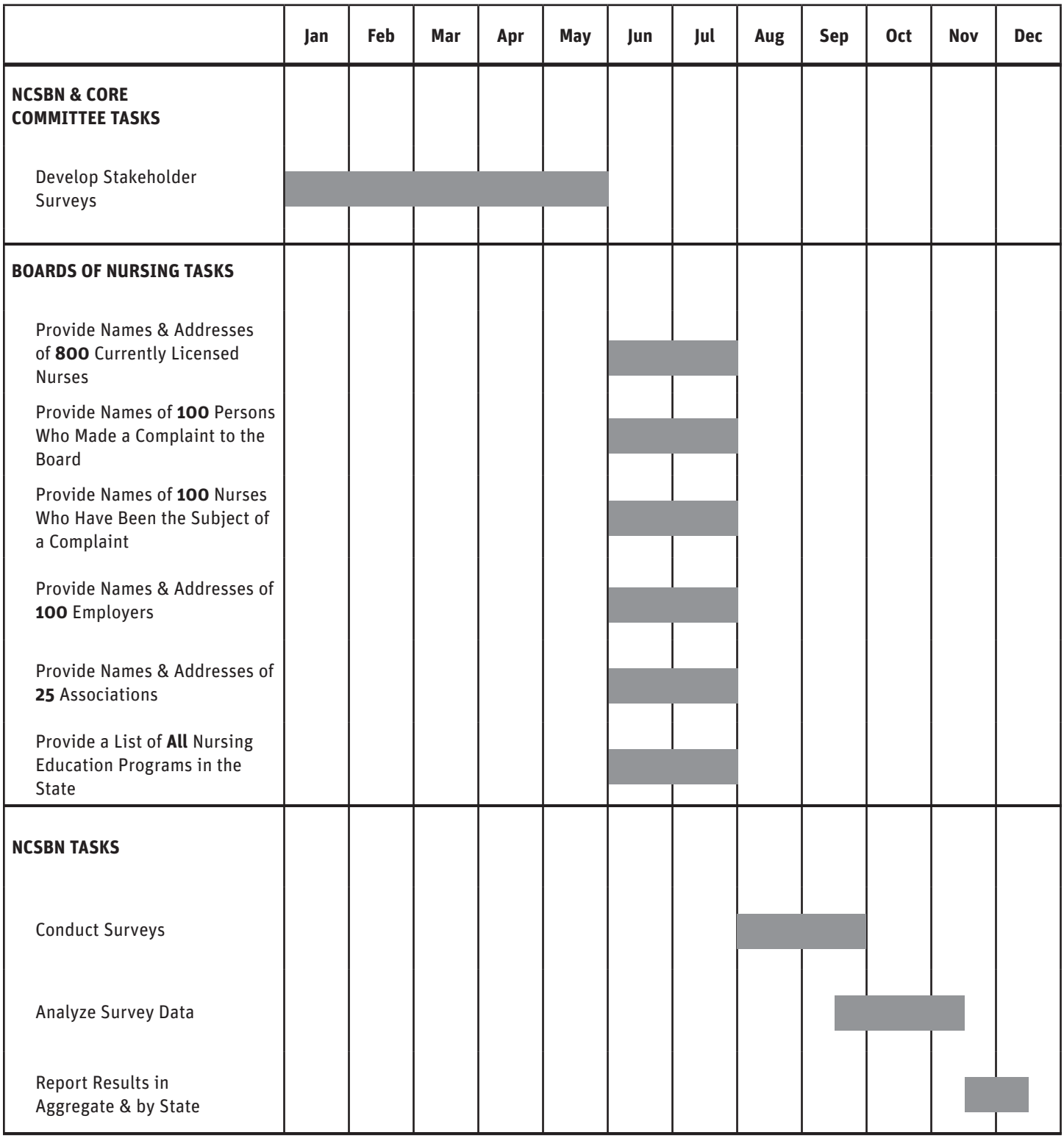
A. CORE Timeline and Activities

B. States Providing Stakeholder Lists

C. Boards Responding CORE Surveys

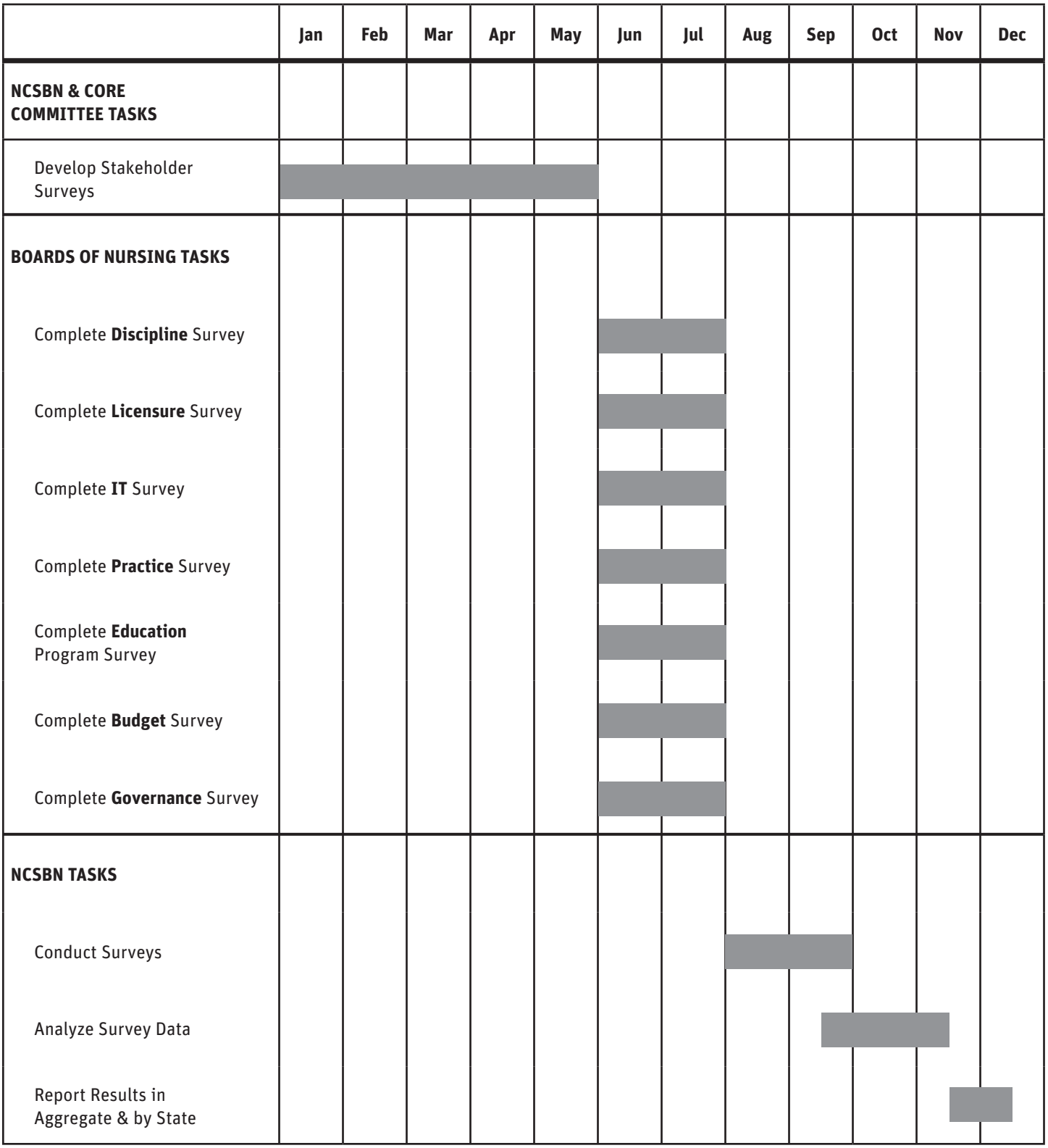
Attachment A

CORE Timeline and Activities – 2005



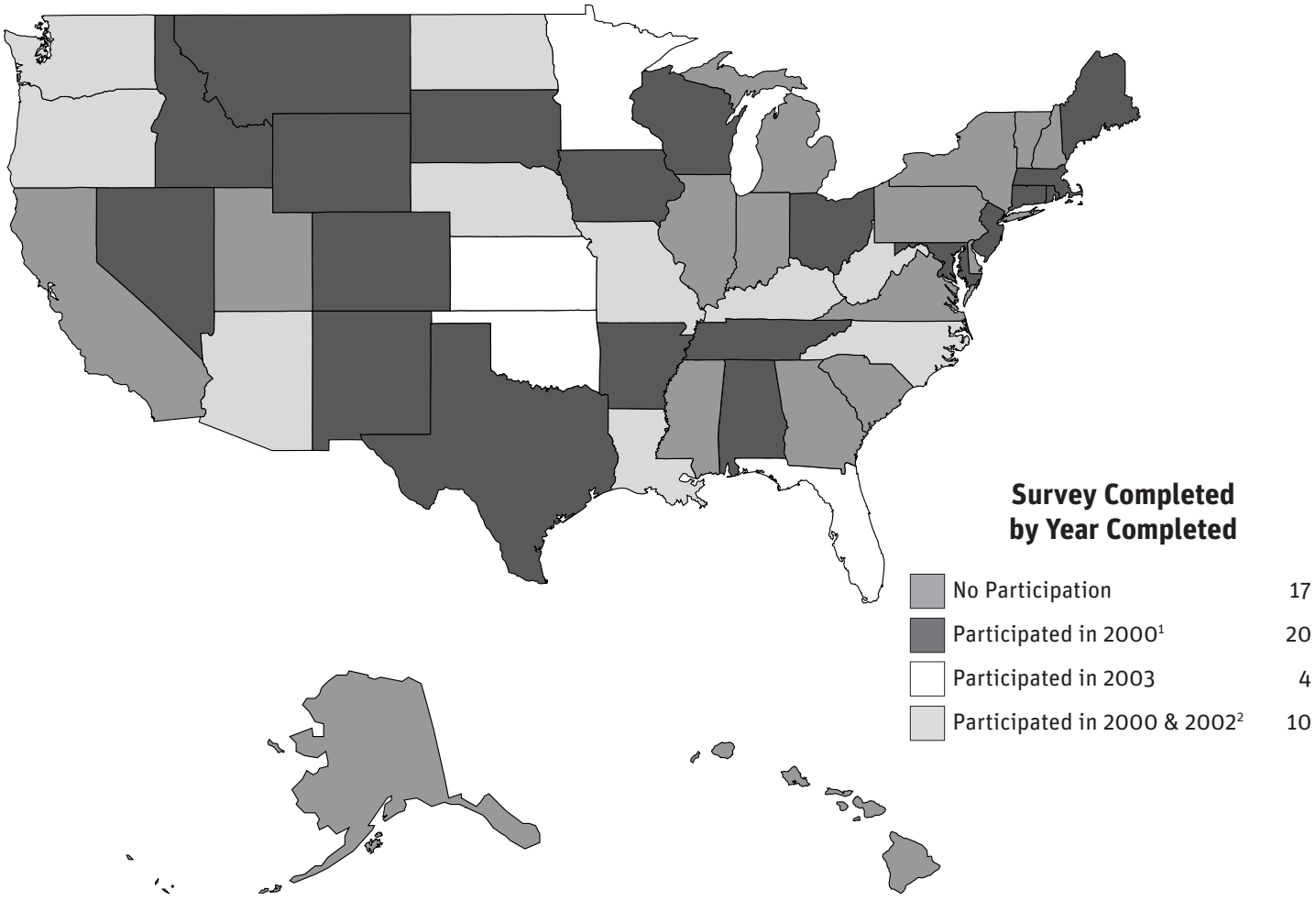
Attachment A

CORE Timeline and Activities – 2006



Attachment B

States Providing Stakeholder Lists

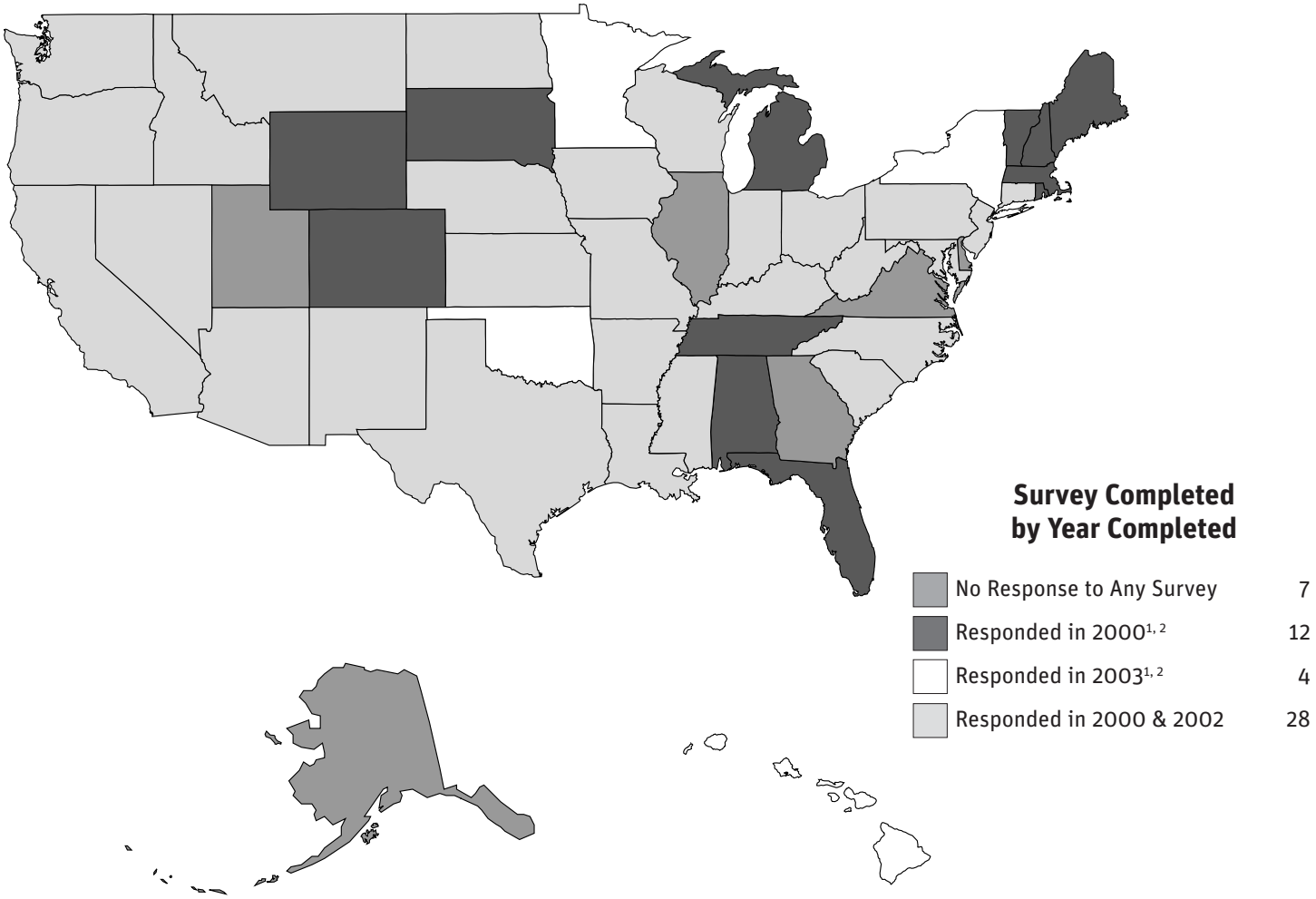


[1] Georgia-RN Board of Nursing provided lists of stakeholders in 2000.

[2] Texas-RN Board of Nursing provided lists of stakeholders in 2000 and 2002.

Attachment C

Boards Responding to CORE Surveys



[1] California-RN Board of Nursing provided lists of stakeholders in 2000 and 2003.

[2] Texas-VN Board of Nursing provided lists of stakeholders in 2000 and 2003.

Report of the Examination Committee

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

As a standing committee of NCSBN, the Examination Committee is charged with providing psychometrically sound and legally defensible entry-level nurse licensure assessments to NCSBN Member Boards. 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 Examination Committee investigates potential future enhancements to the NCLEX® examinations, establishes international testing locations, recommends passing standards for English Language Proficiency examinations used by Member Boards 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 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, which in turn assists with the item development and review process. Individual Examination Committee members act as Chair of the Item Review Subcommittee on a rotating basis. Highlights of the activities of the Examination Committee and Item Review Subcommittee activities follow.

Highlights of FY05 Activities

Assessed Entry-level Nurse Competence by the NCLEX® Examinations.

NCLEX-PN® Test Plan and Passing Standard

In the fall of 2004, the NCSBN Board of Directors voted to revise the passing standard for the NCLEX-PN examination. The new passing standard is -0.42 logits on the NCLEX-PN logistic scale, 0.05 logits higher than the previous standard of -0.47. This standard took effect on April 1, 2005, in conjunction with the new Delegate Assembly approved 2005 *NCLEX-PN® Test Plan*. NCSBN increased the passing standard in response to changes in U.S. health care delivery and nursing practice that have resulted in the increased acuity of clients seen by entry-level PNs. After considering all available information, the NCSBN Board of Directors determined that safe and effective entry-level PN practice requires a greater level of knowledge, skills and abilities than was required in 2002, when NCSBN last evaluated the NCLEX-PN passing standard.

The NCSBN Board of Directors used multiple sources of information to guide its evaluation and discussion regarding the change in passing standard. As part of this process, NCSBN convened an expert panel of nine nurses to perform a criterion-referenced standard setting procedure. The panel's findings supported the creation of a higher passing standard. NCSBN also considered the results of a national survey of nursing professionals including nursing educators, directors of nursing in acute care settings and administrators of long-term care facilities.

Continuously Improved Development and Administration of the NCLEX Examinations.

Evaluated and Monitored NCLEX Examination Policies and Procedures

The Committee evaluated the efficacy of the Board of Directors approved examination-related policies and procedures as well as Examination Committee policies and procedures. New policies were created to reflect processes associated with the NCLEX examination practice analyses. Additionally, revisions were made to pertinent procedures in order to reflect improvements in processes that needed to be changed or refined during the eleventh year of the administration of NCLEX via computerized adaptive testing.

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Relationship to Strategic Plan

Strategic Initiative I
Facilitate Member Board excellence through individual and collective development. (Member Boards).

Strategic Objective 2
Facilitate timely information sharing and networking opportunities.

Strategic Initiative IV
Position NCSBN as the premier organization to measure entry and continuing competence of nurses and related health care providers. (Competence)

Strategic Objective 1
NCLEX is the premier examination for entry into practice.

Strategic Objective 4
Explore innovations in testing to measure entry-level competency.

Time Length for the NCLEX-RN

NCSBN implemented the time change of six hours for the NCLEX-RN examination on October 1, 2004. This implementation resulted from NCSBN's Board of Directors approval of the Examination Committee's recommendation to extend the time limit of the NCLEX-RN examination to six hours. The recommendation was based on the increasing number of RN candidates running out time and the introduction of alternate item formats that will require more time for completion. The number of RN candidates running out of time has decreased significantly since the introduction of the additional hour for the administration of the RN examination in October 2004 with only 2.6% of RN candidates for the October–December 2004 quarter having run out of time, compared to 6.4% for the quarter in 2003.

Monitored All Aspects of Examination Development.

Conduct NCLEX-RN Practice Analysis

Practice Analysis Methodology Experts reviewed and approved the NCSBN process and procedures for conducting the *2005 RN Practice Analysis Study*. An RN Panel of Experts was selected from the names submitted by Member Boards. The RN Panel of Experts met February 23-25, 2005 to develop a comprehensive list of nursing activity statements as well as to approve the survey form. The Examination Committee reviewed and approved a list of activity statements and the survey form that will be used for the 2005 RN practice analysis.

Conducted Committee and Item Review Subcommittee Sessions

In the interest of maintaining consistency regarding the manner in which NCLEX examination items are reviewed before becoming operational, members of the Examination Committee continue to chair Item Review Subcommittee meetings. The Committee and the Subcommittee: (1) reviewed RN and PN operational and pretest items; (2) provided direction regarding RN and PN alternate items and (3) 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 review 100% of all validations for pretest items and 25% of all validations of operational pool items scheduled for review. Assistance from the Item Review Subcommittee continues to reduce the Examination Committee item review workload, facilitating the efforts of the Examination Committee toward achieving defined goals.

As the item pools continue to grow, review of operation items is critical to assure that the item pools reflect current entry-level nursing practice. To this end, the number of Item Review Subcommittee meetings will remain at five for the upcoming year. The length of the meeting has stabilized at three and a half days and the number of volunteers serving on the Subcommittee has increased to 19. Orientation to the Subcommittee occurs annually as well as at each meeting.

Monitored Item Production

Under the direction of the 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 Item Review Subcommittee reviewed real examinations for face validity and provided reports to the Examination Committee. As part of the contractual requirements with 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 Produced	Review Sessions	Items Reviewed
April 02 — March 03	4	47	2,611	7	1,542
April 03 — March 04	2	23	1,097	5	1,446
April 04 — March 05	1	12	301	4	1,415

Table 2 — PN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed
April 02 — March 03	3	33	1,476	6	1,547
April 03 — March 04	2	24	968	5	1,611
April 04 — March 05	1	11	430	3	2,124

Evaluated Item Development Process and Progress

The Committee evaluated item development sessions conducted by test service. Committee representatives attended and monitored each of the item development sessions and provided feedback to the Committee and to the test service. Overall, panelists and Examination Committee representatives in attendance have rated item development sessions favorably.

NCLEX-PN® Detailed Test Plan

The Examination Committee reviewed and approved the *2005 National Council of State Boards of Nursing Detailed Test Plan for the NCLEX-PN® Examination*. In February 2005, the detailed test plan was made available to the public and distributed to Member Boards.

Monitored the Development of Operational NCLEX Item Pools

The 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 subcategory; 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 reenforced by replicating the analyses using actual candidate data. The Examination Committee will continue to monitor performance of the NCLEX examinations through these and other psychometric reports and analyses.

Member Board Review of Items

Boards of nursing were provided with opportunities to conduct reviews of representative NCLEX items in April and October of 2004. Member Board review was scheduled at Pearson Professional Centers during specific, predefined time periods. Activities included reviewing and commenting on newly developed items and simulated operational examinations. Boards referred items for 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

Strategic Initiative V
Advance NCSBN as the leading source of data, information and research regarding nursing regulation and related health care issues.

Strategic Objective 1
Conduct research that provides evidence regarding regulatory initiatives that support public protection.

Strategic Objective 1
Conduct a research study to determine if there is a NCLEX performance differential between U.S.-educated ESL graduates and non-ESL graduates and if there is, to identify contributing factors.

Strategic Initiative VI
Advance NCSBN as a key partner in nursing and health care regulation in the United States and internationally.

Strategic Objective 2
Administer NCLEX effectively and efficiently at international sites

Meeting Dates

Examination Committee
- October 27–29, 2004
- November 30, 2004 (Conference Call)
- December 7, 2004 (Conference Call)
- January 26–28, 2005
- March 16–17, 2005 (Conference Call)
- April 27–29, 2005
- July 21, 2005 (Conference Call)

Item Review Subcommittee
- December 7–10, 2004
- March 1–4, 2005
- May 10–13, 2005
- June 21–24, 2005
- August 23–26, 2005

Joint Research Committee
- March 14, 2005

process. The Committee provided direction on the resolution of each Member Board question and concern reviewed.

In the spring of 2004, six Member Boards referred items to the Examination Committee. In the fall of 2004, three Member Boards referred items. Staff provided Member Boards with feedback on the Committee's decisions on all referred items. The Examination Committee strongly 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 investigate each incident and report their findings to the Examination Committee. At the October 2004 Committee Meeting, four PN items were reviewed and retained and eight RN items were reviewed, with six of the eight items retained. At the January 2005 Committee Meeting six PN items were reviewed with four of the six items retained and five RN items were reviewed with three of the five items retained.

Joint Research Committee (JRC)
The JRC is a small group of NCSBN and Pearson VUE testing staff along with a selected group of prestigious testing industry experts that reviews and conducts psychometric research to provide empirical support for the use of the current NCLEX as well as to investigate possible future enhancements.

Several new pieces of research have either been completed or are in a near final draft stage. Examples include: research to statistically detect items that may have been exposed using the unexpectedness of a response in conjunction with deviations from expected item response times, procedures to identify optimal item pool configurations under NCLEX operational conditions, review of experimental Differential Item Functioning procedures that address unexpected changes across the ability spectrum within identified groups, examination of how much items change in difficulty over time and development of a procedure to detect such changes. The number of research proposals received in the last year has been significantly larger than it has been in recent years. Efforts are underway to maintain and continue this growth.

Recently, the JRC has had an opportunity to showcase some of this work. Six research papers on *The Operational Considerations in Computerized Adaptive Testing* were submitted to the American Educational Research Association (AERA). The research was accepted and was presented as a symposium at the AERA's national meeting in Montreal, Canada. AERA is an internationally recognized professional organization with the primary goal of advancing educational research and its practical application. Acceptance in the program not only helps NCSBN share testing best practice expertise worldwide, but also allows NCSBN to forge 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 Computerized Adaptive Testing.

Monitored all Aspects of Examination Administration.
Monitored Procedures for Candidate Tracking: Candidate Matching Algorithm
The 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 October 1, 2004 through March 31, 2005, and compared over 84,000 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.

This check serves as a reminder of the importance of each board of nursing to carefully review candidate records for accuracy at the time of eligibility declaration. Accurate registration records are required for first-time and repeat candidates in order to properly enforce the waiting period between examinations and to ensure items previously seen by a candidate are not re-administered

in subsequent administrations within a year.

Candidate Tutorial
The NCLEX candidate tutorial has been modified to be interactive and available to all candidates via the Internet. This new opportunity will allow candidates to experience and use the tutorial exactly as it is presented during the examination before they go to a test center.

Monitored the Security of the NCLEX Examination Administrations and Item Pools
The Examination Committee monitored investigations of potential security incidents, reviewed final reports from test service and made determinations and recommendations regarding security of the NCLEX examination administrations and item pools. In FY05, NCSBN engaged the services of an organization that specializes in test security to provide an external security audit of the NCLEX examination program. Although NCSBN's policies, processes and procedures were found to meet or exceed security standards for licensure examinations, the Examination Committee is reviewing suggestions to enhance certain elements of NCLEX security. For FY05, no incidents occurred which were deemed to compromise NCLEX examination administration or the security of item pools. NCSBN and Pearson VUE will continue to vigorously monitor this to ensure NCLEX examination security.

Compliance with the 30/45 Day Scheduling Rule
The Examination Committee monitors compliance with the 30/45-day scheduling rule. For the period of October 1, 2004 to March 31, 2005, there were 11 candidates scheduled out of compliance, out of 84,699 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 60% capacity levels.

Responded to Member Board Inquiries Regarding NCLEX Examination Administration
As part of its activities, the Committee and NCSBN Testing Services staff responded to Member Boards' questions and concerns regarding administration of the NCLEX examinations. The Examination Committee has continued to follow up on post-test service transition activities and has responded to various inquiries regarding system enhancements.

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.

Set Performance Benchmarks for Existing English Proficiency Examinations — IELTS.
In FY04, the Examination Committee reviewed information related to the minimum degree of English proficiency necessary to function safely and effectively as an entry-level nurse. The Committee then deliberated and recommended to the NCSBN Board of Directors a minimum passing score for the TOEFL. This type of activity continued as part of the FY05 strategic initiatives through recommendation of a passing standard for The International English Language Testing System (IELTS) examination.

NCSBN contracted with the Buros Institute at the University of Nebraska to perform the study, which was conducted October 30-31, 2004, in Chicago. The recommendations of this panel reflect the level of English language proficiency, as measured by IELTS, they believed necessary for entry-level nurses to possess in order to be able to perform important nursing responsibilities safely and effectively. It is important to note that the standard is intended to reflect the minimum level of English proficiency necessary for safe and effective entry-level practice, not the level of proficiency necessary for nurse candidates to take the NCLEX examination.

IELTS is an examination designed to assess English language ability in examinees for which English is not their native language. The English that IELTS is designed to measure is not exclusively North American English, but rather a more general English as used in Great Britain, Ireland,

New Zealand and Australia, as well as North America. IELTS covers four different language skills (Listening, Reading, Writing and Speaking) and reports a degree of proficiency in each using "band scores" that range from 0 – 9. The meaning of those scores is provided in Table 3.

Table 3 — IELTS Band Scores
Band 9 — Expert User Has fully operational command of the language: appropriate, accurate and fluent with complete understanding.
Band 8 — Very Good User Has fully operational command of the language with only occasional and unsystematic inaccuracies and inappropriacies. Misunderstandings may occur in unfamiliar situations. Handles complex detailed argumentation well.
Band 7 — Good User Has operational command of the language with occasional inaccuracies, inappropriacies and misunderstandings in some situations. Generally handles complex language well and understands detailed reasoning.
Band 6 — Competent User Has generally effective command of the language despite some inaccuracies, inappropriacies and misunderstandings. Can use and understand fairly complex language, particularly in familiar situations.
Band 5 — Modest User Has partial command of the language, coping with overall meaning in most situations, though is likely to make many mistakes. Should be able to handle basic communication in own field.
Band 4 — Limited User Basic competence is limited to familiar situations. Has frequent problems in understanding and expression. Is not able to use complex language.
Band 3 — Extremely Limited User Conveys and understands only general meaning in very familiar situations. Frequent breakdowns in communication occur.
Band 2 – Intermittent User No real communication is possible except for the most basic information using isolated or short formulae in familiar situations and to meet immediate needs. Has great difficulty in understanding spoken and written English.
Band 1 — Non User Essentially has no ability to use the language beyond possibly a few isolated words.
Band 0 — Did not attempt the test No assessable information provided.

Initially, the panel was lead through a discussion of what does minimal English proficiency mean in the context of safe and effective entry-level nursing. This was supplemented with a discussion of the activities that had been identified by NCSBN practice analyses as being within the scope of entry-level practice. After the panel identified critical nursing activities in which communication plays an important role, the panel was provided with training regarding their role in the standard setting exercise. For each test module, the panelist was required to complete several practice questions before providing the ratings that were to be used. Two standard setting procedures were employed, a modified Angoff (1971) method for the Listening and Academic Reading subtests and a modified Analytical Judgment Method (Plake & Hambleton, 2000) for the Speaking and Academic Writing subtests.

After reviewing the results from the standard setting panel and information regarding IELTS band scores used by other English speaking countries for nurses and other health-related professionals, the Examination Committee decided to approve a band result of 6.5 overall with a minimum of 6.0 in any one module as the NCSBN recommended passing standard for the IELTS examination. The NCSBN Board of Directors approved the Committee's recommendation. A full report regarding setting performance benchmarks for the IELTS examination can be found in Attachment B of this report.

Investigated NCLEX Performance Differential Between U.S.-Educated English as a Second Language (ESL) Graduates and non-ESL graduates.

At the 2004 Delegate Assembly, the following resolution was passed: "The Examination Committee of NCSBN conduct a research study to determine if there is an NCLEX performance differential between U.S.-educated ESL graduates and non-ESL graduates and if there is, to identify contributing factors." Pursuant to that resolution, pass rate, item latency and Differential Item Functioning (DIF) analyses were conducted based upon U.S.-educated candidates.

NCSBN does not have access to empirical assessments of English proficiency for NCLEX candidates; however, the NCLEX application does ask the candidate's primary language. They are four possible responses: "English," "English & Another Language," "Another Language" and no response. Typically, only a small percentage of candidates indicate that their primary language is a language other than "English" or "English & Another Language."

To be consistent with the research question posed by the 2004 NCSBN Delegate Assembly resolution, only U.S.-educated NCLEX candidates were considered for this study. The inclusion of internationally educated examinees would confound the effects of language with potential curriculum effects. Nursing education curricula in other countries, presumably, is designed for the scope of nursing practice in that country, not the United States. Also, to prevent failing candidates from being included in the analysis multiple times and negatively impacting results, only first-time candidates were included in the data analyses. Using only first-time, U.S.-educated candidates has the added advantage of meeting the same criteria used by NCSBN to calibrate new items.

Pass Rates

Using 2003 and 2004 calendar year data (Tables 4 and 5), NCLEX-RN and NCLEX-PN pass rates were computed by the candidate's self-reported primary language status. For first-time, U.S.-educated candidates, the highest pass rates were for those examinees that either indicated that English alone was their primary language or did not identify their primary language category. Pass rates for candidates who indicated that either "another language" was their primary language or that "English & another language" were their primary languages was typically 10-15% lower.

It is a consistent finding over the years, that people who self-report to be multilingual (with English as one of their primary languages), had slightly lower pass rates than those people who self-report that English is not their primary language. It might be that these two groups represent a single category with regard to their English proficiency, but have differences in the standards that they apply to "what is considered to be one's primary language." Similarly, it may be that what separates performance of these candidates is how they choose to present their language ability to the world (e.g., perhaps one group is trying to "put their best foot forward"). In either case, NCSBN has no definitive data on their English proficiency, however, these groups historically pass at a lower rate than candidates who self-report English language proficiency only.

Table 4 — NCLEX-RN® Pass Rates and Volume for First-time, U.S.-Educated Examinees by Primary Language Category

	2003		2004	
	Pass %	# Tested	Pass %	# Tested
English	87.8%	66,462	86.0%	75,617
English & Another Language	76.0%	3,714	76.3%	3,898
Another Language	76.3%	1,328	77.1%	1,681
Missing/Did Not Answer	86.9%	5,227	84.6%	5,985
Total	**87.0%**	**76,731**	**85.3%**	**87,181**

Table 5 — NCLEX-PN® Pass Rates and Volume for First-time, U.S.-Educated Examinees by Primary Language Category

	2003		2004	
	Pass %	# Tested	Pass %	# Tested
English	89.7%	37,990	90.8%	42,305
English & Another Language	72.7%	3,062	75.7%	3,351
Another Language	76.2%	807	76.9%	901
Missing/Did Not Answer	88.2%	2,221	87.5%	2,736
Total	88.2%	44,080	89.4%	49,293

Item Latencies

Table 6 displays mean item response time for the three groups of interest. As expected, average item response time for the "Another Language" group is higher than the "English" and "English & Another Language" groups. Though not definitive, this would suggest that these candidates are taking longer to comprehend and respond to item stimuli. This use of extra time on a per item basis is cumulative and results in the higher proportion of candidates who run out of time or take maximum length examinations as seen in Table 7.

Table 6 — Item Response Time for First-time, U.S.-Educated Examinees by Primary Language Category

	Mean Item Response Time		SD		N	
	RN	PN	RN	PN	RN	PN
English	60.16	57.15	17.05	17.00	75,617	42,305
English & Another Language	72.50	73.96	19.65	20.69	3,898	3,351
Another Language	75.10	76.64	20.96	20.06	1,681	901
Total	61.21	58.90	17.69	18.14	87,181	49,293

- Total also includes those first-time, U.S.-educated candidates that did not indicate the category in which they belong.
- Mean Item Response Time is the ratio of total item time (including pretest) over the number of items.

Although there is a time limit to complete the NCLEX examination, the speed with which candidates answer questions has been shown previously not to impact candidate performance (Bontempo, 2003). Also, when a candidate runs out of time or "ROOTs," the unanswered items are not marked as wrong because on an adaptive test the items are selected based upon the candidate's responses to the earlier questions, thus candidates are not explicitly penalized for not completing a maximum length examination. The decision by NCSBN to increase the amount of time on the NCLEX-RN should result in a reduction in the percentage of people running out of time.

Table 7 — Exam Termination Type for First-time, U.S.-Educated Examinees by Primary Language Category

	% Ending Normally		% ROOT		% Max Item	
	RN	PN	RN	PN	RN	PN
English	84.70	86.96	1.44	0.43	13.86	12.61
English & Another Language	82.50	78.84	5.03	2.54	12.47	18.62
Another Language	83.16	82.91	5.47	2.33	11.36	14.76
Total	84.58	86.27	1.72	0.64	13.69	13.09

- Total also includes those first-time, U.S.-educated candidates that did not indicate the category in which they belong.
- "Ending Normally" means that the pass-fail decision was made with at least 95% certainty.
- ROOT means "Ran Out Of Time." People that run out of time must demonstrate that their ability estimate has been above passing over the last 60 items of their test.
- Max Item means that the test ended because the person took the maximum number of items. Pass-fail decisions from maximum length tests are less than 95% certain.

Differential Item Functioning (DIF)

Differential Item Functioning is a method use to detect whether there is a difference in the probability of correctly answering a question across two groups of examinees after the ability of the two groups has been matched or controlled. This permits item-level bias to be detected. The procedure employed here compares calibrations based on the English only group with the calibrations based upon the ESL group. Using the standard errors for each pair of calibrations, a joint standard error was computed which was used to determine if the two calibrations were significantly different. The test was run with and without corrections for the accumulation of Type 1 error (Alpha).

Type 1 error occurs when a difference or effect is erroneously detected due to chance when drawing from a random sample. An alpha level of 0.05 (sometimes conceived of as a 95% confidence interval) indicates that the researcher is willing to accept a Type 1 error five times in 100. When performing several statistical tests within the same experiment, the probability of finding a difference when there is in fact no difference increases with each additional test performed. If 100 statistical tests were performed, one would expect to find that five of the tests would show a difference just by chance. Using the Bonferroni correction method, the alpha level of each individual test is adjusted downwards to ensure that the overall, experiment-wise, risk for a Type 1 error remains 0.05. Even if more than one test is done, the chance of erroneously finding a significant difference continues to be 0.05.

When performing DIF analyses, the sample size is important. When the number of responses per item is small, only very large bias effects can be detected. When the number of responses is large, then smaller bias effects can be detected. Given the number of U.S.-educated candidates who reported that their primary language was "Another Language" or "English & Another Language," it seemed useful to combine these groups into a generic ESL category. Also given that the pass rates for the "English & Another Language" group was below the pass rate for the "Another Language" group, it seemed reasonable that this group might claim that they are also disadvantaged by language. The increase in statistical power attributable to the increased sample size seemed to outweigh the potential decrease in homogeneity of the ESL sample because it would permit more test items to be considered and the items could be calibrated with greater precision. Despite the limitations of the DIF methodology, it was the only appropriate method sensitive enough, given available examination information to detect nontrivial performance difference between groups of linguistically distinct candidates.

The data selected for analysis were the responses from first-time, U.S.-educated candidates taking the examination between April 1 and September 30, 2004. This sample was selected because it reflected a single item pool for each test (RN and PN) and contains a higher volume of examinees than the October – March time period. Combining language groups did help to boost the samples to sizes adequate to detect differences. Items for which there were fewer than 20 responses

were excluded from the analyses. As a result, 76 RN and 54 PN items could not be analyzed. Of the 2,000 items in the RN operational pool, 1,924 were analyzed. Of the 1,700 items in the PN operational pool, 1,646 were analyzed.

The results, presented in Table 8, without the correction for the Type 1 error show no difference in the probability of a correct response for most (82-83%) of the items. The items that did show a difference were evenly split between providing an advantage for English speaking candidates (8-9%) and ESL candidates (8-9%). After the Bonferroni correction was used, only a trivial number of items continue to show a difference between groups and would not contribute to pass rate differences between groups

Table 8 — Detection of DIF using an Item Recalibration Strategy for First-time, U.S.-Educated Examinees by Primary Language Category

	RN	PN
Operational Pool	2,000	1,700
Excluded for Sample Size	76	54
Analyzed	1,924	1,646
Without Correction for Type 1 Error		
No Difference	1,605 (83%)	1,343 (82%)
Advantage English	162 (8%)	152 (9%)
Advantage ESL	157 (8%)	151 (9%)
Using Bonferroni Correction for Type 1 Error		
No Difference	1,901 (99%)	1,641 (100%)
Advantage English	13 (<1%)	4 (<1%)
Advantage ESL	10 (<1%)	1 (<1%)

In addition to these three sets of analyses it should be noted that all NCLEX items are evaluated for potential bias and sensitivity as part of the NCLEX item development process. The first evaluation of items for sensitivity takes place at NCLEX item writing and review panels. Then all items are evaluated by an independent panel of reviewers who are trained in the sensitivity review process prior to pretesting or any exposure to candidates. Any items that may be identified as unclear or insensitive at this juncture are forwarded to NCSBN's Examination Committee for further evaluation. Next items undergo a check for statistical item bias. Any items that are identified as exhibiting statistical item bias are review by another independent panel of experts who represent the various ethnic groups taking the NCLEX examinations. Items, which this NCLEX-DIF panel identifies as exhibiting potential bias, are referred to NCSBN's Examination Committee for final disposition. The checks for sensitivity and potential bias in the NCLEX item development process are among the most rigorous in the standardized testing industry.

In addition to checks for sensitivity and potential bias, the level of readability for operational item pools is also considered. Because the purpose of the NCLEX examinations is to measure nursing ability, not reading ability, the reading demands of the test should not be so high that the readability of the text becomes a barrier to otherwise qualified candidates. Consequently, the difficulty of an item should be governed by the nursing content rather than the semantic or syntactic complexity of the text. To address this concern, NCSBN assesses the readability of each operational item pool before the pool is deployed for use. This is accomplished by evaluating three simulated tests from the new item pool: a minimum-length easy test, a maximum-length borderline difficulty test and a minimum-length difficult test. Because the items for these tests are from very different sections (with regard to item difficulty) of the item pool, it is unlikely that there would be overlapping items across the three tests. These items (approximately 18% of an operational pool) are then considered as a representative sample of the items in the

operational pool. The samples are then analyzed using the Fry Readability Index (FRI) and the Lexile Framework®.

The FRI considers readability as a combination of sentence length and the number of syllables per word. The average number of syllables and the average sentence length across the three samples are computed and these numbers are plotted on a chart to produce a grade-level readability estimate. The average readability of these three simulated tests is considered to be representative of the readability of the operational item pool. Lexiles® also consider readability as a function of sentence length and the word difficulty, but rather than using the number of syllables as an indicator of word difficulty, Lexiles use the frequency with which words are actually used in the written language. The Lexile Analyzer software is used to determine the readability of each simulated test in Lexiles. The average readability of the three simulated tests is considered to be representative of the readability of the operational item pool. By policy, the readability level of the PN item pool should not exceed 8th grade reading level (with a corresponding range on the Lexile scale) and the readability level of the RN item pool should not exceed 10th grade reading level (with a corresponding range on the Lexile scale). All operational NCLEX item pools are in compliance with readability policy.

As expected, the sum of these analyses indicate that there is some relationship between lack of English language proficiency and NCLEX performance. This is an expected finding due to the fact that the examination is produced in English. Evidence in this study suggests that other language candidates do take more time to respond to items on a per item basis than "English Only" candidates, tend to run out of time more often than do "English Only" candidates and pass at a lower rate than "English Only" candidates, however, this does not support the contention that Other language candidates are somehow disadvantaged in their ability to pass the NCLEX. Results here imply that the same construct of nursing ability is in effect across all language groups. Given that the hierarchy of item difficulty is the same across groups, yet there is a disparate pass rate, one might hypothesize that lack of English proficiency may be a noticeable impediment to acquiring nursing knowledge and skills in U.S. nursing programs.

The DIF and item latency analyses presented are standard testing industry procedures for identifying group performance bias for examination items. This research was not able to identify any contributing factors beyond obvious issues of language competency that may impact performance on the NCLEX examinations because candidates are not being negatively impacted by English language status. Results of this study indicate that the policies and procedures for the maintenance of NCLEX item pools are effective in providing examinations that are psychometrically sound and legally defensible assessments of entry-level nurse competence.

Administered NCLEX Effectively and Efficiently at International Sites.
Beginning January 1, 2005, NCSBN began to schedule candidates at international test centers. The three locations of these centers are Hong Kong, China; London, England; and Seoul, South Korea. These three centers meet the same security specifications and follow the same administration procedures as the professional centers located in Member Board jurisdictions. NCSBN staff conducted site visits at all three international centers to meet test center and regional managerial Pearson VUE staff. A total of 10 Beta examinations were administered across all three centers. All test center procedures were performed in accordance with NCSBN administration expectations.

On January 17, 2005, all three international centers began administration of the NCLEX examinations. For calendar year 2005, a total of 4,500 NCLEX candidates are expected to schedule examination appointments in the international test centers. For the January through March time period, the number of internationally scheduled NCLEX examinations was 1,713, exceeding quarterly projections of 1,125 by almost 53%. Candidate volume, pass rates and country of education for international testing centers are provided in Tables 9 and 10. Country of education, as reflected in Table 10, indicates that, as expected, candidates from the Philippines comprise the vast majority of candidate volume in the London and Hong Kong centers, while Korean candidates comprise the total candidate volume at the test center in Seoul. These patterns

of candidate test center usage are in line with Examination Committee expectations when initial test centers were selected. Please note that information in Tables 9 and 10 reflect information for NCLEX-RN candidates exclusively. As of March 31, 2005, no NCLEX-PN candidates had scheduled examination administrations in any of the three international test centers.

Table 9 — January–March 2005 Test Center Candidate Volume & Pass Rates

	Exams Taken		Exams Passed		Pass Rate	
Test Center	**1st Time**	**All**	**1st Time**	**All**	**1st Time**	**All**
Hong Kong	310	351	207	228	66.8%	65.0%
Seoul	210	264	155	196	73.8%	74.2%
London	122	165	71	88	58.2%	53.3%
All International Centers	642	780	433	512	67.5%	65.6%
All Domestic Centers	23,636	31,462	19,593	22,633	82.9%	71.9%

Table 10 — January–March 2005 Test Center Candidate Volume by Country of Education for International Centers

	Test Center					
	Hong Kong		Seoul		London	
Rank	**Country**	**Volume**	**Country**	**Volume**	**Country**	**Volume**
1	Philippines	293	Korea	264	Philippines	89
2	India	28	-	-	UK	26
3	Thailand	9	-	-	India	17
4	Taiwan	8	-	-	Nigeria	5
5	China	4	-	-	South Africa	5
All Others		**9**		**0**		**23**
Total		**351**		**264**		**165**

Table 11 reflects the number and proportion of candidates who tested in international test centers by the jurisdiction by of intended licensure. During the first three months of 2005, 26 of 60 Member Boards had applicants for licensure who received an NCLEX examination in an international test center.

Table 11 — January–March 2005 Candidate Volume by Jurisdiction of Intended Licensure

Jurisdiction	Number of Candidates	Percent of Total Candidates
New York	280	35.9
California RN	197	25.3
New Mexico	89	11.4
Vermont	61	7.8
Northern Mariana Islands	28	3.6
Pennsylvania	21	2.7
Illinois	13	1.7
Georgia-RN	12	1.5
Texas	12	1.5
Maryland	11	1.4
Alaska	9	1.2

Florida	8	1.0
New Hampshire	8	1.0
Nevada	7	0.9
Colorado	3	0.4
New Jersey	3	0.4
North Carolina	3	0.4
Ohio	3	0.4
Arizona	2	0.3
District Of Columbia	2	0.3
Massachusetts	2	0.3
Oregon	2	0.3
Arkansas	1	0.1
Hawaii	1	0.1
Kentucky	1	0.1
Wisconsin	1	0.1
Total	**780**	**100**

From a test center security and administration perspective, international test centers have performed in line with expectations for domestic test centers. Using incident reports as a broad measure of test center performance, between January 1 and March 31 2005, international centers had a rate of 16 incidents per 100 examination administrations as compared to domestic centers that had an incident rate of 20 per 100 examinations administered. Incident reports encompass all nonstandard test center activity, from the admittance of trivial comfort aids, such as tissue, into the testing room, to serious potential security incidents, such as cheating. No security incidents were recorded in international test centers during this time period.

Educated Stakeholders about the NCLEX Examination Program and Related Products/Services.

Presentations

NCSBN Testing Services staff conducted more than 11 NCLEX informational presentations. Additionally, staff has exhibited at eight conferences during FY05. These opportunities assist NCSBN's Testing Services department to educate stakeholders 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.

NCLEX Invitational

For the past five years, Testing Services 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 2004 NCLEX Invitational was held on September 13, 2004 at the Fairmont Hotel San Francisco. Although this year's Invitational did not break last year's attendance record of 252 participants, 221 attendees from Member Boards, nursing education programs and nurse/health care recruiters did attend for 2004. The FY06 NCLEX Invitational is scheduled for Monday, September 19, 2005, at the Hilton New Orleans Riverside.

NCLEX® Program Reports

The Committee monitored production of the NCLEX Program Reports. NCLEX Program Reports were modified to reflect operational test plan and passing standard changes made to the examination during the course of the year. NCLEX Program Reports were distributed to subscribing nursing education programs during the current fiscal year in October 2004 and April 2005.

Several actions have been taken to increase the number of programs subscribing to NCLEX Program Reports: (1) The Testing Services department automatically sends new programs a letter and brochure introducing them to the product; (2) NCSBN proactively verifies contact information; (3) The NCSBN Web site now has a section that describes NCLEX Program Reports and how to subscribe and (4) Program Reports have been promoted whenever NCSBN staff exhibits at meetings or holds an NCLEX Invitational.

NCLEX Unofficial 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, 39 boards of nursing participate in offering this service to their candidates. For the last six months approximately 75,000 candidates utilized this service.

Future Activities

- Continue to monitor all administrative, test development and psychometric aspects of the NCLEX examination program.
- Evaluate enhancements to NCSBN examination process.
- Evaluate NCLEX outreach initiatives.
- Evaluate existing and additional international testing locations.

Attachments

A. Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX®)
B. IELTS Passing Standard Report
   Appendix A: Group Discussion of Minimally Competent Candidate — Summary of Group Discussion
   Appendix B: Evaluation Comments
   Appendix C: Panelists' Round 2 Data for Each IELTS Module

Attachment A

Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX®)

This report represents Pearson VUE's full second year of providing test delivery service for the NCLEX® examination program to the National Council of State Boards of Nursing (NCSBN). This report summarizes the activities of the past year.

Pearson VUE Organizational Change

Julie White, RN, MSN, was promoted to fill the position of NCLEX Content Manager. She has been with Pearson VUE and the NCLEX project since Pearson VUE began item development for the NCLEX examinations in 2001. She brings a wealth of nursing expertise and previous management experience, as well as her item-development experience on this contract, to her new position.

Test Development

Psychometric and statistical analyses of the NCLEX data continue to be conducted and documented as expected. We successfully conducted a standard-setting workshop last fall with a panel of expert judges and made recommendations for the new passing score on the NCLEX-PN® exam (which took effect April 1, 2005).

In addition to continuing to develop multiple-choice items, we are also developing items in alternate formats (fill-in-the-blank calculation, multiple response, drag-and-drop ordered response and chart/exhibit items). Our biggest item-development challenges are ensuring that we produce the traditional and alternate format items in quantities sufficient to meet our contractual obligations, and to develop them at targeted levels of difficulty. To that end, we are intensifying our staff-education efforts (supplementing internal resources with external training consultants as necessary). We are also increasing our content-development staff levels and are currently recruiting for two and a half full-time positions (one of which is to replace a content developer who recently left Pearson VUE).

NCLEX Examination Operations

Pearson VUE added three International Pearson Professional Centers to our testing network to help launch the NCLEX international program. There are currently sites in London, Seoul and Hong Kong. The site in London opened January 3, 2005, and the Seoul and Hong Kong sites opened and delivered their first exams on January 17, 2005. These additions raise the number of Pearson Professional Centers delivering the NCLEX to 205, total.

Pearson VUE Visits to NCSBN

- September 29 – October 1, 2004 (PN Standard Setting Meeting)
- October 27–29, 2004 (Examination Committee Business Meeting)
- December 7–10, 2004 (Item Review Subcommittee Meeting)
- January 26–28, 2005 (Examination Committee Business Meeting)
- March 1–4, 2005 (Item Review Subcommittee Meeting)
- March 14, 2005 (Joint Research Committee Meeting)
- April 27–29, 2005 (Examination Committee Business Meeting)
- May 10–13, 2005 (Item Review Subcommittee Meeting)
- May 12, 2005 (Contract Evaluation Meeting)

- June 21-24, 2005 (Item Review Subcommittee Meeting)
- August 23-26, 2005 (Item Review Subcommittee Meeting)
- The first Tuesday of every month there is an operations conference call with Pearson VUE and NCSBN.
- A conference call with Pearson VUE and NCSBN content staff is scheduled for every Tuesday.
- Other visits and conference calls on an as needed basis.

Summary of NCLEX Examination Results for the 2004 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 2003, the overall candidate volumes were higher for both the NCLEX-RN® (about +15.1%) and NCLEX-PN® (about +9.8%). The RN passing rate for the overall group was 0.9 percentage points lower for this testing period than for the same period in 2003 and the passing rate for the reference group was 1.7 percentage points lower for this period compared to 2003.

The PN passing rate for the overall group was 1.4 percentage points higher for this testing period than for the same period in 2003 and the passing rate for the reference group was 1.1 percentage points higher than the previous year's passing rate. 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 bullet points are candidate highlights of the 2004 testing year for the NCLEX-RN examination:

- Overall, 143,553 NCLEX-RN examination candidates tested during 2004, as compared to 124,737 during the 2003 testing year. This represents an increase of about 15.1 percent.
- The candidate population reflected 87,175 first-time, U.S.-educated candidates who tested, as compared to 76,719 for the 2003 testing year.
- The overall passing rate was 70.2 percent in 2004, compared to 71.1 percent in 2003. The passing rate for the reference group was 85.3 percent in 2004, as compared to 87.0 percent in 2003.
- Of the total group, 47.9 percent and 51.3 percent of the reference group ended their tests after a minimum of 75 items were administered. This is about the same as the 2003 testing year in which 47.5 percent of the total group and 51.2 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 14.8 percent for the total group and 13.7 percent for the reference group. This is this is slightly higher than last year's percentages (13.8 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 2004 testing period was 2.3 hours (or two hours, 18 minutes) for the overall group, and 2.06 hours (or two hours, 4 minutes) for the reference group.
- A total of 50.6 percent of the candidates chose to take a break during their examinations.
- Overall, 3.2 percent of the total group and 1.7 percent of the reference group ran out of time before completing the test. These percentages of candidates timing out were slightly lower than the overall cumulative percentages for candidates during the 2003 testing year.
- In general, the NCLEX-RN examination summary statistics for the 2004 testing period indicated patterns that were similar to those observed for the 2003 testing period. These

results provide continued evidence that the administration of the NCLEX-RN examination is psychometrically sound.

The following bullet points are candidate highlights of the 2004 testing year for the NCLEX-PN examination:

- Overall 62,112 PN candidates tested in 2004, as compared to 56,579 PN candidates tested during 2003. This represents an increase of about 9.8% percent.
- The candidate population reflected 49,289 first-time, U.S.-educated candidates who tested in 2004, as compared to 44,078 for the 2003 testing year.
- The overall passing rate was 79.9 percent in 2004, compared to 78.5 percent in 2003 and the reference group passing rate was 89.3 percent in 2004, compared to 88.2 percent in 2003.
- There were 56.8 percent of the total group and 61.9 percent of the reference group who ended their tests after a minimum of 85 items were administered. This is higher than the 2003 testing year in which 55.3 percent of the total group and 60.1 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 16.1 percent for the total group and 13.1 percent for the reference group. This is higher than last year's percentages (17.0 percent for the total group and 14.0 percent for the reference group).
- The average time needed to take the NCLEX-PN examination during the 2004 testing period was 2.08 hours (or two hours, 5 minutes) for the overall group and 1.89 hours (one hour, 53 minutes) for the reference group.
- Overall, 1.4 percent of the total group and 0.6 percent of the reference group ran out of time before completing the test.
- In general, the NCLEX-PN examination summary statistics for the 2004 testing period indicated patterns that were similar to those observed for the 2003 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 2004 Testing Year

RN	Jan 04 – Mar 04		Apr 04 – Jun 04		Jul 04 – Sep 04		Oct 04 – Dec 04		Cumulative 2004	
	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	31,891	18,358	34,869	22,762	54,247	39,089	22,546	6,966	143,553	87,175
Percent Passing	69.9	87.0	73.4	88.5	74.3	83.9	56.0	78.1	70.2	85.3
Average # Items Taken	125.8	118.8	120.0	115.5	124.5	121.7	133.0	129.1	125.0	120.1
% Taking Min. # Items	47.8	53.0	50.9	54.6	47.6	49.5	44.3	46.7	47.9	51.3
% Taking Max. # Items	14.9	13.4	12.7	12.0	14.6	14.1	18.7	17.6	14.8	13.7
Average Test Time	2.35	2.06	2.16	1.91	2.22	2.07	2.82	2.47	2.33	2.06
% Taking Break	51.2	40.1	44.6	34.6	46.6	40.6	68.5	55.4	50.6	40.1
% Timing Out	4.3	2.0	3.0	1.3	3.0	1.9	2.6	1.3	3.2	1.7

Table 2 — Longitudinal Technical Summary for the NCLEX-RN® Examination: Group Statistics for 2003 Testing Year

RN	Jan 03 – Mar 03		Apr 03 – Jun 03		Jul 03 – Sep 03		Oct 03 – Dec 03		Cumulative 2003	
	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	26,085	14,905	31,440	20,201	47,882	36,287	19,330	5,326	124,737	76,719
Percent Passing	69.1	87.1	74.3	90.1	76.6	86.5	54.9	78.2	71.1	87.0
Average # Items Taken	124.8	118.5	119.0	113.2	122.0	120.1	135.6	127.1	123.9	118.5
% Taking Min # Items	47.7	52.3	50.5	54.6	48.2	49.6	40.8	46.6	47.5	51.2
% Taking Max # Items	13.7	12.5	12.1	10.9	13.4	13.3	17.6	15.8	13.8	12.7
Average Test Time	2.30	2.02	2.10	1.84	2.21	2.06	2.65	2.26	2.3	2.0
% Taking Break	49.9	39.2	43.7	33.1	46.9	40.9	62.6	48.5	49.2	39.0
% Timing Out	4.3	1.9	3.0	1.2	3.0	1.9	6.4	3.4	3.8	1.8

Table 3 — Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2004 Testing Year

Operational Item Statistics										
RN	**Jan 04 – Mar 04**		**Apr 04 – Jun 04**		**Jul 04 – Sep 04**		**Oct 04 – Dec 04**		**Cumulative 2004**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**
Point-Biserial	0.20	0.09	0.20	0.08	0.19	0.08	0.17	0.07	N/A	N/A
Z-Statistic	0.25	2.50	0.24	2.55	0.35	2.75	0.12	2.37	N/A	N/A
Average Item Time (secs)	67.6	15.9	64.9	16.8	64.6	16.6	74.8	26.8	N/A	N/A
Pretest Item Statistics										
# of Items	335		447		662		130		1,574	
Average Sample Size	743		699		802		651		748	
Mean Point-Biserial	0.09		0.08		0.06		0.09		0.07	
Mean P+	0.68		0.64		0.69		0.66		0.67	
Mean B-Value	-0.96		-0.65		-1.05		-0.96		-0.91	
SD B-Value	1.56		1.53		1.53		1.70		1.56	
Total Number Flagged	138		177		339		51		705	
Percent Items Flagged	41.2%		39.6%		51.2%		39.2%		44.8%	

Table 4 — Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2003 Testing Year

Operational Item Statistics										
RN	**Jan 03 – Mar 03**		**Apr 03 – Jun 03**		**Jul 03 – Sep 03**		**Oct 03 – Dec 03**		**Cumulative 2003**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**
Point-Biserial	0.20	0.08	0.21	0.09	0.20	0.09	0.20	0.08	N/A	N/A
Z-Statistic	0.24	2.53	0.22	2.50	0.31	2.69	0.09	2.24	N/A	N/A
Average Item Time (secs)	66.1	15.4	64.4	16.9	63.8	16.7	69.5	16.6	N/A	N/A
Pretest Item Statistics										
# of Items	320		329		1,012		129		1,790	
Average Sample Size	602		666		490		554		547	
Mean Point-Biserial	0.09		0.09		0.08		0.11		0.09	
Mean P+	0.70		0.69		0.65		0.61		0.66	
Mean B-Value	-1.05		-1.03		-0.84		-0.66		-0.90	
SD B-Value	1.51		1.63		1.61		1.60		1.60	
Total Number Flagged	126		148		449		39		762	
Percent Items Flagged	39.4%		45.0%		44.4%		30.2%		42.6%	

Table 5 — Longitudinal Technical Summary for the NCLEX-PN® Group Statistics for 2004 Testing Year

PN	Jan 04 – Mar 04		Apr 04 – Jun 04		Jul 04 – Sep 04		Oct 04 – Dec 04		Cumulative 2004	
	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	13,137	10,064	12,464	9,131	21,800	18,690	14,711	11,404	62,112	49,289
Percent Passing	77.9	88.2	76.0	87.7	84.1	91.2	78.9	88.6	79.9	89.3
Average # Items Taken	116	110.6	116.4	110.2	111.3	107.6	116.3	111.1	114.3	109.5
% Taking Min. # Items	55.4	60.7	55.1	62.0	60.3	64.0	54.2	59.3	56.8	61.9
% Taking Max. # Items	17.4	14.1	17.3	13.6	14.2	11.9	16.8	13.6	16.1	13.1
Average Test Time	2.11	1.90	2.17	1.93	1.92	1.78	2.21	2.01	2.08	1.89
% Taking Break	47.9	38.8	50.6	41.0	39.2	33.3	52.4	44	46.5	38.3
% Timing Out	1.4	0.6	1.8	0.8	0.9	0.4	1.9	0.9	1.4	0.6

Table 6 — Longitudinal Technical Summary for the NCLEX-PN® Group Statistics for 2003 Testing Year

PN	Jan 03 – Mar 03		Apr 03 – Jun 03		Jul 03 – Sep 03		Oct 03 – Dec 03		Cumulative 2003	
	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	12,119	8,903	10,646	7,496	20,796	17,759	13,018	9,920	56,579	44,078
Percent Passing	76.1	86.9	73.8	86.2	83.8	90.7	76.3	86.5	78.5	88.2
Average # Items Taken	119.1	113.3	118.2	112.2	111.9	108.4	117.8	113.1	116.0	111.1
% Taking Min # Items	52.2	57.8	53.1	58.9	59.4	63.0	53.4	58.1	55.3	60.1
% Taking Max # Items	19.2	15.6	18.1	14.3	14.4	12.3	18.4	15.6	17.0	14.0
Average Test Time	2.16	1.94	2.13	1.90	1.98	1.83	2.22	2.02	2.1	1.9
% Taking Break	50.5	40.9	51.2	40.8	42.6	36.6	53.2	45.1	48.3	40.1
% Timing Out	1.7	1.0	1.9	1.0	1.1	0.5	1.6	0.7	1.5	0.7

Table 7 — Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2004 Testing Year

Operational Item Statistics										
PN	**Jan 04 – Mar 04**		**Apr 04 – Jun 04**		**Jul 04 – Sep 04**		**Oct 04 – Dec 04**		**Cumulative 2004**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**
Point-Biserial	0.21	0.09	0.20	0.07	0.21	0.07	0.19	0.08	N/A	N/A
Z-Statistic	0.13	2.44	0.12	2.44	0.20	2.50	0.14	2.25	N/A	N/A
Average Item Time (secs)	64.7	17.8	64.8	18.2	61.5	17.1	65.5	19.6	N/A	N/A
Pretest Item Statistics										
# of Items	368		278		523		409		1,578	
Average Sample Size	616		740		807		620		702	
Mean Point-Biserial	0.11		0.12		0.11		0.10		0.11	
Mean P+	0.67		0.67		0.65		0.61		0.65	
Mean B-Value	-0.85		-0.94		-0.72		-0.49		-0.73	
SD B-Value	1.33		1.46		1.32		1.61		1.43	
Total Number Flagged	113		75		161		136		485	
Percent Items Flagged	30.7%		27.0%		30.8%		33.3%		30.7%	

Table 8 — Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2003 Testing Year

Operational Item Statistics										
PN	**Jan 03 – Mar 03**		**Apr 03 – Jun 03**		**Jul 03 – Sep 03**		**Oct 03 – Dec 03**		**Cumulative 2003**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**
Point-Biserial	0.21	0.08	0.21	0.08	0.22	0.08	0.21	0.09	N/A	N/A
Z-Statistic	0.09	2.48	0.07	2.42	0.16	2.54	0.12	2.41	N/A	N/A
Average Item Time (secs)	64.8	18.8	65.6	18.2	61.8	17.1	65.2	18.2	N/A	N/A
Pretest Item Statistics										
# of Items	296		259		534		375		1,464	
Average Sample Size	672		609		745		592		667	
Mean Point-Biserial	0.11		0.13		0.12		0.13		0.12	
Mean P+	0.64		0.67		0.65		0.66		0.65	
Mean B-Value	-0.80		-0.86		-0.71		-0.86		-0.79	
SD B-Value	1.52		1.35		1.43		1.48		1.45	
Total Number Flagged	82		68		142		111		403	
Percent Items Flagged	27.7%		26.3%		26.6%		29.6%		27.5%	

Attachment B

International English Language Testing System Standard-Setting Study

Final Report

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Nurses made up the largest contingent of people whose work contributed to the outcome of the standard-setting workshop. They provided estimates of performance on the IELTS tasks by entry-level nurses for whom English is a second language, which resulted in the cut score recommendation. Additionally, Thomas O'Neill and Anne Wendt from NCSBN assisted in the standard-setting workshop. Without their efforts and diligence we would not have been able to conduct the project.

Introduction

The purpose of this report is to document the procedures and analyses undertaken to assist NCSBN in setting the cut score for the International English Language Testing System (IELTS). The report summarizes the procedures and results of a standard-setting study conducted October 30-31, 2004. The report also provides recommendations for the establishment of a cut score for the IELTS based on the results of the October 30-31 study.

Information About the IELTS

The International English Language Testing System (IELTS) has been chosen by NCSBN as a method to determine minimal competency in English language proficiency for nurses for whom English is a second language. This test could be used by state boards of nursing to identify nurses who meet minimal expectations for English language proficiency as part of the eligibility for licensure. Because the IELTS is to be used to make decisions about individual nursing candidates, NCSBN has recognized the importance of using scientifically accepted methods for setting these performance standards that aid in this decision process.

IELTS is comprised of four modules: Listening, Reading, Writing and Speaking. The Listening and "Academic" Reading Modules of the exam each contain 40 multiple-choice, short answer

and completion items. The "Academic" Writing Module consists of two tasks. Task 1 requires the preparation of a response of at least 150 words. For this task, test takers are asked to interpret a diagram or table and present the information in their own words. Task 2 requires a minimum of 250 words and is the more heavily weighted of the two writing tasks. For Task 2, test takers are asked to respond to a point of view or argument by presenting a solution and justifying their opinion. The Speaking Module is a one-on-one interview consisting of three parts: introduction and interview, individual long-term speaking and a two-way discussion. The writing performance is scored for three elements on a 9-point rubric. The speaking performance is scored for four elements on a 9-point rubric. Items on the Listening and Reading Modules are each valued at one point and total scores for each module are converted to a band score of 0–9. For each test taker, an overall band score is calculated from the equally weighted four individual band scores.

The purpose of this study was to provide a range of reasonable cut scores to NCSBN staff. This report focuses on the results of the standard-setting study for the IELTS conducted October 30–31, 2004. The report provides an overview of the methods and procedures for the study and includes a recommendation for a range within which a reasonable cut score may be set. Reasonable, in this case, is a cut score that will serve to identify the nurses for whom English is a second language who have attained the language skills necessary to safely and effectively act as entry-level nurses in the United States.

Methods and Procedures

Overview of Standard-Setting Methods

The recommended range of cut scores for each module is based on two methods for estimating a cut score that were used in this study. Each method relies on different assumptions and is unique to the type of assessment (i.e., objectively scored versus subjectively scored). The use of methods that are appropriate given the nature of the measurement within a given module provides a more defensible range of possible cut scores within which NCSBN staff can determine the final cut score. These methods included: (a) a modified Analytical Judgment method (Plake & Hambleton, 2000) and (b) a modified Angoff (1971) method. Each of these methods is described briefly below.

Analytical Judgment Method

The Analytical Judgment method used is a modification of the method described by Plake and Hambleton (2000). This method entails asking practicing nurses to classify entry-level nurses' performance into defined categories. Classification is first at a broad level and then narrowed down to identify the performance that would likely be produced by a target entry-level nurse. This method was used for the Writing and Speaking Modules of the IELTS for the October 30-31, 2004, workshop.

Yes/No Variation of the Angoff Method

The Yes/No Variation of the Angoff method (Impara and Plake, 1997) entailed using nurses to examine each item on the test and estimate how a typical borderline "Minimally Competent" entry-level nurse for whom English is a second language will perform on that item. For the IELTS, panelists were asked (after a training activity) to conceptualize a specific minimally competent nurse with whom they had worked or supervised. Keeping this entry-level nurse in mind, they were directed to indicate, for each item, whether the entry-level nurse they had in mind would answer the item correctly or not (Right or Wrong). This was done for the multiple-choice, short answer and completion items the nurses rated. After an initial rating, actual performance data (proportion answering each item correctly) from a representative sample of over 8,000[1] IELTS test takers was provided to the panelists. After seeing the data, the panelists were asked to make a

[1]Test takers in this sample include candidates for professional positions and college admissions in addition to nurse candidates.

second estimate of whether the "Minimally Competent" entry-level nurse would answer correctly or not. The second estimate could be either the same or different from their first estimate. These data provide a reality check to ensure that expected performance is not set either unrealistically high or low because the nurse has misjudged how hard or easy the item actually is. The cut score is based on the second estimate and is calculated by summing, for each panelist, the number of "Right" items and then averaging those values across the panelists. This value typically represents the lower boundary of the recommended cut score range. This method was used for the Listening and Academic Reading Modules of the IELTS for the October 30-31, 2004, workshop.

Overview of Procedures

The procedures describe how each of the standard-setting methods was completed. Analytical Judgment and Yes/No data were collected after orientation and practice activities during the standard-setting workshop on October 30-31, 2004. An evaluation of the workshop was also conducted.

Panelists for the workshop consisted of a panel of 27 nurses and one public member. The 27 nurse panelists were selected by NCSBN such that they collectively represented a cross-section of the nation's nurses who speak English is a second language or they supervise nurses for whom English is a second language. The average years of nursing experience for this panel was 15 years with a range of one to 33 years.

During the workshop, (a) the panelists were told the purpose of the meeting; (b) the test specifications were reviewed; (c) a process for helping the panelists conceptualize the "Minimally Competent" entry-level nurse was undertaken; (d) specific training in the item performance estimation procedure was provided; (e) panelists made their analytical judgments on the performance assessments; (f) panelists made Yes/No estimates for multiple-choice, short answer and completion items and (g) panelists evaluated the standard-setting workshop.

Orientation and Training

The workshop began with Barbara Plake describing the importance of the standard-setting task and discussing the procedures that would take place over the next day and a half. This orientation included reviewing the content of the panelists' packets (agenda, table of specifications of the test, description of student proficiency levels and various forms to be completed). Anne Wendt from NCSBN discussed with the panelists the expectations for the entry-level nurse in order to frame the professional requirements for nurses taking the IELTS. After Anne's discussion, Beryl Meiron from IELTS discussed the table of specifications for the IELTS with the panelists, informing them of the structure, content and scoring of the four modules of the exam.

Following the discussion of the Table of Specifications, Plake began the discussion of the Minimally Competent Candidate (MCC). She used several metaphors to help panelists come to an understanding of the cut score process and the conceptual underpinnings of identifying the MCC. The initial training on the conceptualization of the MCC began by dividing the panelists into four groups of seven, one for each of the four components of the IELTS. The groups were asked to visualize the specific Minimally Competent Candidate with whom they have interacted, consider a specific module of the IELTS and describe the aspects of the language concept the MCC would do well on and those aspects the MCC would find challenging. Panelists were given approximately 45 minutes to articulate the knowledge, skills and abilities of the MCC relative to the table of specifications for the test. Once they finished with this process in their small groups, the overall group was reconvened to consolidate their small group discussions into a uniform conceptualization of the MCC. The purpose in seeking more refined behavioral descriptions of the MCC was so that all panelists would have a common understanding of the skills of entry-level nurses. This consolidated discussion was transcribed and copies were provided to panelists prior to their operational judgments to use as a reference (see Appendix A).

Once the panelists indicated that they understood the basic structure of the standard-setting

process, the initial training for the panelists began. At this point, Chad Buckendahl led the training for the Analytical Judgment and Yes/No methods, practicing the process. Buckendahl engaged the panelists in activities designed to demonstrate the importance of considering item difficulty when setting passing scores. These activities provided the panelists with concrete examples of how an item is structured as well as how the difficulty of the concept may influence performance.

As a practice activity for Yes/No ratings, multiple-choice, short answer and completion items were included. For each item, panelists indicated a "Right" or a "Wrong" (R or W) for the specific "Minimally Competent" entry-level nurse they had in mind. An "R" suggested the panelist believed the entry-level nurse would answer the item correctly and a "W" indicated the panelist believed the entry-level nurse would answer incorrectly. Panelists were told that variability among the panel was expected, that MCCs were not expected to all be the same in their ability to answer questions, so some may be able to respond correctly and others not for a particular item.

The panelists were then provided with actual performance data on each item. The performance data consisted of the proportion of IELTS test takers[2] who had answered each item correctly (called p-values). The practice test consisted of items that had a range in difficulty similar to the range found in the operational test. After discussion of all practice items, the panelists were shown the impact of several possible cut scores. The impact data were based on cumulative percentages that were derived from the sample of IELTS test takers' performance on these items. This was followed by more discussion of the test and the task.

Buckendahl continued the practice activity to include an example of the Analytical Judgment method. Panelists were given 10 "marker" papers across the range of score points that represent the performance of test takers on Writing Task 2. Panelists then classified the papers into three categories, "Incompetent", "Competent" and "Very Competent." This was the broader classification. Panelists were then asked to go back to their "Incompetent" papers and select the one paper that represented the "best" performance among those papers. They were then asked to go back to the papers they classified as "Competent" and select the one that represented the "worst" performance among those papers. This refined classification produces a distribution of score judgments around the point of focus for the study, the Minimally Competent Candidate's performance. After these broad and refined classifications, panelists were given their individual score judgments and the average score for the group. This feedback was the same type of information that panelists would receive during the operational rounds. This completed the training.

Operational Ratings

After lunch, the panelists began the operational portion of the standard-setting workshop with the Listening Module of the International English Language Testing System (IELTS). Copies of the test and a separate answer key for the multiple-choice, short answer and completion items were distributed. The Listening Module is an auditory measure of listening comprehension. The audio portion was played and panelists answered the items as the passages were read aloud. Once the audio recording was completed, the panelists made their first round Yes/No ratings. As the panelists made their ratings, their rating forms were collected and the ratings entered into a computer program designed to compute the cut score. After the panelists completed their first round of ratings, their rating forms were individually returned and actual performance data were provided and explained. The actual performance data included item p-values from nearly 8,000 IELTS test takers. Panelists then made their second (final) rating of the 40-item Listening Module.

The next module completed by the panelists was the Speaking Module of the IELTS. This module consisted of 15 video-recorded interviews. Panelists viewed the interviews and recorded notes onto forms unique to each candidate interviewed. The forms facilitated the identification of the MCC by providing a frame of reference for candidate performance. The panelists selected four

[2]Test takers in this sample include candidates for professional positions and college admissions, in addition to nurse candidates.

interviews (two that were the best of the "Incompetent" and two that were the worst of the "Competent") that would form the basis for their recommendation of a passing score for that module of the assessment. After the panelists completed their first round of selections, their rating forms were collected and ratings were entered into a computer program. Their rating forms were returned and their individual mean score and the group mean score were provided and explained. The panelists then made their second rating of the Speaking Module.

The last module for the first day of the workshop was the Academic Reading Module of the IELTS. Copies of the test and a separate answer key for the multiple-choice, short answer and completion items were distributed. The panelists made their first round Yes/No ratings. As the panelists made their ratings, their rating forms were collected and the ratings entered into a computer program designed to compute the cut score. After the panelists completed their first round of ratings, their rating forms were individually returned and actual performance data were provided and explained. The actual performance data included item p-values from over 12,000[3] IELTS test takers. Panelists then made their second rating of the 40-item Academic Reading Module. This concluded the activities for Day 1 of the workshop.

Panelists reviewed the Writing Module of the IELTS exam on the second day. The Writing Module consists of two tasks. A passing score was identified for each of the writing tasks. Panelists were given a total of 40 papers for Task 1. The panelists selected six papers (three that were the best of the "Incompetent" and three that were the worst of the "Competent") that would form the basis for their recommendation of a passing score for Task 1 of the Writing Module. After the panelists completed their first round of selections for Task 1, their rating forms were collected and ratings were entered into a computer program. Their rating forms were returned and their individual mean score and the group mean score were provided and explained. The panelists then made their second rating for Task 1 of the Writing Module. For Task 2 panelists were given 30 papers. The process was repeated and the panelists chose six papers from the Task 2 set. Again, upon completion of their first round selections, individual mean scores and group mean scores were shared with the panelists and they made their second round ratings for Task 2. This concluded the operational portion of the standard-setting workshop.

Evaluation and Conclusion of Workshop

The final activity for the panelists was the completion of an evaluation form. After finishing their item ratings and evaluation forms, materials were collected. After the evaluations were completed the workshop was concluded. Certificates of participation were provided to the panelists as evidence of their participation in the workshop.

Results

Panelists utilized two methods for the four modules of the IELTS. For the Listening and Academic Reading Modules, the panelists provided Yes/No item performance estimates before and after being given actual performance data (p-values) and impact data (cumulative percents). For the Speaking and Academic Writing Modules, the panelists made broad and refined classifications of examinee performance before and after receiving their individual and group rating data. The recommended cut scores from each module are shown below.

Listening

The recommended cut score for the Listening Module is based on the Yes/No ratings from the selected and constructed response items. Providing actual performance data between Rounds 1 and 2 for listening appeared to have little influence on the panelists as the second round cut score stayed the same. Panelists received their individual ratings and feedback in raw scores, however, the converted band score is also reported in Table 1.

[3]Test takers in this sample include candidates for professional positions and college admissions in addition to nurse candidates.

Table 1 — Change in cut score mean and standard deviation between Rounds 1 and 2 for the Listening Module.

Round	Cut score	Standard Deviation	% below	Band Score
1	29	4.07	67%	6.5
2	29	4.00	67%	6.5

The cut scores and associated ranges within which the final cut score might be set as a result of using the Yes/No method are shown in Table 2. If the cut score were set at the average final value across the panel, it would be 29 (SD = 4). The impact of this cut score would be that 67% of the examinees that took the IELTS Listening Module would be classified as being "Incompetent." Note this does not provide specific information on the percent of nursing candidates because this sample included all examinees. If the cut score were set at one standard deviation below the average cut score (25) the impact would be that 49.5% of examinees would be classified as being "Incompetent."

Table 2 — Listening Round 2 cut score and impact within two standard deviations (cut scores are rounded to closest half point).

Range	Cut Score	Impact (% below)	Band Score
2 SD Below	21	33.3%	5.5
1 SD Below	25	49.5%	6
Average	**29**	**67.0%**	**6.5**
1 SD above	33	83.5%	7.5
2 SD above	37	95.9%	8.5

Reading

The recommended cut score for the Academic Reading Module is based on the Yes/No ratings from the selected and constructed response items. Impact data may have influenced panelists between Rounds 1 and 2, as the second round resulted in a lower score mean and a higher standard deviation. Panelists received their individual ratings and feedback in raw scores, however, the converted band score is also reported below in Table 3.

Table 3 — Change in cut score mean and standard deviation between Rounds 1 and 2 for the Academic Reading Module.

Round	Cut score	Standard Deviation	% below	Band Score
1	26	3.91	69.6%	6.5
2	24	5.45	62.7%	6.5

The cut scores and associated ranges within which the final cut score might be set as a result of using the Yes/No method are shown in Table 4. If the cut score were set at the average final value across the panel, it would be 24 (SD = 5.45). The impact of this cut score would be that 62.7% of the examinees who took the IELTS Academic Reading Module would be classified as being "Incompetent." Note: this does not provide specific information on the percent of nursing candidates because this sample included all examinees. If the cut score were set at one standard deviation below the average cut score (19) the impact would be that 42.2% of the examinees would be classified as being "Incompetent."

Table 4 — Academic Reading Round 2 cut score and impact within two standard deviations (cut scores are rounded to closest half point).

Range	Cut Score	Impact (% below)	Band Score
2 SD Below	13	14.6%	5
1 SD Below	19	42.2%	5.5
Average	**24**	**62.7%**	**6.5**
1 SD above	29	78.6%	7
2 SD above	35	93.4%	8

Speaking

The recommended cut score using the Analytical Judgment method for the Speaking Module is shown in Table 5. Panelists were asked to identify two speaking performances that were the worst of the "Competent" performances and the two best of the "Incompetent" performances. Those averaged scores resulted in a first round cut score of 5.5 with a standard deviation of 0.7. These values are represented in band scores. Panelists were given feedback data on their individual cut score and the mean of the panelists' cut scores. They were then given the opportunity to change the performances they identified as the worst of the "Competent" performances and the best of the "Incompetent" performances. This resulted in the second round cut score of 5.6 with a standard deviation of 0.67.

Table 5 — Change in cut score mean and standard deviation between Rounds 1 and 2 for the Speaking Module.

Round	Cut score	Standard Deviation
1	5.5	0.70
2	5.6	0.67

Table 6 shows the range of results for two standard deviations above and below the recommended Round 2 cut score.

Table 6 — Speaking Round 2 cut score within two standard deviations (cut scores are rounded to closest half point).

Range	Band Score
2 SD Below	4.5
1 SD Below	5.0
Average	5.5
1 SD above	6.5
2 SD above	7.0

Writing

The cut scores using the Analytical Judgment method for the Task 1 Writing Module are shown in Table 7. Panelists were asked to identify three writing performances that were the worst of the "Competent" performances and the three best of the "Incompetent" performances. Those averaged scores resulted in a Round 1 cut score of 5.2 and a standard deviation of 0.53. Panelists were given feedback data on their individual cut score and the mean of the panelists' cut scores.

They were then given the opportunity to change the performances they identified as the worst of the "Competent" performances and the best of the "Incompetent" performances. This resulted in the Round 2 cut score of 5.3 with a standard deviation of 0.49.

Table 7 — Change in cut score mean and standard deviation between Rounds 1 and 2 for the Task 1 Writing Module

Round	Cut score	Standard Deviation
1	5.2	0.53
2	5.3	0.49

The cut scores using the Analytical Judgment method for the Task 2 Writing Module are shown in Table 8. Panelists were asked to identify three writing performances that were the worst of the "Competent" performances and the three best of the "Incompetent" performances. Those averaged scores resulted in a Round 1 cut score of 5.4 and a standard deviation of 0.34. Panelists were given feedback data on their individual cut score and the mean of the panelists' cut scores. They were then given the opportunity to change the performances they identified as the worst of the "Competent" performances and the best of the "Incompetent" performances. This resulted in the Round 2 cut score of 5.4 with a standard deviation of 0.35.

Table 8 — Change in cut score mean and standard deviation between Rounds 1 and 2 for the Task 2 Writing Module.

Round	Cut score	Standard Deviation
1	5.4	0.34
2	5.4	0.35

The two scores taken from Task 1 and Task 2 in the Writing Module of the IELTS are combined into one overall band score. In the computation of the overall band score for writing, the Task 1 band score is weighted a third and the Task 2 band score has a weight of two-thirds. A conversion grid has been developed by IELTS to convert the two independent band scores from the writing tasks into one band score for the Writing Module. For the purpose of this standard-setting workshop, the final band score was calculated using the panelists' cut score for each task and multiplying it by the weighting for each task and summing those scores. The final recommended band scores are shown in Table 9.

The pooled standard deviation was calculated to determine the amount of error present in combining the two cut scores for the Writing Module. The pooled standard deviation for each round is shown in Table 9.

Table 9 — Recommended combined band scores and pooled standard deviation for the Writing Module.

Round	Pooled Standard Deviation	Final Band Score
1	0.63	5.3
2	0.60	5.4

Table 10 shows the range of cut score values for the Writing Module that would be consistent with the results of the standard-setting workshop.

Table 10 — Writing Module Round 2 band score within two standard deviations (cut scores are rounded to closest half point).

Range	Band Score
2 SD Below	4.0
1 SD Below	5.0
Average	5.5
1 SD above	6.0
2 SD above	6.5

Workshop Evaluation

At the conclusion of the Standard-setting Workshop, panelists completed an evaluation form consisting of six parts. Part 1 focused on the orientation and training; Parts 2 and 3 focused on the levels of confidence, comfort and length of time for Rounds 1 and 2 of the Analytical Judgments; Parts 4 and 5 focused on Rounds 1 and 2 of the Yes/No ratings and on the levels of confidence and comfort in making the performance estimates and on the amount of time allowed to make the ratings; and Part 6 assessed the overall workshop quality. An open-ended item asking about recommended changes that might be made to improve the workshop or make future workshops run more smoothly was also included at the end of Part 6.

Part 1: Training

On a scale ranging from 1–6, where 1 = Very Unsuccessful and 6 = Very Successful, on average, the panelists rated all components of the training as a 5.1 or higher (Orientation mean = 5.3, Training on Method mean = 5.2, Description of MCC mean = 5.1, Practice with Method mean = 5.2, Interpretation of Feedback mean = 5.2 and Overall Training mean = 5.2).

Panelists also rated the adequacy of the time provided for training and orientation. On a 6-point scale, where 1 = Totally Inadequate and 6 = Totally Adequate, all ratings equaled or exceeded 4.8 (Orientation mean = 5.0, Training on Method mean = 5.0, Description of MCC mean = 4.8, Practice with Method mean = 5.0, Interpretation of Feedback mean = 5.0 and Overall Training mean = 5.0).

When asked to rate the amount of time allocated to training, the average rating was 2.0, where a value of 2 was "The right amount of time was allocated to training." A value of 1 = too little time was allocated to training and 3 = too much time was allocated to training. Of the 28 panelists who responded, five felt that too much time was allocated to training and four felt too little time was allocated to training.

Part 2: Analytical Judgments

The panelists' confidence in their ability to provide their Analytical Judgments was a mean of 3.7 on a 4-point scale (1 = Not Confident and 4 = Confident). The average Comfort rating on the 4-point scale (1=Uncomfortable and 4 = Comfortable) for the Analytical Judgments was 3.8.

The final item in Part 2 asked about the adequacy of time allocated for completing their initial estimates of group performance. On the 4-point scale (1 = More time needed and 4 = More than enough time was allotted), the average rating was 2.6.

Part 3: Round 1 Analytic Ratings

The panelists' confidence in their ability to provide meaningful Analytic ratings in Round 2 was 3.8 (mean) on a 4-point scale (1 = Not Confident and 4 = Confident). The average Comfort rating on the 4-point scale (1=Not Comfortable and 4= Comfortable) for the Round 2 ratings was 3.8.

The final item in Part 3 asked about the adequacy of time allocated for making the item ratings. On the 4-point scale (1 = More time needed and 4 = More than enough time was allotted) the average rating was 3.0.

Part 4: Round 1 Yes/No Ratings

When asked about their levels of confidence and comfort in making their Round 1 performance estimates, the mean ratings were both 3.6. The mean for the allocation of time for making the Round 1 rating was 2.9.

Part 5: Round 2 Yes/No Ratings

Panelists' mean level of confidence and comfort in making their Round 2 performance estimates was 3.8. The mean for the allocation of time for making the Round 2 rating was 3.1.

Part 6: Overall Evaluation of the Standard-Setting Workshop

The first item in Part 6 asked about the panelists' confidence in the cut score that would result from their Round 2 ratings. The average level of confidence was 3.5 on a 4-point scale (1 = Not Confident and 4 = Confident). Thus, the average panelist indicated he or she was more than "Somewhat Confident" about the appropriateness of the passing standard. All but three panelists rated this item as a 3 or 4. Two questions asked the panelists about the type of data that was most useful in making their Round 2 ratings. The most useful data were the p-values (n=13) with impact data being the next most useful (n=5). The least useful were impact data (n=9) and group discussion (n=8). The final two questions asked panelists to rate the success and coordination of the workshop (1 = Totally Unsuccessful and 4 = Totally Successful). The average rating for each of these items was 3.4.

Conclusions and Recommendations

The recommendations presented below for the range of possible values of the cut score for each module are based on the final results using data from the 28 panelists at the workshop. NCSBN may wish to consider these modules separately and require candidates to meet a specific cut score for each module (conjunctive) or they may choose to set a cut score based on a total combined score across modules that would allow candidates to compensate lower performance on one section with higher performance on other sections (compensatory). It is a policy decision as to whether to use a conjunctive or compensatory approach for the final cut score decision. Table 11 presents the recommended range of cut scores based on this workshop.

Table 11 — Range of recommended values for each IELTS Module.

Module	Cut Score (Range)
Listening	6.5 (6.0 – 7.5)
Academic Reading	6.5 (5.5 – 7.0)
Speaking	5.5 (5.0 – 6.5)
Writing	5.5 (5.0 – 6.0)

Panelists' evaluation of their experience in the standard-setting workshop was positive. The panelists indicated confidence in the process used to set a cut score for both the Analytical Judgment and Round 2 of the Yes/No methods. They felt similarly confident in their overall estimation of the appropriateness of the passing scores they recommended. These factors lead us to conclude that selecting cut scores within the range of recommended cut scores for each module will result in making appropriate classifications of candidates based on the language skills for being at least minimally competent for entry-level nursing.

References

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Appendix A

Group Discussion of the Minimally Competent Candidate – Summary of Group Discussion NCSBN Standard Setting

October 30, 2004

Listening

Easy:

- Face-to-face, where there are a number of nonverbal clues
- Common terminology

Hard:

- Nonstandard word usage, jargon, abbreviations
- Nuances, double negatives, language that is complicated or contextual

Distinguish:

- Fine distinctions among common words that are critical to practice
- Minimally competent will be able to determine distinctions within context
- Speed of comprehension

Speaking

Easy:

- Verb tense
- Academically correct English

Hard:

- Using colloquialisms or slang
- Multiple meanings of the same word
- Culturally correct English usage

Distinguish:

- Appropriate use of jargon or technical language
- Questioning to ascertain understanding
- Sensitivity to the communication message
- Fluency, ability to generate more developed sentences

Reading

Easy:

- Nurses notes
- History/physical record
- Medication list

Hard:

- Doctors' orders
- Medical/technical words
- Reports from consultants
- Diagnostic reports

Distinguish:

- Comprehension, understanding of reading text
- Speed of reading
- Word recognition
- Medical/technical knowledge
- Grasp of English grammar
- Familiarity of the context they are asked to comprehend

Writing

Easy:

- Routine documentation within the nursing field
- Familiar words, context and terminology

Hard:

- Documenting nonroutine words
- Nonroutine tasks, (e.g., patient complaints, legal documentation)

Distinguish:

- Word choice, vocabulary
- Accuracy of the words, spelling
- Communicating and interpreting events (sequencing, organizing)
- Technically correct grammar
- Relevance, on target
- Translating patients words into relevant text

Appendix B

Evaluation Comments

Question 17 Other:

- Impact data was not always provided.
- I find all of the above useful.
- I used and weighed all.
- Professional judgment.
- Impact data and panel information.
- Second thought on the topic.
- P-values and Impact data.
- I was confident about my round one choice; thus, not much changes were made.

Question 18 Other:

- There really was no group discussion.
- All of them are useful tools.
- Weighed all.
- Copanelist choice.

Comments:

- More time should be allotted given the importance of the decisions being made on the basis of this workshop.
- I salute the staff and organizers of this semi-workshop! Great hardworking! Participants were all involved and friendly.
- First, thanks for the opportunity given me to be here as part of the panel. In the near future, though I do not know how the panel was drawn – I would suggest that those countries directly involved should be the majority. In as much as the panel is not supposed to set the passing standard, they can use the opportunity to communicate on face value the problems they encountered at their own time. The setting for the workshop should be rotated if possible – i.e., from place to place to make it more exciting. Everything considered, it was a wonderful experience – thanks.
- While Barbara is wonderful and put information in context, I wish she had given instructions more quickly. For some members of the group it seemed that longer explanations provided more time for their minds to wander. I appreciate her cheerful attitude and her patience. Thank you to everyone who helped organize this standard setting panel for all of their hard work. Thank you for inviting me. Please contact me when other panels are being organized [name and e-mail of panelist given].
- Everything went through as planned. It was a good experience and nothing needs to be changed.
- Yesterday's session was too long. The task done was also too much. I hope in the next standard setting workshop, we will be giving more time. Three days workshop will be better than one and a half days. All the same I enjoyed the standard setting workshop and looking forward to future workshops.

- Thank you so much for the opportunity to be a part of these very helpful workshops. I believe these are helpful in soliciting first hand experiences and set the standard of IELTS exams.
- I was not comfortable with the thought that I have to think or consider the number of test takers passing the IELTS. I thought more of how difficult it would be for the minimally competent to pass the IELTS and have a hard time being understood (conversational English) in the nurses, in my opinion, thus, I was not comfortable thinking about the minimally competent. I can speak through my own experience how disastrous it will be dealing with minimally competent English speaking nurses.
- The workshop was a very professional – growth for me in my nursing career. Thank you for choosing me. I feel so honored. Just a note: if you can add more time to all the writing area [because] I think when we had short time our mean score got closer (medium/maximum).
- Intro/Orientation: it was very interesting/helpful to hear from Annie Wendt about specific impacts on different populations and in specific circumstance. I think there might be changes in the actual test format (i.e., the first section – rockets) to make the test taking experience more conducive to assessing the skills you target. Another suggestion is separating the test questions and answer sheet from the reasoning to alleviate so much back and forth page turning. Thank you! The facilitators were excellent. I enjoyed the process – Good Luck.
- More information on lounge/expenses. Information on the task (can be send to some extend before the meeting). Better allocation of time (two equal work days, rather than a long and half day.)
- I felt the reading module should have been done earlier on Day 1 due to lack of focus toward the end of day. I felt the workshop in it of itself didn't promote group discussion except for the group report on Day 1 – possibly due to the fact we were pressed for time or this study didn't allow for discussion.
- Its an honor to be part of this workshop — thank you.
- I think supplying facilitators to guide the minimally competent candidate discussion could have helped the groups stay on task a bit better. Some panel members had their own agendas.
- I would like to suggest in the future standard setting workshops to give more extra time in conducting the workshop, because from my point of view, two days is not enough for the kind of meeting. We need a lot of time to listen, read and understand each topic. Thank you very much for inviting me in this workshop. It's a great experience for me.
- It would have helped if we were informed of change in agenda (e.g., dismissal at noon earlier to make changed in flights). Good arrangements otherwise.
- It was a good experience for me. I would be interested in future workshops.
- Need to go at a slower pace — Add 10-15 minutes to each session of review. I read slower than most people and felt rushed with the assignments. I usually finished only 5-10 minutes before the last finishers. This was a great learning experience [thanks] for all your support in helping make this a great experience!
- More explanation of the MCC within the context of nursing needs to be provided — descriptors such as a new graduate who passes the licensure exam; works in hospitals/long-term care, etc., would have been more helpful. Anne did a nice job, but facilitators did not incorporate her information — there was pressure to lower standards on all Round 2s that showed impact data. Telling us how much time left would have helped pace the work.

- It has been my pleasure being chosen to be part of this exercise. It did afford me the opportunity of putting what I learned in the University regarding testing into practice. I have to make the following recommendations, which I hope will be beneficial in planning future standard setting workshops.
  - I strongly believe that [the] people present here today should be used since their (previous) experiences would be an asset and thus promote understanding and accomplishments of the tasks expected.
  - That the location for the conference should be rotated around the USA. In so doing, the cost of hosting it in another state should be considered (i.e., cost benefit analysis).
  - Careful selection of participants should always be made so as to get the best result from all the resources invested in the project.
  - Once again thank you all for giving me an opportunity to make an input into this project. I shall make myself available for future assignment even higher than this one.
- Time is use efficiently – very good time management but physically draining.

Appendix C

Panelists' Round 2 Data for Each IELTS Module

Panelists' Rating for Round 2 Listening																														
Item Number	**Panelist**																													
	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39		
1	0	1	1	1	0	1	1	0	0	1	1	1	1	0	1	1	1	1	1	1	0	0	1	0	0	1	1	1	0.68	
2	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.96	
3	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1.00	
4	1	1	1	1	0	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.93	
5	1	1	0	1	1	1	1	0	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0.89	
6	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	0.93	
7	0	0	1	0	0	0	0	0	0	0	0	1	1	1	0	1	1	1	0	1	0	0	0	0	0	0	0	0	0.29	
8	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	0.96	
9	1	0	1	1	0	1	0	1	1	0	1	1	1	1	0	1	1	1	1	1	0	0	1	0	1	1	1	1	0.71	
10	1	1	1	1	0	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0.93	
11	1	1	0	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.93	
12	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	0	1	1	1	0.82	
13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0	1	0	0.18	
14	0	1	0	1	0	1	1	1	1	0	0	0	1	0	0	1	1	1	1	1	1	1	1	0	0	1	1	1	0.64	
15	0	1	1	0	0	1	1	0	0	0	1	1	1	0	0	0	1	1	0	1	0	0	0	0	0	1	0	0	0.39	
16	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	0.93	
17	1	1	1	1	1	0	1	1	1	1	1	1	1	1	0	1	0	1	1	1	1	1	1	1	1	1	1	1	0.89	
18	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	0	1	1	1	1	0	0	1	0.86	
19	0	0	0	1	0	0	0	0	0	1	1	0	1	0	0	1	1	0	0	1	0	0	1	0	0	0	0	1	0.32	
20	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0.14	
21	1	1	0	0	0	1	0	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.82	
22	1	1	0	0	1	1	1	1	1	0	1	0	0	1	0	0	1	1	1	1	0	0	0	1	0	0	0	0	0.50	
23	1	1	0	1	0	0	0	1	1	1	0	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0.79	
24	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	0	0.89	
25	0	0	0	1	0	0	0	0	0	0	1	1	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0	1	0.25	
26	0	1	1	1	1	0	0	0	1	0	1	0	0	1	1	1	1	1	1	1	0	1	1	1	0	0	1	1	0.64	
27	1	1	1	1	1	0	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0.89	
28	1	0	0	1	0	1	0	0	1	1	0	1	1	1	1	1	1	0	1	1	1	0	1	0	0	1	1	0	0.61	
29	1	1	1	1	1	1	0	1	1	1	1	1	1	0	0	0	1	0	1	1	1	1	1	1	0	1	1	1	0.79	
30	1	1	1	1	1	1	1	1	1	1	1	0	0	1	0	0	1	0	1	1	1	1	1	1	1	1	1	1	0.82	
31	1	1	0	1	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	0.86	
32	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0	1	1	1	0.86	
33	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.96	
34	0	0	1	0	0	1	1	0	0	1	1	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0	1	1	0.39	
35	1	0	0	1	1	1	1	0	1	1	1	0	1	1	0	1	1	0	1	1	1	1	1	1	0	1	1	1	0.75	
36	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	0	0.93	
37	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0.25	
38	0	0	1	1	1	0	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	0	0	0	1	0	1	0.71	
39	0	1	1	0	0	1	0	0	0	0	0	1	0	0	0	0	1	1	0	1	0	0	0	0	1	0	1	1	0.36	
40	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	0	1	0	0	1	1	1	0.82	
																													28.68	Sum of Item Averages
Panelist's rec	27	29	26	31	21	28	26	26	30	27	29	28	30	29	23	26	38	32	32	40	26	25	30	24	32	28	30	30	28.68	Panelists' Averages

Group Mean	28.68	Group Maximum	40
Group Median	28.5	Standard Deviation	4.00
Group Minimum	21		

Panelists' Rating for Round 2 Academic Reading

Item Number	Panelist																														
	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39			
1	1	1	1	1	0	0	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	0.82		
2	1	1	0	1	0	0	1	1	1	1	0	0	1	1	0	1	1	0	1	1	0	0	1	1	0	1	0	0	0.57		
3	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	0.93		
4	1	1	0	1	1	0	1	0	1	1	1	0	1	1	1	1	0	0	1	1	0	1	1	1	0	1	1	1	0.71		
5	0	1	1	0	0	1	1	1	1	1	1	1	0	1	1	0	1	1	0	1	1	1	1	1	1	0	0	1	0.71		
6	0	0	0	1	0	1	1	1	1	1	0	1	1	1	1	1	1	1	0	1	1	1	0	1	0	0	1	1	0.68		
7	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	0	0	1	1	0	0.82		
8	1	1	1	0	1	0	0	1	1	1	1	0	0	1	1	1	1	0	1	1	0	0	0	0	0	1	0	0	0.54		
9	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	1	0	0	0	0	1	0	1	0	0.21		
10	0	0	0	1	0	0	0	0	0	1	0	1	1	1	0	1	1	0	1	1	1	0	0	0	1	1	0	1	0.46		
11	0	1	1	1	1	0	0	0	0	1	1	1	0	1	1	1	1	1	1	1	0	0	1	0	0	1	0	1	0.61		
12	1	1	1	1	1	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1	0	1	1	0	1	1	1	0.86		
13	1	0	0	0	0	1	0	0	0	1	1	1	0	0	0	1	1	0	0	1	0	0	1	0	0	0	1	0	0.36		
14	0	0	0	0	0	1	0	0	0	1	1	1	0	0	0	1	1	0	0	1	0	0	1	0	1	0	1	1	0.39		
15	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	0	1	0	1	1	1	0.86		
16	0	1	0	0	0	0	0	0	0	1	1	1	0	0	0	0	1	0	1	1	0	0	0	0	0	1	0	0	0.29		
17	0	1	1	0	1	1	1	0	1	1	1	0	0	0	0	1	1	0	1	1	0	0	0	0	0	1	1	1	0.54		
18	1	1	1	1	1	1	1	1	1	1	1	0	0	1	1	1	1	1	0	1	0	1	0	1	0	1	1	0	0.75		
19	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	0.93		
20	1	1	1	1	0	1	1	0	1	0	1	0	1	1	1	0	1	1	0	1	1	1	1	1	0	1	0	1	0.71		
21	1	0	1	1	0	1	0	0	0	0	0	0	1	0	0	0	1	1	0	1	0	0	1	0	1	0	1	1	0.43		
22	1	0	0	1	1	0	1	1	0	0	1	1	1	0	0	1	1	0	1	1	1	0	1	0	1	1	1	1	0.64		
23	1	1	0	1	1	1	1	1	1	1	1	0	0	1	0	1	1	0	1	1	0	1	1	1	1	1	1	0	0.75		
24	0	1	0	0	0	1	0	0	0	0	1	1	0	0	0	0	1	0	0	1	0	0	0	0	0	1	0	0	0.25		
25	0	1	0	1	0	1	1	1	1	1	1	1	0	0	0	0	1	1	0	1	1	0	1	0	1	1	0	1	0.61		
26	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	0	1	1	0	1	0	1	1	1	1	1	0.86		
27	1	1	0	1	1	0	1	1	1	1	1	0	1	1	1	1	0	1	1	1	1	1	1	0	0	1	1	0	0.75		
28	0	1	0	0	1	1	1	1	1	0	1	0	1	1	1	1	0	1	1	1	1	1	1	0	1	1	1	1	0.75		
29	0	1	1	1	0	0	0	0	0	1	1	0	0	0	0	0	0	1	1	1	0	0	0	0	1	1	0	1	0.39		
30	0	0	1	0	0	1	0	0	0	1	1	0	0	0	0	0	1	0	0	1	1	0	0	1	0	0	0	0	0.29		
31	0	0	0	1	1	1	0	0	0	0	1	1	0	0	0	0	0	0	0	1	1	0	1	1	0	0	0	1	0.36		
32	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	0	1	0	1	1	1	1	1	1	1	1	1	1	0.89		
33	1	0	1	0	0	1	1	1	1	0	0	1	0	1	1	1	1	1	1	1	1	0	1	1	1	0	1	1	0.71		
34	0	0	1	1	1	1	1	1	1	0	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	0	1	0.82		
35	1	1	0	1	0	1	1	1	1	1	1	1	1	1	0	0	1	0	1	1	0	1	1	1	0	1	0	1	0.71		
36	1	1	1	1	1	0	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.93		
37	0	0	1	0	0	0	0	0	0	1	0	1	0	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0.21		
38	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0	1	0.18		
39	0	0	0	1	0	1	0	1	0	1	1	0	0	0	0	0	1	1	1	1	0	0	0	0	0	1	0	1	0.39		
40	0	0	1	0	0	1	0	0	0	1	1	0	0	0	0	0	1	0	1	1	0	0	0	0	0	1	0	1	0.32		
																													24.00	Sum of Item Averages	
Panelist's Rec	21	24	22	26	18	26	23	23	24	29	33	21	18	23	19	24	35	22	26	40	20	17	23	20	17	29	21	28	24.00	Panelists' Averages	

Group Mean	24	Group Maximum	40
Group Median	23	Standard Deviation	5.45
Group Minimum	17		

Panelists' Rating for Round 2 Speaking						
Panelist	**Incompetent**	**Incompetent**	**Competent**	**Competent**	**Mean**	**Median**
11	4	7	8	6	6.25	6.5
12	5	6	4	7	5.50	5.5
13	7	4	5	8	6.00	6.0
14	6	6	7	7	6.50	6.5
15	6	7	4	4	5.25	5.0
17	5	4	5	4	4.50	4.5
18	6	7	6	6	6.25	6.0
19	4	4	5	7	5.00	4.5
20	7	3	6	5	5.25	5.5
21	5	7	7	7	6.50	7.0
22	4	3	6	6	4.75	5.0
23	7	7	5	8	6.75	7.0
24	5	4	7	4	5.00	4.5
25	7	4	6	8	6.25	6.5
26	4	6	7	5	5.50	5.5
27	6	4	5	7	5.50	5.5
28	5	7	7	7	6.50	7.0
29	4	8	6	6	6.00	6.0
30	5	7	4	4	5.00	4.5
31	4	5	5	4	4.50	4.5
32	4	3	5	7	4.75	4.5
33	4	4	6	6	5.00	5.0
34	6	6	7	7	6.50	6.5
35	4	6	5	7	5.50	5.5
36	8	7	4	3	5.50	5.5
37	4	7	7	6	6.00	6.5
38	4	6	8	6	6.00	6
39	5	7	7	5	6.00	6

Group Mean	5.64
Group Median	6.00
Group Minimum	4.50
Group Maximum	6.75
Standard Deviation	0.67

Panelists' Rating for Round 2 Writing Task 1								
Panelist	**Incompetent**	**Incompetent**	**Incompetent**	**Competent**	**Competent**	**Competent**	**Mean**	**Median**
11	5	3	4	8	5	5	5.00	5.0
12	3	3	5	5	5	5	4.33	5.0
13	6	5	8	5	6	5	5.83	5.5
14	5	5	5	5	5	6	5.17	5.0
15	3	5	5	5	6	5	4.83	5.0
17	7	5	6	5	4	7	5.67	5.5
18	7	6	5	5	5	4	5.33	5.0
19	7	6	7	6	5	6	6.17	6.0
20	3	5	5	5	7	6	5.17	5.0
21	6	6	5	5	5	5	5.33	5.0
22	5	4	4	5	7	3	4.67	4.5
23	3	5	5	6	6	4	4.83	5.0
24	5	6	5	6	6	4	5.33	5.5
25	4	4	5	7	5	7	5.33	5.0
26	5	5	5	6	6	5	5.33	5.0
27	6	5	5	6	5	5	5.33	5.0
28	4	6	3	6	5	7	5.17	5.5
29	5	5	3	6	5	5	4.83	5.0
30	3	5	5	5	5	4	4.50	5.0
31	5	5	5	6	6	8	5.83	5.5
32	6	5	4	6	5	5	5.17	5.0
33	3	4	8	5	5	6	5.17	5.0
34	5	5	6	5	7	4	5.33	5.0
35	5	5	4	5	6	5	5.00	5.0
36	6	6	7	4	3	4	5.00	5.0
37	5	5	5	5	5	6	5.17	5.0
38	6	5	5	8	5	6	5.83	5.5
39	5	7	8	6	8	6	6.67	6.5

Group Mean	5.26
Group Median	5.00
Group Minimum	4.33
Group Maximum	6.67
Standard Deviation	0.49

Panelists' Rating for Round 2 Writing Task 2								
Panelist	**Incompetent**	**Incompetent**	**Incompetent**	**Competent**	**Competent**	**Competent**	**Mean**	**Median**
11	4	7	5	5	6	7	5.67	5.5
12	5	5	6	7	6	5	5.67	5.5
13	5	4	7	6	5	3	5.00	5.0
14	6	7	6	8	3	4	5.67	6.0
15	3	6	4	5	6	5	4.83	5.0
17	6	4	6	5	7	6	5.67	6.0
18	5	6	5	4	6	8	5.67	5.5
19	6	4	5	6	5	7	5.50	5.5
20	3	4	7	5	5	4	4.67	4.5
21	5	7	6	6	7	5	6.00	6.0
22	4	4	4	5	8	5	5.00	4.5
23	8	5	6	5	6	6	6.00	6.0
24	6	3	5	7	7	4	5.33	5.5
25	4	4	5	6	5	6	5.00	5.0
26	6	5	5	5	7	4	5.33	5.0
27	5	6	6	6	4	5	5.33	5.5
28	3	6	4	7	6	4	5.00	5.0
29	5	3	5	7	6	6	5.33	5.5
30	6	8	7	4	6	4	5.83	6.0
31	4	4	8	4	8	3	5.17	4.0
32	7	4	8	3	5	4	5.17	4.5
33	5	5	7	4	6	6	5.50	5.5
34	6	4	4	5	7	7	5.50	5.5
35	5	7	5	5	6	5	5.50	5.0
36	7	7	8	4	3	4	5.50	5.5
37	5	6	7	6	6	6	6.00	6.0
38	5	5	4	5	6	8	5.50	5.0
39	5	5	5	6	5	6	5.33	5.0

Group Mean	5.42
Group Median	5.00
Group Minimum	4.67
Group Maximum	6.00
Standard Deviation	0.35

Report of the Finance Committee

Recommendations to the Delegate Assembly

None. This report is for information only.

Background of the Finance Committee

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 FY05 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 ending September 30, 2004. With and without management present, the 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 (Attachment B).
- Reviewed and discussed with management and Legacy Professionals LLP the benefits and feasibility of establishing an Independent Audit Committee separate from the Finance Committee. Based on the review and discussion, The Finance Committee recommended to the Board of Directors to retain the current Finance Committee structure. The Finance Committee already serves as an independent audit committee. Establishing a second financial committee would not increase the independence of the audit oversight function or raise the standard of fiduciary care for the organization.
- Reviewed the "General Accounting Office Report" on mandatory auditor rotation (setting a limit on the number of years a public accounting firm may be allowed to audit NCSBN financial statements). The Finance Committee recommended an annual performance review of the independent accountant, but was not in favor of mandatory rotation. The cost out weighed the potential benefits and would not necessarily provide greater assurance of auditor independence.
- Reviewed and discussed the Long Range Forecast and proposed NCSBN budget for FY04. Recommended to the Board approval of the FY05 Budget.
- 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 Web site.
- Reviewed and discussed the results of the procedural Assessment and Investment Strategy review conducted by the investment consulting firm, Gofen and Glossberg. Reviewed and discussed the performance of NCSBN investments with representatives from the organization's investment consultant, Becker Burke, and the organization's Bond Investment

Members

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

Nancy Bafundo, BSN, MS, RN
Connecticut, Area IV

N Genell Lee, JD, MSN, RN
Alabama, Area III

Elizabeth Lund, MSN, RN
Tennessee, Area III

Rolf Olson, JD
Oregon, Area I

Charles Meyer, CRNA, MPA
Nebraska, Area II

Mary Dowd Struck, MSN, RN, CNM
Rhode Island, Area IV

Kathleen Sullivan, MBA, RN
Wisconsin, Area II

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

Staff

Robert Clayborne, CPA, MBA
Director of Finance

Meeting Dates

- October 28, 2004
- November 22, 2004
- January 31, 2005
- May 2, 2005
- July 7–8, 2005
- July 2005 (Conference Call, date TBD)

Manager, Richmond Capital Management. Based on the review and discussions referred to above, the Finance Committee recommended to the Board of Directors to revise the investment policy statement, to increase the designated permanent reserve amount and to change the asset allocation. The Committee approved the performance of the Investment Manager and reaffirmed the current investment policy (Attachment C).

- Advised the Board and made recommendations related to the finances of program activities:

  Nursys® Database

  a. Endorsed the staff recommendation to move the Nursys® data collection processing from the outside vendor to NCSBN.

  b. Recommended not sharing revenue from license verifications with Member Boards at this time. Should Member Board participation in Nursys® increase and verifications begin to generate a positive net revenue, the Committee would give further consideration to revenue sharing models.

Future Activities

- Review the budget proposal for the fiscal year beginning October 1, 2005.
- Review the liability insurance coverage.

Attachments

A. Financial Report FY05

B. Report of the Independent Auditors FY04

C. Investment Policy Statement

Attachment A

Financial Report FY05

At March 31, 2005, invested reserves equaled $45.4 million. The change in net assets totaled $3.3 million for the first six months of the fiscal year.

Revenue

NCLEX® Exam Revenue for the first half of FY05 increased by $889,000 from prior year for the same period. 86,468 paid registrations were processed for the six-month period ending March 31, 2005. This was a 5% increase over the FY05 count of 82,025.

31 boards are currently using Nur*sys*® for licensure by endorsement. Fee revenue totaling $817,000 for Nur*sys*® verifications is ahead of expectations and is projected to exceed the budgeted amount for the year.

NCSBN Learning Extension sales revenue increased by 27% for the first six months of FY05 compared to the same period for prior year. Sales revenue has been growing annually at an average of 20% for the last three years. With the addition of the NCLEX-PN® course, total sales growth for the unit was budgeted to grow by 36% for FY05. The early projections have sales revenue continuing double-digit growth for the full year, but less than the budgeted amount.

Investment returns were negative for the second quarter as both the stock and bond markets were down for the period. Year to date earnings totaling $310,000 provided a positive 0.7% return on investments for the six-month period ended March 31, 2005.

Expenditures

Total expenditures are projected to be favorable to budget. Savings on Nur*sys*® data collection expenses, Testing and Research projects, open positions and lower than expected travel rates will more than offset any unplanned spending. The pricing arrangement under the current contract for Nur*sys*® data collection services provides a significant cost savings. Some budgeted research projects will be deferred. Testing will spend significantly less than budget for two projects. There were 11 open positions for most of the first quarter, including six that remained unfilled on March 31, 2005. Actual airfare rates through the first half of the year have averaged 17% less than the budgeted amounts. In addition, travel activity for Testing Committees and test site visits will be less than planned. Also, there was a savings on staff travel because the Midyear Meeting was held in Chicago. The Board-approved project to bring the Nur*sys*® data collection process in-house was not budgeted for FY05. The project is estimated to cost $1.2 million. Work will start at the beginning of the third quarter of FY05 and is not expected to be completed until the second quarter of FY06.

Summary

Greater Pearson volume discounts, higher NCLEX registration income, along with lower spending will all contribute to what should be a significant increase in net assets for the fiscal year. If the forecast is accurate, NCSBN will add $6 million to its financial reserves. An already solid financial position continues to get stronger.

NCSBN FY05 Statements of Revenue/Expenses

	Year to Date Actual at 3/31/05	Annual Budget	Projected Actual	Variance Favorable/ (Unfavorable)	Variance %	Year to Date Actual as a % of Annual Budget
Revenue						
NCLEX® Revenue	17,907,896	40,800,000	43,514,000	2,714,000	7%	44%
NCLEX® Program Reports Royalty	0	80,000		(80,000)	-100%	0%
NCLEX® Quick results	150,295	240,000	300,000	60,000	25%	63%
NNAAP® Royalty Income	111,266	245,000	235,000	(10,000)	-4%	45%
NCSBN Learning Extension	457,265	1,168,000	1,111,000	(57,000)	-5%	39%
Nur*sys*® License Verification Fees	816,938	1,350,000	1,350,000	0	0%	61%
Nur*sys*® Data Query Fees	4,540	8,000	8,000	0	0%	57%
Meeting Revenue	35,875	143,000	140,000	(3,000)	-2%	25%
Other Publication Sales	13,503	14,000	14,000	0	0%	96%
Membership Fees	180,000	180,000	180,000	0	0%	100%
Investment Income	310,081	1,516,000	1,210,000	(306,000)	-20%	20%
NLCA Fees	48,400	43,000	43,000	0	0%	113%
Other Revenue	350	0	400	400		
	20,036,409	45,787,000	48,105,400	2,318,400	5%	44%
Expense						
Salaries	1,930,582	4,937,000	4,453,000	484,000	10%	39%
Fringe Benefits	524,214	1,297,000	1,227,000	70,000	5%	40%
NCLEX® Processing Costs	10,299,969	23,566,000	24,351,000	(785,000)	-3%	44%
Other Professional Service Fees	1,018,445	4,931,000	3,650,000	1,281,000	26%	21%
Supplies & Materials	37,754	119,000	119,000	0	0%	32%
Meetings & Travel	786,678	3,006,000	2,766,000	240,000	8%	26%
Telephone & Communications	91,873	399,000	399,000	0	0%	23%
Postage & Shipping	126,993	270,000	270,000	0	0%	47%
Occupancy	402,348	787,000	787,000	0	0%	51%
Printing, copying & Publications	113,925	453,000	453,000	0	0%	25%
Library/Memberships	33,010	67,000	67,000	0	0%	49%
Insurance	55,101	63,000	63,000	0	0%	87%
Equipment Rental & Maintenance	516,759	960,000	960,000	0	0%	54%
Depreciation & Amortization	817,871	1,697,000	1,697,000	0	0%	48%
Other Expenses	22,068	348,000	348,000	0	0%	6%
Total Expense	16,777,590	42,900,000	41,610,000	1,290,000	3%	39%
Surplus/(Deficit)	3,258,819	2,887,000	6,495,400	3,608,400		
Capital	209,673	1,021,000	1,621,000	(600,000)	-59%	

Attachment B

Report of the Independent Auditors FY04

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. (National Council) as of September 30, 2004 and 2003 and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the National Council'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, 2004 and 2003 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

November 9, 2004

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 Positions
Years Ended September 30, 2004 and 2003

ASSETS	2004	2003
Current assets		
Cash	$11,371,612	$6,655,974
Accounts receivable	317,846	342,776
Due from test vendor	1,299,729	138,298
Accrued investment income	352,181	268,777
Prepaid expenses	548,422	533,370
Inventories	-	4,018
Total current assets	13,889,790	7,943,213
Investments	36,081,967	27,785,117
Property and equipment		
Furniture and equipment	920,860	907,119
Course development costs	271,729	186,769
Computer hardware and software	6,848,710	5,461,805
Leasehold improvements	320,036	315,785
	8,361,335	6,871,478
Less accumulated depreciation and amortization	(5,179,070)	(3,770,952)
Net property and equipment	3,182,265	3,100,526
Cash held for others	478,903	368,901
Total assets	$53,632,925	$39,197,757
LIABILITIES AND NET ASSETS		
Current liabilities		
Accounts payable	$567,842	$559,536
Accrued payroll, payroll taxes and compensated absences	422,769	357,757
Due to test vendor	5,755,797	5,000,252
Deferred rent credits	576,804	606,807
Deferred revenue	254,296	231,161
Total current liabilities	7,577,508	6,755,513
Cash held for others	478,903	368,901
Total liabilities	8,056,411	7,124,414
Unrestricted net assets	45,576,514	32,073,343
Total liabilities and net assets	$53,632,925	$39,197,757

National Council of State Boards of Nursing, Inc.
Statements of Activities
Years Ended September 30, 2004 and 2003

	2004	2003
Revenue		
Examination fees	$42,361,987	$37,346,808
Other program services income	3,332,188	3,145,839
Net realized and unrealized gain (loss) on investments	(35,444)	348,996
Net realized (loss) on disposal of property and equipment	(1,439)	(91,679)
Interest and dividend income	1,520,861	1,121,622
Membership fees	183,000	-
Total revenue	47,361,153	41,871,586
Expenses		
Program services		
Nurse competence	24,009,745	23,838,930
Nurse practice and regulatory outcome	3,059,023	3,037,096
Information	5,057,624	4,627,426
Total program services	32,126,392	31,503,452
Supporting services		
Management and general	1,731,590	1,647,302
Total expenses	33,857,982	33,150,754
Net increase	13,503,171	8,720,832
Unrestricted net assets		
Beginning of year	32,073,343	23,352,511
End of year	$45,576,514	$32,073,343

National Council of State Boards of Nursing, Inc.
Statements of Cash Flows
Years Ended September 30, 2004 and 2003

	2004	2003
Cash flows from operating activities		
Net increase	$13,503,171	$8,720,832
Adjustments to reconcile net increase to net cash provided by (used in) operating activities		
Depreciation and amortization	1,476,306	1,377,524
Net realized and unrealized (gain) on investments	(259,114)	(428,000)
Net realized loss on disposal property and equipment	1,439	91,679
Loss on disposal of inventory	4,018	-
Bad debt expense	1,623	2,782
Changes in assets and liabilities affecting operations		
Decrease in accounts receivable	23,307	81,704
(Increase) decrease in due from test vendors	(1,161,431)	1,418,908
(Increase) in accrued investment income	(83,404)	(73,726)
(Increase) in prepaid expenses	(15,052)	(205,544)
(Increase) in inventories	-	(2,748)
Increase (decrease) in accounts payable	8,306	(212,910)
Increase (decrease) in accrued payroll, payroll taxes and compensated absences	65,012	(57,525)
Increase in due to test vendors	755,545	2,719,037
Increase (decrease) in deferred rent credits	(30,003)	606,807
Increase (decrease) in deferred revenue	23,135	(222,839)
Net cash provided by operating activities	14,312,858	13,815,981
Cash flows from investing activities		
Purchases of property and equipment	(1,474,524)	(1,669,513)
Investment in course development costs	(84,960)	(59,253)
Purchases of investments	(50,613,556)	(38,515,145)
Proceeds on sale of investments	42,575,820	29,964,237
Net cash (used in) investing activities	(9,597,220)	(10,279,674)
Net increase	4,715,638	3,536,307
Cash		
Beginning of year	6,655,974	3,119,667
End of year	$11,371,612	$6,655,974

National Council of State Boards of Nursing, Inc.
Notes to Financial Statements
Years Ended September 30, 2004 and 2003

Note 1. Description of the Organization

The National Council of State Boards of Nursing, Inc. (National Council[1]) is a not-for-profit corporation organized under the statutes of the Commonwealth of Pennsylvania. The primary purpose of the National Council 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 National Council 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, National Council 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. National Council does not have any temporarily or permanently restricted net assets.

Investments — Investments are carried at fair value that generally represents quoted market price as of the last business day of the year.

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 over the estimated useful lives of the related assets by the straight-line method. Furniture and leasehold improvements have estimated useful lives ranging from three and one-half to ten years, equipment and computer hardware and software have estimated useful lives ranging from three to five years and course development costs have estimated useful lives of three years.

Inventory — Inventories are valued at lower of first-in, first-out cost or market. Inventory is comprised of merchandise held for resale.

[1] Editor's Note: "National Council" is the legal name used by the National Council of State Boards of Nursing.

Due from Test Vendor — Due from Test Vendor represents amounts owed by NCS Pearson[2] for candidate applications received as well as rebates calculated on vendor performance and volume per contract. The amounts owed by NCS Pearson for the years ended September 30, 2004 and 2003 were $1,299,729 and $138,298, respectively.

Due to Test Vendor — Due to Test Vendor represents unpaid amounts to NCS Pearson for candidate testing. The amounts owed to NCS Pearson for the years ended September 30, 2004 and 2003 were $5,755,797 and $5,000,252, respectively.

Deferred Rent Credits — Deferred Rent Credits were established in conjunction with taking possession of new leased office space in 2003. The landlord abated the first three months of rent and made cash disbursements to the National Council in connection with the lease. These amounts are amortized to reduce rent expense over the term of the lease.

Deferred Revenue — Deferred Revenue consists of membership fees of $183,000 for 2004 and $189,000 for 2003, online course revenue of $18,296 for 2004 and $0 for 2003 and secretarial fees assessed to National Licensure Compact Administrators (NLCA) members of $53,000 for 2004 and $42,160 for 2003.

Statement of Cash Flows — For purposes of the statement of cash flows, the National Council considers all marketable securities as investments. Cash includes only monies held on deposit at banking institutions and petty cash. This 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.

Reclassifications — Certain reclassifications have been made to the prior year amounts to conform to the presentation for the current year.

Note 3. Tax Status

National Council 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, 2004 and 2003 consisted of the following:

	2004	2003
Bank One:		
Checking account	$538,368	$240,832
Money market account	10,123,399	6,042,253
SunTrust Bank:		
Checking account	68,862	28,188
Wells Fargo Bank:		
Commercial account	636,868	341,951
Credit card merchant accounts	3,865	2,500
Petty cash	250	250
Total	$11,371,612	$6,655,974

[2]Editor's Note: "NCS Pearson" is the legal name used by Pearson VUE.

National Council places its cash with financial institutions deemed to be creditworthy. Cash balances may at times exceed the insured deposit limits.

Note 5. Operating Lease

Effective May 29, 1997, National Council entered into a lease agreement for office space expiring April 30, 2004. During April 2003, National Council bought out the remaining term of the lease for $250,000. In July 2002, National Council entered into a lease agreement for new office space that commenced February 1, 2003, and expires January 31, 2013. In 2004, National Council signed two amendments to the lease for additional space, one commencing in January 2004 and the other in January 2005. The following is a summary by year of future minimum lease payments required under the new office lease as of September 30, 2004:

Year ending September 30	
2005	$434,399
2006	461,606
2007	477,047
2008	491,910
2009	506,950
Thereafter	1,801,299
Total	$4,173,211

Rent expense for the years ended September 30, 2004 and 2003 was $620,781 and $814,854, respectively.

Note 6. Investments

The composition of investments at September 30, 2004 and 2003 is as follows:

	2004	**2003**
U.S. Government and Government Agency obligations	$13,305,558	$12,569,350
Corporate bonds	18,330,917	11,320,420
Foreign obligations	—	254,480
Mutual fund	4,063,110	3,576,515
Money market fund	382,382	64,352
Total	$36,081,967	$27,785,117

Note 7. Retirement Plan

National Council maintains a defined contribution pension plan covering all employees who complete six months of employment. Contributions are based on employee compensation. National Council's policy is to fund accrued pension contributions. Pension expense was $325,421 and $296,906 for the years ended September 30, 2004 and 2003, respectively.

Note 8. Future Meetings

National Council has entered into contracts for services and accommodations for future meetings. These contracts include penalty clauses that would require the Commission to pay certain amounts if a meeting were to be canceled or guarantees for room blocks are not fulfilled.

Attachment C

Investment Policy Statement

POLICY NUMBER 8.5

POLICY NAME INVESTMENTS

DATE OF ORIGIN December 2002

PURPOSE The purpose of this investment policy is to assist the Board of Directors (Board) of National Council of State Boards of Nursing (NCSBN) in effectively monitoring and evaluating the investment funds to assure support for NCSBN activities in perpetuity.

1.0 POLICY

1.1 **Responsibilities and Delegation:** The Board, in fulfillment of its duty to oversee the management of funds of NCSBN shall:

- Establish the Investment Policy
- Ensure the prudent diversification of assets
- Delegate the management of investment funds to prudent experts
- Review at least annually the manager's investment performance, asset allocation, investment strategy and compliance with the Policy
- Review at least annually the Investment Policy, asset allocation guidelines and other policies impacting the funds
- Disburse investment funds for operations and other approved purposes.

The Board, at its discretion, may delegate all or portions of the ongoing oversight to the Finance Committee or an independent professional third party. In such instance, the Board retains the responsibility to monitor the delegated tasks. As fiduciaries, third party advisors, at all times shall be guided by the Standards set forth in the Uniform Prudent Investor Act.

1.2 **Spending:** The Board of Directors implements the spending rules (See Policy 8.2) pursuant to investment funds (reserve funds) for NCSBN. Fifteen million dollars of total reserve funds is designated as a permanent reserve fund. The designated permanent reserve fund allocation is nonexpendable. Liquid net assets in excess of $15 million serve as an operating reserve fund.

1.3 **Objective:** The reserve fund's primary objective is to support the NCSBN activities in perpetuity.

a. **Rate of Return:** NCSBN investment objective is to achieve a target rate of return (net of fee) over a three to five year period that will grow the total fund's value in real terms (after inflation) that at least equals 4% real growth.

b. **Risk Tolerance:** The perpetual nature of the designated permanent reserve allocation and the lack of regular withdrawals allows for significant short-term investment risk in terms of volatility in exchange for a high probability of long-term capital growth. The investment risk in terms of short-term volatility should be limited for the operating reserve fund. Liquidity needs for the operating reserve fund allocation are low and a liquidity reserve beyond that needed to facilitate trading is not currently necessary.

1.4 **Asset Allocation:** The Board of Directors has adopted asset allocation strategies for each reserve fund.

Designated Permanent Reserve ($15 million)

EQUITY	Lower Limit	Target	Upper Limit
U.S. Large Capitalization	$5.7 million	$6 million	$6.3 million
U.S. Small Capitalization	$1.35 million	$1.5 million	$1.65 million
International	$1.35 million	$1.5 million	$1.65 million
U.S. Bonds	$5.4 million	$6 million	$6.6 million
Cash			

Operating Reserve (Amount in excess of $15 million)

EQUITY	Lower Limit	Target	Upper Limit
U.S. Bonds	85%	90%	100%
Cash	0%	10%	15%

The Finance Committee will monitor allocations among Investment Managers to maintain asset allocation within the policy guidelines set forth herein. The Investment Management Consultant (the "Consultant") shall monitor asset allocations and recommend to the Finance Committee any changes needed to rebalance the fund. The Consultant also shall confer with the Committee at least semiannually, to determine whether to recommend any changes in the Acceptable Ranges of Commitment or changes in classes of assets held by NCSBN.

1.5 **Portfolio Management:** The permanent fund and the designated operating fund allocations are managed in a single portfolio.

- **Prohibited Transactions:** All Investment Managers are prohibited from investing in the following types of securities and or transactions: (1) derivative securities (for purposes of these guidelines, traditional mortgage and asset-backed securities are not considered derivatives, (2) margin buying or short selling (3) commodities and (4) private placements.
- **Diversification:** Funds are to be broadly diversified so as to limit the impact of large losses in individual investments.
- **Equities:** Equities purchased will be marketable on nationally recognized exchanges. The fund should not invest more than 5% of its equity investments in securities in a single company. Small cap equity exposure shall be achieved through purchase of a well-diversified index fund, mutual fund or exchange traded index shares. International equity exposure shall be achieved through purchase of a well-diversified index fund, mutual fund or exchange traded index shares.
- **Fixed Income:** With the exception of U.S. government bonds or government agency bonds, the total value of bond holdings of any single issuer will not exceed 10% of total bond holdings at the time of purchase. Should subsequent changes in asset allocation result in the bond holdings from a single issuer exceeding 10% of total bond holdings, reasonable efforts will be made to reduce the exposure to 10% or less. All securities held in the portfolio shall have a "Baa" or better rating at the time of purchase. In the event that a security's rating falls below "Baa," the security will be liquidated in an orderly fashion. The bond portfolio will be managed so that the aggregate credit rating of the portfolio will be at least an "AA-." Should changes in the ratings of individual issues cause the aggregate to fall below "AA-," an orderly restructuring will occur — through sales and/or purchases — to restore the aggregate to at least "AA-."

1.6 **Investment Managers:** The Finance Committee, with the assistance of third party experts, will identify and select appropriate Investment Managers. Any Manager must be a bank, an insurance company, an investment management company or an investment advisor as defined by the Registered Investment Advisers Act of 1940. The Investment Manager shall have full responsibility to vote all proxies prudently and in the interest of the fund. The Finance Committee will review the results of the Investment Manager at least semiannually. These reviews will focus on: (1) The Investment Managers' adherence to the guidelines, (2) Comparison of Investment Managers' results against funds using similar policies (in terms of diversification, volatility, style, etc.) and (3) Material changes in the Investment Managers' organizations, such as philosophical and personnel changes, acquisitions or losses of major accounts, etc. Additionally, each Investment Manager has the responsibility to promptly advise NCSBN staff and the Finance Committee of material changes in personnel, investment strategies or other pertinent information potentially affecting performance.

1.0 STANDARDS/CRITERIA

2.0 OPERATIONAL PROCEDURE

Report of the Governance and Leadership Task Force

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

Organizational Culture: A pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way you perceive, think and feel in relation to those problems.

Edgar Schein
Organizational Culture & Leadership, 1992, Jossey-Bass, Inc, Publishers

What have we learned as we have solved problems over time and what do we believe today? What were the assumptions and problems that helped build a strong NCSBN twenty-seven years ago and what are the assumptions and problems for today's environment? How will NCSBN stay strong now and in the future?

These questions have been the focus of the Governance and Leadership Task Force, which was directed by the Board of Directors to analyze the dynamics and structure of NCSBN and make recommendations to enhance the organizational culture that will support change and innovation. This task force's charge is one of three strategic objectives directed by the Board of Directors to fulfill the strategic initiative to enhance the organizational culture to support change and innovation.

This strategic initiative was the result of an intense planning process in which the Board of Directors identified key interdependent processes that drive strategic success. The NCSBN Strategic Map was created to illustrate this interdependence (See Attachment A). In order to fulfill the mission of the organization, there must be organizational development and organizational openness. This involves learning and growth related to dynamic governance, developing strong leaders, building organizational capacity, valuing communication with the membership and learning from others. Successful implementation of these concepts drives improvement of internal organizational efficiencies including enhancing organizational culture. An enhanced culture based on trust, transparency and communication is a blueprint for superior performance.

The Governance and Leadership Task Force began with a review of the Articles of Incorporation; the Bylaws; the work of the Practice, Education and Regulation Congruence Committee (PERC); the current mission, vision and organizational values and the 2000 Governance Survey of the membership. A consultant in governance assisted the task force in understanding best practices of not-for-profit organizations, legal responsibilities of a not-for-profit board, drivers of change, effective boards and committees and board trends.

A new membership survey on key governance issues was developed and distributed (See Attachment B). The results were shared with all boards of nursing. Key findings and further discussion was facilitated with the membership at the 2005 Midyear Meeting in Chicago. Recommendations for change are under development for presentation to the Board of Directors.

Highlights of FY05 Activities

- Reviewed charge and organized scope of work.
- Generated a list of organizational successes and challenge issues.
- Adopted Edgar Schein's definition of Organizational Culture.

Members

Polly Johnson, MSN, RN, Chair
North Carolina, Area III

Mary Ann Alexander, PhD
Illinois, Area II

Mary Way Bolt, EdD, RN
Maryland, Area IV

Shirley Brekken, MS, RN
Minnesota, Area II

Dan Coble, PhD, RN
Florida, Area III

Roberta Connelley, RN, BSN, MA
Louisiana, Area III

Marcia Hobbs, RN, DSN
Kentucky, Area III

Genell Lee, MSN, RN, JD
Alabama, Area III

Maris Lown, MS, RN
New Jersey, Area IV

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

Barbara Morvant, MN, RN
Louisiana, Area III

Laura Rhodes, MSN, RN
West Virginia, Area II

Sandra Hughes, Consultant

Staff

Kathy Apple, MS, RN, CAE
Executive Director

Chrissy Ward, Executive Office Relations/Meeting Manager

Beth DeMars, Executive Office Meeting Coordinator

Meeting Dates

January 6–7, 2005

March 9, 2005 (Conference Call)

April 10–11, 2005

June 20–21, 2005

Relationship to Strategic Plan

Strategic Initiative III
Enhance the organizational culture to support change and innovation.

Strategic Objective 1
Assess strengths and limitations in NCSBN that impact the organization's ability to be progressive, creative and responsive to change.

- Reviewed the NCSBN governance philosophy, role and responsibilities of the Board of Directors, Delegate Assembly and staff, the articles of incorporation, the Bylaws, volunteer leadership development and how to institutionalize effective governance.
- Developed and implemented a membership governance survey.
- Reviewed the results of the survey.
- Identified areas needing further input from the membership.
- Major topic areas identified were membership, nominations, Board of Directors, Delegate Assembly, Bylaws and committees.

Future Activities

- Develop specific recommendations for consideration by the Board of Directors.
- Develop a communication plan that keeps the membership informed and involved.

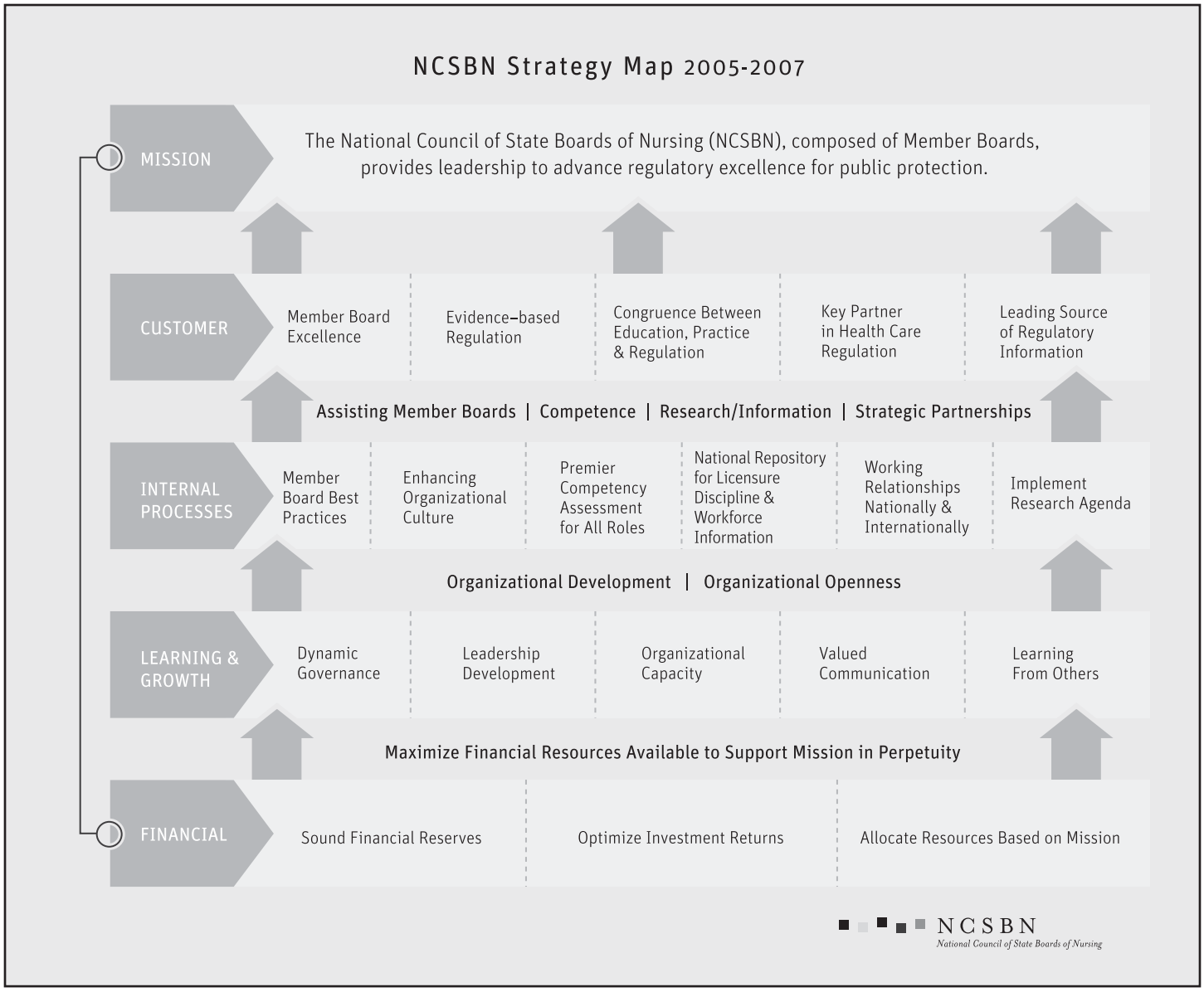
Attachments

A. NCSBN Strategy Map 2005-2007

B. February 2005 Governance Survey and Comments

Attachment A

NCSBN Strategy Map 2005-2007



Attachment B

2005 NCSBN Governance Survey and Comments

NCSBN would like to enhance the organizational culture to be more responsive to change and innovation. As part of studying the organization's governance structure, please offer your assessment of the strengths and limitations of the organization's ability to be responsive to change and innovation.

GOVERNANCE STRUCTURES:

The concept of geographical areas should be dissolved throughout the organizational structure.					
	A	B	C	D	Response Total
	10.9% (10)	20.7% (19)	31.5% (29)	25% (23)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: The concept of geographical areas should be dissolved throughout the organizational structure.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

BYLAWS

Consideration should be given to a membership category for former members of Member Boards or former Member Board staff.					
	A	B	C	D	Response Total
	12% (11)	32.6% (30)	31.5% (29)	18.5% (17)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: Consideration should be given to a membership category for former members of Member Boards or former Member Board staff.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

The Bylaws adequately reflect the legal, ethical, moral and fiduciary responsibilities of the Board of Directors.					
	A	B	C	D	Response Total
	14.1% (13)	59.8% (55)	5.4% (5)	3.3% (3)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: The Bylaws adequately reflect the legal, ethical, moral and fiduciary responsibilities of the Board of Directors.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

Consideration should be given to opening the membership to nurse regulators from other countries.					
	A	B	C	D	Response Total
	4.3% (4)	35.9% (33)	30.4% (28)	14.1% (13)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: Consideration should be given to opening the membership to nurse regulators from other countries.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

BOARD OF DIRECTORS

A consumer, who is not from a board of nursing, should be given a position on the Board of Directors.					
	A	B	C	D	Response Total
	9.8% (9)	31.5% (29)	27.2% (25)	23.9% (22)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: A consumer, who is not from a board of nursing, should be given a position on the Board of Directors.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

Increase the opportunity for membership participation by adding two additional positions to the Board of Directors for a total of eleven members.					
	A	B	C	D	Response Total
	14.1% (13)	45.7% (42)	25% (23)	4.3% (4)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: Increase the opportunity for membership participation by adding two additional positions to the Board of Directors for a total of eleven members.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

All terms of the Board of Directors should be either two-year or three-year terms to permit board development and continuity.					
	A	B	C	D	Response Total
	32.6% (30)	52.2% (48)	8.7% (8)	3.3% (3)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: All terms of the Board of Directors should be either two-year or three-year terms to permit board development and continuity.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

The Board of Directors should include a President Elect position to ensure effective continuity.					
	A	B	C	D	Response Total
	28.3% (26)	50% (46)	13% (12)	3.3% (3)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: The Board of Directors should include a President Elect position to ensure effective continuity.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

It is clear that the Board of Directors is accountable to the public interest.					
	A	B	C	D	Response Total
	16.3% (15)	44.6% (41)	17.4% (16)	4.3% (4)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: It is clear that the Board of Directors is accountable to the public interest.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

The role of the Board of Directors is to set organizational policy.					
	A	B	C	D	Response Total
	27.2% (25)	62% (57)	3.3% (3)	3.3% (3)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: The role of the Board of Directors is to set organizational policy.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

DELEGATE ASSEMBLY

The current Delegate Assembly allows for, and values, open debate and dissent.					
	A	B	C	D	Response Total
	14.1% (13)	55.4% (51)	18.5% (17)	4.3% (4)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: The current Delegate Assembly allows for, and values, open debate and dissent.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

The current Delegate Assembly structure allows for informed input by the Delegates on complex issues.					
	A	B	C	D	Response Total
	14.1% (13)	59.8% (55)	16.3% (15)	2.2% (2)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: The current Delegate Assembly structure allows for informed input by the Delegates on complex issues.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

Resolutions should be submitted 60 days in advance of Delegate Assembly to adequately assess all potential policy, fiscal and legal implications including consistency with the mission, vision and strategic initiatives.					
	A	B	C	D	Response Total
	18.5% (17)	46.7% (43)	22.8% (21)	4.3% (4)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: Resolutions should be submitted 60 days in advance of Delegate Assembly to adequately assess all potential policy, fiscal and legal implications including consistency with the mission, vision and strategic initiatives.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

NOMINATIONS & ELECTIONS

Persons who have a thorough understanding of the issues facing NCSBN and its Board of Directors should be an integral part of the nominating process.					
	A	B	C	D	Response Total
	31.5% (29)	54.3% (50)	10.9% (10)	0% (0)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: Persons who have a thorough understanding of the issues facing NCSBN and its Board of Directors should be an integral part of the nominating process.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

It is appropriate for NCSBN to utilize the experience and expertise of former Board members in the nominating process.					
	A	B	C	D	Response Total
	18.5% (17)	37% (34)	23.9% (22)	7.6% (7)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: It is appropriate for NCSBN to utilize the experience and expertise of former Board members in the nominating process.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

Board of Directors core competencies should be used to assess the viability of initial candidates and incumbents for placement on the slate.					
	A	B	C	D	Response Total
	22.8% (21)	55.4% (51)	8.7% (8)	4.3% (4)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: Board of Directors core competencies should be used to assess the viability of initial candidates and incumbents for placement on the slate.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

The Committee on Nominations should allow anyone who is qualified per the Bylaws, regardless of number, to be placed on the Slate of Candidates.					
	A	B	C	D	Response Total
	14.1% (13)	50% (46)	17.4% (16)	12% (11)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: The Committee on Nominations should allow anyone who is qualified per the Bylaws, regardless of number, to be placed on the Slate of Candidates.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

The term length of members of the Committee on Nominations should be expanded beyond two years.					
	A	B	C	D	Response Total
	4.3% (4)	18.5% (17)	50% (46)	7.6% (7)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: The term length of members of the Committee on Nominations should be expanded beyond two years.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

COMMITTEES

All committees should exist to support the Board's strategic decision making rather than to assist the staff in their work.					
	A	B	C	D	Response Total
	37% (34)	37% (34)	18.5% (17)	1.1% (1)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: All committees should exist to support the Board's strategic decision-making rather than to assist the staff in their work.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

Standing committees are essential to the effective operation of the organization.					
	A	B	C	D	Response Total
	39.1% (36)	48.9% (45)	4.3% (4)	3.3% (3)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: Standing committees are essential to the effective operation of the organization.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

Special committees are created to perform a specific task and dissolved when the task is completed and the final report given.					
	A	B	C	D	Response Total
	48.9% (45)	48.9% (45)	0% (0)	2.2% (2)	92
Total # of respondents: 92. Statistics based on 92 respondents; 0 filtered; 0 skipped.					

Legend for Rank Grid table: Special committees are created to perform a specific task and dissolved when the task is completed and the final report given.

Columns:
A - Strongly Agree
B - Agree
C - Disagree
D - Strongly Disagree
E - Don't Know/Unsure

OPEN ENDED QUESTIONS

What is the one thing you would do to enhance the organizational culture?	Response Total
	55
Total # of respondents: 92. Statistics based on 55 respondents; 0 filtered; 37 skipped.	

The Delegate Assembly should only make what decisions?	Response Total
	56
Total # of respondents: 92. Statistics based on 56 respondents; 0 filtered; 36 skipped.	

The Board of Directors should only make what decisions?	Response Total
	57
Total # of respondents: 92. Statistics based on 57 respondents; 0 filtered; 35 skipped.	

How can NCSBN demonstrate that your input as a member is heard and valued?	Response Total
	53
Total # of respondents: 92. Statistics based on 53 respondents; 0 filtered; 39 skipped.	

Which standing committees do you think are absolutely essential?	Response Total
	56
Total # of respondents: 92. Statistics based on 56 respondents; 0 filtered; 36 skipped.	

Are there any other comments you would like to add?	Response Total
	42
Total # of respondents: 92. Statistics based on 42 respondents; 0 filtered; 50 skipped.	

Survey Comments

What is the one thing you would do to enhance the organizational culture?

1. Minutes of the Board of Directors meetings should be sent to Executive Officer and Board Presidents for review after each meeting.
2. Look at work processes of staff.
3. I would enhance the leadership development offered by NCSBN at the Member Board level with new Executive Officers and board members. Some sort of online course for new Member Board staff and board members to introduce them the NCSBN and the work that is done.
4. Solidify official communications into one to two avenues; there are too many groups getting conflicting information within the organization.
5. Communication — not in terms of volume — but transparency and trust.
6. Increase the organization's efforts to assist Member Boards with regulatory initiatives — identify hot topics and provide readily available resources.
7. Establish greater clarity regarding the role of the Delegate Assembly vs. the role of the Board of Directors and restructure the Annual meeting with more opportunities for "issue-focused discussion/debate/dissent."
8. I believe we are not always as open or embrace new or potential new members or those who for what ever reason are not as active in NCSBN as some of us. Example at some of our meetings we have had people make comments or suggestions and we have not really recognized them or encouraged them. Example last summer in our discussion of having a Spanish form of NCLEX — we had a gentlemen who was an expert in is field that was a Consumer representative for his Board give good input and we seemed to not welcome it. We need to be very aware of others and listen and not give lip service. The feeling I got was in this situation that the Board had basically made up their mind and the discussion was an after thought. I would make sure we are not perceived doing this — How? — good question. But do believe the more active our membership is, the better organizational culture we will have.
9. Try and plan all meetings concurrently so less travel involved.
10. Provide information to schools of nursing about the organization.
11. Trust between the state bon and NCSBN.
12. I would facilitate more participation by State constituency board members, at all levels of the organization. However, from my experience, board staff, and NCSBN staff make up most committees, and participate most in the governance of the organization. This is probably due to the fact that Board members are volunteers, and board staff has more time to participate at NCSBN, however, NCSBN loses an important constituency voice with the current system.
13. Need to attract more qualified staff. The staff is sometimes excellent and sometimes clueless about regulation. I have been told that incompetent staff members cannot be replaced.
14. Have a closed executive session with delegates only and allow anyone to complain, present "concerns," etc., and allow for facts to be presented. Otherwise, speak now and stop your complaining.
15. Redefine the roles of the Delegate Assembly and the Board of Directors to clarify responsibilities for setting policy, for supporting the interests of the body at large, etc. and determine the need for and purpose of committees and task forces as either committees of the Board of Directors and task forces to assist staff/the Board with special projects.

16. Balance Board Member participation with professional staff members.
17. Change the qualifications of delegates in an effort to assure some consistency in the group from year to year.
18. Progress has been made in this area over the past couple of years. Various categories of regular conference calls, and more frequent written (e-mail) communications from staff regarding important matters are two examples of this.
19. Increase internal communication so there is a greater understanding of all that is being done rather than independent isolated work being done without link to appropriate other group's activities, e.g., staff person working on Nurse Aid Summit independent of group working on UAP/Delegation. Research is a prime example of duplicative efforts — Many individual groups looking at the same need for both literature and studies to be done — but no communication between the groups so that a consistent cost effective approach could be taken.
20. A better structure to the committees interfacing with each other and the interaction of the work so that it is not duplicated but compliments each other.
21. Work on establishing trust in the organization.
22. Enhance the dialogue among the state representatives.
23. Clarify the role of Board, Delegates and staff.
24. All committees need to work together. So many times two groups are working on the same topic and they are duplicating services.
25. As a new Executive Director I am very much impressed by the supportive culture.
26. Allow for more "inclusiveness" Involve more state board members and board staff in addition to executive officers. I think to keep these three legs of the stool equal is difficult, but is important to try to do.
27. Value volunteers. I believe NCSBN does this and it is one of their greatest strengths.
28. Have honest, open conversations about tough issues with the goal of having clear understandings at the end of the conversations. There appear to be issues/concerns that are pushed under the table and/or decided by a small group of individuals prior to consideration by the full membership if they are ever offered for consideration by the full membership and this needs to stop.
29. Allow boards who are unable to attend the delegate assembly to vote on issues by e-mail or mail.
30. I would like to see more Diversity in the make up of the Board of Directors. I don't think you should just put a minority on the board just to fill the minority slot; rather the person needs to have the appropriate credentials as required by Bylaws.
31. Utilize Midyear for decisions — in a time of rapid change, decisions only annually is limiting.
32. Encourage more participation by the LPN membership, perhaps by designating two Board positions to be LPN positions, as seen on State Boards. LPNs are an integral part of the health care team, and their opinions should matter.
33. I think the organization is fearful of new thought processes. The organization seems to find comfort in "legacy" members. Very little change.
34. More Member Board input into major initiatives.
35. Ensure balanced representation of paid staff and board members in leadership positions, standing committees, and task forces so that NCSBN is an inclusive organization

36. Increase Diversity.
37. Have fewer Executive Directors serving in leadership positions.
38. Set up plenty of networking opportunities.
39. People who are appointed to boards in states are often disadvantaged and not knowledgeable about the bigger national picture. To promote a culture of global thinking, a uniform NCSBN orientation video/DVT could be helpful to get new member up to speed. This would need to be updated annually.
40. IMPROVE DELEGATE COMMUNICATION WITH THE COUNCIL.
41. (1) Try to an active participant of the activities of NCSBN and make use of the knowledge and skills gained to bring nursing regulation/education/practice issues up to national standards in our own Member Board jurisdiction. (2) Educate nurses/nursing students about the mission and vision of NCSBN.
42. Somehow develop trust between the Delegate Assembly and the Board of Directors. I'm tired of the "us" and "them" mentality.
43. Clearly articulate the work of the board and the work and responsibilities of the delegate assembly as well as continuing to enhance the communication to the membership.
44. Encourage more futuristic thinking and challenging to the "way we have always done it."
45. Set up networking meetings, and Area Meetings at Midyear and Delegate Assembly at a time and way that shows they are valued. Small groups should have a culture of bringing forth new ideas.
46. Strengthen member input.
47. Make clear the provision of the certificate of incorporation to all delegates.
48. Shorten committee terms to one year to encourage participation.
49. Better communication between the Board of Directors and Member Boards.
50. Have two business meetings a year. Allow the delegate assembly to vote on yearly initiatives of the organization.
51. Assure inclusiveness of all members and increase opportunities for mentoring of delegates and new members.
52. There is an appearance of an old-boys network. A few select people tend to push all the initiatives. It takes too long for new members to learn the ropes and to be effective. States without term-limited boards exercise disproportionate control.
53. Develop new approaches to recruitment of Board Members that stresses ability to frame issues, tolerance for ambiguity, appetite for NCSBN organizational puzzles, support robust discourse from Member Boards on critical issues at Delegate Assembly and in between, a commitment to developing the core competencies/capacity of all staff within the membership and NCSBN.
54. Socialize new members into the role Allow for more discussion Allow dissention as part of healthy debate but once the vote is taken the group should project to constituents that there is one voice.
55. To constantly reinforce the belief that the NCSBN is there for the state boards of nursing. If the Member Boards start to believe that the Council thinks it's bigger than the boards or gives the impression that boards get in their way of what they want to do or feel they should do, there will be a backlash on the part of the boards and the boards will feel a greater need for control and power.

The Delegate Assembly should only make what decisions?

1. Anything that may impact Member Boards.
2. Broad Policy.
3. Approve Bylaws Decisions regarding the NCLEX examination (fees, approve test plan, etc.).
4. Goals of the organization election of officers approval of budget changes to NCLEX examinations.
5. Policy decisions for the direction of the organization.
6. Strategic — including evaluative decisions.
7. Major NCLEX-related decisions (that need to be spelled out by policy); approve annual budget; Bylaws; election of officers/Board of Directors.
8. All decisions that are related to our mission, strategic initiatives, issues on the NCLEX development and implementation.
9. Strategic.
10. Proposed changes in Bylaws or major changes in processes that affect Member Boards.
11. Election of Board of Directors, Bylaws, strategic planning.
12. Major policy decisions.
13. Elect the board and set very general direction. They should get out of the micromanaging, especially in regards to the exam.
14. Elect the Board of Directors, establish and affirm mission, set broad organizational direction, identify key issues and concerns, adopt examination test plans, adopt and amend Bylaws.
15. Those that require buy-in by Member Boards.
16. Examination related decisions — changes, where given, who can take it, for what reasons can a person take the exam. Anything exam related that is not a process issue between NCSBN and Pearson VUE. Any decision that has a history of being a passionate issue or that you think will be a passionate issue. Better to err on the side of seeking input from the membership. Dissolution. Other membership categories.
17. The Delegate Assembly should make decisions which impact the profession as a whole, or which impact how Boards do their work. Over the years there has occasionally been some degree of "territorial conflict" as to whose authority supersedes whose (e.g., Delegate Assembly vs. Board of Directors).
18. Approval of work products.
19. Those that effect the organization's plans, goals, leadership and Bylaws.
20. In my opinion, the delegate assembly should make any decisions that the collective body supports.
21. What is provided in Bylaws.
22. I am not able to answer this question.
23. What the Bylaws allow....testing issues, direction of organization.
24. All major decisions, e.g., cost of NCLEX, procedures for the exam, major policy issues.
25. Unable to respond at this time (new).
26. Mission of the organization Strategic plan of the organization Structure of the organization Test plan and some related testing decisions that may have significant ramifications for

individual states. Bylaws of the organization.

27. Test service selection Bylaws changes elect officers/nominating committee adopt strategic plan accept reports, provide feedback on those reports.
28. This issue needs to hashed out among the members. If it is not specifically and clearly addressed there will continued dissension. Delegate Assembly should make or minimally be consulted concerning all major policy decisions and the Board of Directors should handle the day to day issues and emergency matters required to make the organization successful in fulfilling its mission.
29. If the majority of state boards is represented at the Delegate Assembly then it should have the right to vote on issues impacting all states but preclude decision-making that address third-party reimbursement and fee structure.
30. Policy decisions.
31. Decisions that the Board of Directors deem necessary to be brought to the Delegates.
32. Policy.
33. Election of Board of Directors; decisions related to NCLEX as an assessment of competency for state licensure; adopt strategic plan developed by the Board of Directors.
34. Major direction of the organization.
35. All decisions which affect constituent members.
36. Bylaws, elect officers, mission, vision, approve strategic plan (major programs).
37. Test plan.
38. Structure, NCLEX decisions, various membership concerns. Actually, I like it the way it is being done now.
39. Major decisions on strategy and initiatives that impact boards across the nation.
40. QUESTION TOO BROAD.
41. (1) NCLEX exam issues. (2) Practice/Education/Research issues. (3) Finances of the organization. (4) Membership issues to NCSBN. (5) Election of officers; Board of Directors; standing committee's chair.
42. Vision Mission Test Plan.
43. Approval of fiduciary process; resolutions that are consistent with the strategic plan; elect board members; set the direction of the organization.
44. Those identified in the Bylaws and that represent a major change in organizational goals, structures or processes.
45. Acceptance or approval of position papers. Approve the test plan. It should not approve the test company contract. Approve Bylaws.
46. Resolutions.
47. NCLEX and Compact (when all are on board).
48. All policy decisions.
49. All exam-related issues. Board of Directors election. Strategic plan approval — but it needs to be fleshed out with enough detail to know what the initiative means.
50. The delegate assembly should vote on all matters that any one Member Board would have jurisdiction over. Membership in the organization should not be aiding and abetting jurisdictions to skirt the laws/rules/regulations regulating their agency.

51. This should be the place where policies are discussed and agreed upon. There should be ample opportunity at annual meeting and midyear meeting for debate/discussion of issues.
52. Good ones :) governance decisions impacting nursing regulation.
53. Don't know.
54. The Board of Directors and Member Boards should use the annual meeting to think together to discover strategic priorities and drivers that are currently or futuristically intended to enhance the organizational value to the Member Boards and their mission. Board of Directors and Member Boards should discuss strategic data/evidence from multiple sources to make decisions that support evidenced based regulation.
55. NCLEX.
56. Major policy decisions and directions. Testing Service contracts. Approval of NCSBN Strategic Plan — Goals and Objectives, not Tactics. The Delegate Assembly should not micromanage, nor should it put up barriers that hinder the NCSBN to be able to respond to issues in a timely manner.

The Board of Directors should only make what decisions?

1. Decide on the direction of NCSBN, and then based on what is decided, this is brought for discussion at Delegate Assembly.
2. More specific policy.
3. Decisions regarding the operations of the organization.
4. Implementation of strategic plan Monitoring of budget/finances.
5. Strategic planning to ensure policy direction is on target.
6. Policy and monitor how the strategic decisions are being carried out.
7. Strategic initiatives and objectives; Vendor selection for NCLEX-related services (to be spelled out in policy); committee appointments and charges; fiscal and governance policies.
8. Should make decisions that will enact the strategic initiatives, resolutions of the Delegate Assembly and management of the NCLEX as indicated by the Delegate Assembly.
9. Policy and Strategic Planning.
10. Office policies and operational decisions that decisions are needed more quickly and that have minimal affect on Member Boards.
11. Decisions that reflect the charge of every state nursing board which is protect the public.
12. Implement policy and oversee direction.
13. Policies, council operations, the exam and all other decisions of national stature.
14. Determine long-range strategic goals and annual objectives, establish organizational (not operational) policy, hire and evaluate the Executive officer, appoint standing committees, set executive compensation, adopt the annual operating budget.
15. What NCSBN represents to public and to Member Boards.
16. Any decision that is in the best interest of the organization as a business, however, any business decisions that relate to the exam should go before the Delegate Assembly. Any decision for which they believe they have all the information and the information is current. I'm thinking of any decisions about letters expressing positions on issues.
17. The Board of Directors sets policy for the organization, which will be implemented by staff. This is based in part upon the directives set forth from the Delegate Assembly, however the Board is elected by the membership and therefore should have some degree of decision-

making authority on their behalf.

18. Policy.
19. On how the above are implemented.
20. The Board of Directors should operate at the behest of the Delegate Assembly, carrying out the strategic initiatives authorized. In addition, the board should function between delegate assemblies to set policy to keep the organization "nimble", i.e., functioning effectively, efficiently and proactive.
21. What is provided in Bylaws.
22. Same.
23. Strategic planning, policy, fiscal.
24. Internal organization. The Board of Directors guides the Executive Officer of the NCSBN.
25. Unable to respond at this time (new).
26. Executive Director and other key positions of the organization. Objectives, plans to carry out strategic plan of the organization Committee structure and membership Organizational membership in other organizations Priorities of funding of activities Consistency within the various departments of the organization.
27. Appoint special committees, select members evaluate executive director, make hiring/firing decisions on executive director act on recommendations of committees, give feedback to committees accept fiduciary responsibility for NCSBN Decisions necessary to monitor/lead the organization between meetings of the delegate assembly.
28. Decisions concerning those policy issues, which are emerging, issues that have clearly been delegated to the Board of Directors and those needed for day-to-day operation of the organization that are outside the scope of the Executive Directors authority.
29. Issues, which the Delegate Assembly is unable to reach consensus.
30. Decisions necessary to function between meetings.
31. The Board of Directors should have the authority to make most of the decisions.
32. Policy recommendations to the Delegate Assembly and operational decisions during the year.
33. Allocation of organizational resources (fiscal and human) by broad categories of function; business decisions related to the direction of the organization's strategic initiatives; fiscal responsibilities related to revenue/investments and review of audit; committee appointments and charges; evaluation of organizational effectiveness.
34. Those reflected in the Mission of the organization.
35. Carrying out the directives of the Delegate Assembly.
36. Operational decisions to facilitate board functioning.
37. Everything else, policy related to strategic plan, not to get involved in operations.
38. Everything but test plan.
39. Personnel and budgetary operations.
40. Operational decisions that support major strategy decisions accept reports and serve in a role that guides the HOD in the same way an exec can guide a state board.
41. DECISIONS AFFECTING HOW THE COMPANY IS RUN. THIS QUESTION IS ALSO TOO BROAD.
42. (1) Issues discussed/presented at General Assembly and need a final decision. (2) Pressing issues that require decision, but within the authority of the Board of Directors, without

approval of general assembly.

43. Should govern the organization by developing and monitoring strategic initiatives, contracts, exam test plans.
44. Overall all responsibility for the budgetary process; Decisions consistent with the strategic plan and direction set by the Delegate Assembly.
45. Decisions specific to continuing to advance the work/goals of the organization; respond to national / international regulatory issues; selection of committee chairs (committee chairs should select members); hiring of executive director.
46. Governance decisions There should be greater separation of the Examination work and the Board work. There needs to be almost a separate entity, much like organizations that do program review are separated from the rest of the organization and its work.
47. Decisions of policy and strategic direction.
48. Policy and strategic planning.
49. Staffing and personnel. It should be quite clear that most members do not favor or want a strong central Board of Directors, but want to retain the control within the membership at large.
50. Organization governance decisions. Committee membership and charge. Should guide committee work and review and accept committee recommendations for consideration. Issues that impact the fiscal health of the organization.
51. How to carry out the will of the delegate assembly.
52. On issues that are clearly defined by previously delineated policies.
53. Governance.
54. Don't know.
55. Ensure a balanced budget based on the strategic plan. Review and accept the annual audit. Approve contracts with vendors. Hire the right CEO. Interact with Member Boards when making decisions that impact their Nurse Practice Act/Rules/Policies. Decide proposals submitted are consistent with the mission and values of NCSBN. Identify and work to resolve really significant issues; e.g., full participation in Nur*sys*, full participation of CORE Data Collection/Reporting, participation in Practice Breakdown data collection; development of evaluation tools to objectively assess safety to practice; develop software options to make the Member Boards more effective/efficient and to facilitate the export/ collection of data from Member Boards that support evidenced based regulation.
56. Policies Procedures Day to day operations.
57. Implementation of Delegate Assembly decisions and Strategic Plan. Issues that come up and must be dealt with between Delegate Assemblies. Relationships with other national nursing organizations. Major contracts, except for the testing services.

How can NCSBN demonstrate that your input as a member is heard and valued?

1. Responding to inquiries, bringing up ideas brought forth. I see a problem at this time.
2. It already does.
3. I think that happens currently.
4. Provide policy feedback on drafts with 30 day time frame for responses.
5. Not have to get it validated by two or three others — but NCSBN does do OK on this.
6. Through outcomes — actively seeking out the needs or wants of the member and then demonstrating how they were achieved.

7. Have more open discussion sessions on current issues at annual meeting rather so much formal Delegate Assembly structure; acknowledge the breadth of input received and value of such when decisions are made.
8. We do give good recognition to those members who are active in NCSBN committees and etc., but we need to make sure that the Board members, committee members and or staff give some personal feedback with all of members for their input or even attending that first meeting. The personal touch does make people feel valued. Sometimes in big organizations the little person feels lost or not valued.
9. Have area reps contact Member Boards for input and then report back to the NCSBN board.
10. By actually responding in a helpful way to a request for national data. I am usually told to do it myself even though the issue is a national one.
11. I think they do a great job already.
12. By reporting on how decisions are made, indicating consideration of input from all constituent members, by soliciting involvement of each Board as committee members, responders to surveys, invitations to participate in meetings, recognition of outstanding work and contributions to nursing regulation.
13. Call and talk with Board Presidents or Executive Officers and ask opinions. Schedule 10 or 15 minute blocks of time to meet with the President or Executive Officers during Midyear or Delegate Assembly.
14. I feel that this is already the case.
15. Changes in work products in response Realigning strategic initiatives as situation changes Don't give "false reassurances" about what can be accomplished. Review the literature and identify best practices in valuing others.
16. By continuing and fostering those opportunities for ideas to be exchanged.
17. Report out the collective results and not defend current policy if it disagrees with the results.
18. Have it brought up at Midyear so the board of directors can assess it and then bring it to the delegate assembly.
19. Committee participation.
20. So far the input appears unwanted so it would be nice to assure that Board members and staff actually hear those with dissenting opinions.
21. I believe it is doing a much better job. Input is received and implemented. Although I am still very concerned with the research department and all the projects we have going on. Because of the sudden departure of research staff, studies are not being done/completed and I question someone stepping in the role in the middle of these studies. This is not a good practice in research.
22. Unable to respond at this time (new).
23. This is real difficult — probably best by actions taken from issues that are brought up at the Delegate Assembly. A major problem is that "member" is not clearly defined in this organization. "Member" is really a Member Board, but yet this question is focused on member as an individual. What are you wanting for input from individual members versus Member Boards?
24. Most importantly a culture that is open and supportive of differences where opinions are thoughtfully considered and where input is sought. The organization must be accessible and responsive, respectful and fair to all. The organization must be courageous and unapologetic in taking a position after the member's input has been appropriately solicited and considered.

25. Allow each member to vote on issues regardless of whether a representative can be physically at a Delegate Assembly.
26. By acknowledging input.
27. By having the Board of Directors bring decisions that they deem necessary to have input from the general body.
28. Utilize Midyear as described above.
29. I do receive feedback for most comments that I have. I do feel that LPNs are not as valued as they should be, however.
30. Sufficient forums (virtual and physical) to consider issues.
31. Perhaps placing a "response" to issues on the Web site...such as a FAQ section to address Member Board issues.
32. By doing such as this.
33. By bringing regulatory function issues to Delegate Assembly, and trusting the Member Boards to fairly debate and vote on these issues.
34. NCSBN does it well.
35. I think that is already happening.
36. I do not have any strong advice on this question.
37. KEEP BREAK OUT GROUPS TO ENCOURAGE FREE DIALOGUE.
38. (1) Should be addressed in standing committees, Midyear meetings, or general assembly and be given feedback. (2) Territories Member Boards should be made a participant of research to see what's happening with nursing regulation, education and practice in this part of the world, because of lack of resources.
39. No comments.
40. Provision of opportunities for open dialogue with the Board and Executive Director at annual and Midyear meetings.
41. Timely feedback.
42. Respond to what is said. Summarize this survey and report to the membership what has been learned. Provide greater opportunities to network. This should go beyond the hallway conversations over break. Because Areas have been almost dissolved, some of the working together of groups that are non committee has been lost.
43. Decisions reflect the input of all members with differing views acknowledged.
44. Continue open and forthright discussing at Delegate Assembly as well as reports from committees and research results.
45. Conduct business at both the midwinter meeting and the Delegate Assembly. A year is too long to wait for most issues.
46. Remain open to advice and comments.
47. NCSBN, stop marketing yourself. This organization is not about you, the NCSBN. It is about Member Boards.
48. Distribution of minutes to all Member Boards so that we are informed.
49. That is not currently a problem in my opinion.
50. Don't know.
51. I applaud the work of this task force in collecting information to improve NCSBN. Encourage

the task force to develop two "dashboards" to monitor the organizational performance and the Boards performance.

52. Do not discount opinions from certain members who tend to dissent, act supportive, be supportive.
53. I feel that NCSBN does hear and value my input. However, I do think there is a some feeling in the organization that NCSBN Board and staff only value and listen to an informal group of the "chosen few" that influences the decisions/direction of the organization.

Which Standing Committees do you think are absolutely essential?

1. The ones we have currently. I think the Board did a good job a few years back by decreasing the number of standing committees.
2. PR&E Committee. I am on this committee and we met last week and discussed how, perhaps, other committees could present info to this committee who would then decide what to submit to the Board of Directors (not exam or finance). Each of the members on this committee would be a member on one of the other committees so we have a better cohesion of what we are doing. We found other committees are working on things that impact this committee and provide valuable information. It could be used to develop a continuum from prelicensure to competency as we discussed in the PR&E committee.
3. Not sure.
4. Education, Bylaws, Resolutions and Finance.
5. Bylaws, Finance and Exam.
6. Finance, maybe Exam.
7. Testing, Practice and Education.
8. Finance, Board governance/leadership development (remake of Nominating Committee); Bylaws called only when necessary.
9. Believe that all of the current ones are still essential — if we do change the geographic issue — we still need to be assured of representation by all — committees could be a part of that process for grass roots input.
10. The ones currently in place.
11. Exam, PR&E, finance.
12. Exam, Advanced Practice, Finance, Nominations, Resolutions, CORE, Practice Breakdown, Regulation.
13. None.
14. Nominating, Finance/Audit, Bylaws.
15. I think they all are at a minimum. The importance of NCSBN has grown to amazing proportions and its work is very, very important.
16. The ones currently listed in the Bylaws; however, in many cases the Bylaws Committee is not a standing Committee. I can see it either way.
17. Finance, Exam, PR&E.
18. Nomination, PR&E, Exam.
19. PR&E as oversight to all committees that work on practice, regulation and education. I think the time is at hand to study the committee structure and the role.
20. Exam and Practice. Not sure what the other committees are.
21. The five in the Bylaws.

22. Nominations, Policy, Research.
23. Examination, Bylaws, Finance.
24. PR&E, Nominations, Examination, Item Review, Policy, Discipline.
25. Unable to respond at this time (new).
26. Nominating Bylaws Examination Practice Nursys Compact Administrators When ever there is a service developed to be utilized by the Member Boards such as the exam, Nursys, the compact then there needs to be a committee overseeing these activities to assure that they are serving their users and to get input on how best to expand and/or modify their service.
27. Exam.
28. Practice, Regulation & Education; Examination Committee.
29. Bylaws, nominations, executive strategic planning.
30. I think that decision should be made by the Board of Directors and NCSBN staff.
31. PR&E, PERC, Nominations, Examinations, Bylaws, Finance, Resolutions.
32. I think that all of the standing committees are equally essential.
33. Nominating Committee; NCLEX Committee.
34. Financial There is great waste in most committee/task force meetings.
35. CORE is the only one I am familiar with.
36. Exam Committee; Practice, Regulation and Education Committee; Finance Committee.
37. Exam Committee
38. Bylaws, finance, nomination.
39. Bylaws; Nominating; Practice, Education and Research.
40. Finance, Bylaws, Nominations, Compact Administration, Testing related.
41. Examination, Practice/Education/Research, Finance, Nominations, Bylaws.
42. Exam Practice.
43. Finance, Bylaws, Nominations, Item review — I believe any others should be task forces with assigned charges. It seems some committees are doing the work of staff particularly the Practice Breakdown Research Advisory Panel.
44. CORE, APN Practice Breakdown Governance.
45. Examination, Practice/Education, Finance Bylaws should be a dormant committee like a volcano. The committee only comes to life when there is a need for change. Careful drafting of Bylaws should lead to infrequent changes.
46. Finance.
47. Strategic Planning, Practice and Education, NCLEX.
48. Finance.
49. Bylaws, Finance and Examination.
50. Examination, Discipline, Advanced practice, Finance, Practice.
51. Nominating, Bylaws, Examination Committee.
52. Not sure at this time.
53. Finance, practice, testing.

54. Don't know.
55. Committees must adapt to the strategic priorities/imperatives, not the organizational chart of NCSBN. Would suggest the finance committee be renamed "finance & investments" and remain to handle importance fiduciary responsibilities. Would ask the Board of Directors to explore these questions: does the committee structure match the NCSBN 2005 priorities? What did each committee accomplish over the past two years that was strategically indispensable? And based on that data, determine which standing committees are absolutely essential.
56. Finance Examination.

Are there any other comments you would like to add?

1. I do think it's a disadvantage to be a board member that has been active to suddenly, when my term is up, to lose any input I might be able to give. Currently on the PR&E Committee I believe I am the only "practicing" member of the committee. Perhaps adding a "public member" who is not affiliated with the board would be helpful. Also when you asked about a "public member" being added to the board of directors, have you considered the public member to be just that, not a member of the Member Boards? Thanks for the inquiries.
2. I would consider opening membership to regulators from other countries in an associate category (nonvoting).
3. The staff need customer service training and responsiveness time frames, performance measures set in policy.
4. Thank you for opportunity to evaluate and comment.
5. Need to eliminate dual reporting lines for Exam Committee and make that committee consistent with all others in terms of reporting to the Board of Directors. Need to focus the annual meeting on education/discussion sessions on a variety of regulatory issues with only a small amount of time spent in doing business in the Delegate Assembly structure; this includes limiting the amount of business that would come to delegates who are often not nearly as informed, as is the Board of Directors.
6. Thanks for this opportunity. A number of good questions and thoughts — after I think some more and have more discussion of these ideas my view may change. Always open to change.
7. I have really appreciated the support and opportunity to work with NCSBN.
8. Increased efficiencies of committees would allow Member Board members to participate more frequently in NCSBN governance.
9. PERC committee can be eliminated.
10. We still have too many "us v them" in this organization which keeps the organization moving forward. We are still strapped in an isolationist mentality. This needs to end.
11. I think it is time to consider reorganization of NCSBN in order to allow for a broadening of our focus (globalization of nursing regulation) and to capitalize on the talent and creativity of our membership as well as the commitment of the Board of Directors to lead NCSBN forward. It's time for the membership to trust the Board of Directors to do what they have been elected to do and for the membership to focus its energy on the bigger picture.
12. Educate Member Boards. They do not have the resources to make smart decisions without help.
13. Surveys such as this is a great way for members to be heard and I encourage you to continue using them. I hope that this survey or at least one that is similar is used for Member Boards.
14. I would like to serve as a Director-at-Large or a Regional Director.
15. The questions presuppose that the current organizational structure does not work and yet,

innovation and creativity has more to do with the individuals than the organization, I think.

16. Since I have been associated with NCSBN for over five years, I have seen a great many of positive changes. I would like to see the NCSBN open the delegate assemblies to more member staff. I have only been to one (Washington, D.C.) and was disturbed at so many of the office assistants for the NCSBN attending. I would rather see Member Boards staff (disciplinary, Practice, Education staff — RN) attend.
17. I have asked the President of our State's BON to respond to this survey since I felt I was unable to contribute the information that may prove useful to NCSBN.
18. Not really — other than to look at and determine if a Midyear meeting is really needed — it seems sometimes pretty redundant to the Delegate Assembly. It's also very disconcerting when so many attendees leave the Midyear meeting and the Delegate Assembly prior to the conclusion of the meetings. Also with so much turn-over in that position and lack of attendance by all, are the Executive Officer retreats really that beneficial or are they turning into professional development for a select few paid for by the many? I think the individual Executive Officer orientation that is being done at the NCSBN offices sounds like a wonderful idea.
19. No.
20. I commend the officers of the NCSBN for doing a wonderful job. You have brought many issues to light in an approachable, handle able manner.
21. Good survey.
22. I have thoroughly enjoyed all of the opportunities that I have had to serve NCSBN.
23. NCSBN is a vibrant organization which must poise itself as a significant player in regulation in a global environment.
24. I personally feel that the NCSBN has become an "empire" and has moved well beyond its original intent. It appears that there are hidden agendas driven by persons who are in repeating roles in the organization (e.g., Board members elected — reelected, etc).
25. I believe NCSBN sometimes pursues initiatives (such as testing in foreign countries) and excessive emphasis on mutual recognition that is not necessarily efforts that support Member Boards to better fulfill their missions.
26. If I may speak candidly, I would like to identify a concern. I have heard and share the perception that there exists an elite "inner circle" inside the NCSBN leadership structure. Whenever there is an inner circle, there coexists a larger outer circle. Granted, inner and outer circles exist in most large organizations. The challenge within NCSBN, as I see it, is to create an atmosphere of trust so that open dialogue can occur between these circles. Our organization will be strengthened by embracing an inclusive rather than exclusive culture.
27. No.
28. Like anything, you get out of it what you are willing to put into it. If people are willing to participate and be involved, I have found the door to be open and welcoming.
29. CONSIDER OPENING UP THE COMPACT DIRECTORS MEETINGS AS EDUCATIONAL OPPORTUNITIES. RIGHT NOW IT HAS A SENSE OF BEING AN EXCLUSIVE CLUB.
30. 1. NCSBN should plan a site visit to U.S. Territories Member Boards at least every two years or send representatives to assist with technological advancement (technical assistance); and education consultant to review/assist approval of nursing programs due to lack of resources. 2. NCSBN should write a position paper on how to deal with foreign educated physicians who are switching to nursing and wanting to challenge the NCLEX exam.
31. I believe the leadership of the council has been greatly improved in the past two to three years and the Board has become a policy making board. Certainly the loss of staff has

created discontent but the work goes on!!!

32. The skills of board staff are mixed and often outdated; many focus on sustaining the current work and are reluctant to challenge existing processes that are problematic or burdensome to effective work processes.
33. The survey questions were biased. A more thoughtful input could have been obtained if this survey were printable for complete understanding of the survey before responding. Two-year terms for board members and committees may not be appropriate to get the best input. Most Member Boards have longer terms than does the NCSBN Board of Directors and committees.
34. Committees are important to the organization and allow for gathering of all viewpoints. There is no reason to have standing committees but members should be included in committees, task force etc.
35. No.
36. Question 15: It is unclear if "former board members" means former members of the Board of Directors or former members of Member Boards.
37. Stop redoing the mission statement. I know "consultants" have suggested these revisions. However, there is lots of literature and organizational success stories of groups that stayed true to the mission. We need to decide who we are, what we are trying to do and do those things. We can't be all things to all people. Go back to the original mission of the organization. Go back to the basics. International regulation should be handled by a different group. You can't specialize in U.S. regulation and international regulation and do both well.
38. I am concerned that NCSBN is not very connected with the other Advance Practice national organizations. The discussion of the ND as level of entry for APNs is an issue that needs a lot more discussion with all stakeholders.
39. Keep up the good work.
40. You need to be careful where you hold the national committee meetings. They are so isolated that you cannot leave the premises, or it is too expensive to leave. You need to improve this group planning and location.
41. To think strategically, the Board need only intelligent questions and not necessarily all the answers. The answers emerge with two-way communication with Member Boards. NCSBN needs to be a strong organization where "gifted leaders facilitate consensus on issues."
42. Thank you for asking for our input. NCSBN does a nice job and we should be proud of our organization.

Report of the Member Board Leadership Development Advisory Panel

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

The Member Board Leadership Development Advisory Group is charged with developing continuing education programs for Member Boards and providing orientation for newly appointed board presidents and executive officers. It assures the functioning of a mentorship program and reviews recommendations of the board presidents participating in the network session.

Highlights of FY05 Activities

- Conducted the second annual Institute of Regulatory Competence: Practice Violations and Discipline in San Francisco, January 10–12, 2005.
- Recommended an Institute of Regulatory Excellence logo to the Board of Directors.
- Recommended a project evaluation form for the Institute of Regulatory fellowship program (Attachment A) and an evaluation plan for the Institute of Regulatory Excellence (Attachment B).
- Developed an Institute of Regulatory Excellence project development review process.
- Planned for the third annual Institute of Regulatory Excellence: Nursing Competence and Evaluation/Remediation Strategies.
- Discussed the feasibility of a certification program.
- Assigned seasoned executive directors as coaches to new executive directors.
- Developed a networking program for the Member Board presidents at the 2005 Midyear Meeting.
- Provided Member Board presidents with the publication, *Nonprofit Board Answer Book* .
- Provided executive directors and Member Board presidents with the publication, *Governance as Leadership*.
- Reviewed the outline and program objectives of the web-based NCSBN 101 Membership Orientation Program before implementation in May 2005.
- Developed the 2005 Midyear leadership program for Member Board presidents and executive directors.
- Explored opportunities for education development of Member Board operations staff and methodology to collect data regarding a needs assessment.
- Needs assessment of Member Boards operations staff to be conducted in May 2005.

Future Activities

- Implement third annual Institute of Regulatory Excellence: Nursing Competence and Evaluation/Remediation Strategies to be held in Atlanta, Georgia on January 9–11, 2006.
- Complete content/budget planning, for the fourth annual Institute of Regulatory Excellence: Organizational Structure and Behavior.
- Continue to evaluate the Institute of Regulatory Excellence impact in expanding the body of

Members

Joey Ridenour, MNC, RN, Chair
Arizona, Area I

Joan Bouchard, MSN, RN
Oregon, Area I

Shirley Brekken, MS, RN
Minnesota, Area II

Dan Coble, PhD, RN
Florida, Area III

Cynthia Persily, PhD, RN
West Virginia–RN, Area II

Board Liaison
Gregory Y. Harris, JD
Arizona, Area I

Staff

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

Alicia Byrd, BSN, RN
Member Relations Manager

Meeting Dates

- September 20–21, 2004
- November 22–23, 2005
- March 7–8, 2005
- June 23–24, 2005
- September 26–27, 2005

Relationship to Strategic Plan

Strategic Initiative I
Facilitate Member Board excellence through individual and collective development.

Strategic Objective 1
Conduct regulatory leadership and governance education in accordance with three-year plan.

knowledge related to regulation and research through scholarly work.

- Conduct a series of educational sessions for operations staff based on needs assessment data.
- Develop program for Member Board presidents at the 2006 Annual Meeting based on the Midyear session evaluations.
- Conduct quarterly conference calls with Institute of Regulatory Excellence participants to discuss progress on projects/research.
- Offer a research course to interested individuals.

Attachments

A. Institute of Regulatory Excellence Project/Research Evaluation Form

B. Institute of Regulatory Excellence Program Evaluation Plan

Attachment A

Institute of Regulatory Excellence Project/Research Form

Proposal Title:

I. Abstract

Provide a brief summary of your proposed project/research study.

II. Background/Significance

Project: Discuss briefly your project including the value of it to regulation. Include any relevant background information in this field and why you feel the project would benefit nursing regulation.

Research study: Discuss briefly the status of work in this field and give the most recent findings in the literature with emphasis on relevant discrepancies in knowledge. The literature should provide supporting rationale for this project. References for the literature review should be provided. How will data provide answers to the specific aims stated in your study? Why is it important to answer these questions? How will your study fill gaps in existing knowledge?

III. Specific Objectives/Goals

Project: What is/are the major objective(s)/goals of your project? This information should be clear and concise.

Research Study: What is/are the major objective(s)/question(s)/issue(s) of the investigation? This information should be clear and concise. What are the study hypotheses? If no hypotheses are generated, please justify.

IV. Process

Project: Describe the process by which the project will be completed.

Research Study:

Design: Describe the study design with rationale for elements of design (e.g., cohort, case control, randomized).

Sample: Identify the study setting and the source of the study participants. Describe the target population from which your sample will be drawn. Specify how the sample size was determined. If the sample size was determined in combination with a power calculation, give the details of the calculation. Give the inclusion and exclusion criteria for the study.

Procedures/Protocol: If applicable, describe fully the treatment under study, including procedures to be performed, number, frequency and duration of visits and specific study requirements. Provide operational definitions for all explanatory variables (e.g., independent variables, contributory variables, risk factors, predictive variables or prognostic factors) and all response variables (e.g., dependent variables, endpoints or outcomes). Describe any potential confounding variables and the methods used to control for them.

Data Collection/Instrumentation: Describe the methods of data collection or measurement. Include a full description of instruments as applicable, including amount of time necessary to complete, appropriateness to population, established psychometric properties, reliability, validity, precision and accuracy. Describe any quality-control methods that will be used to ensure completeness and accuracy of data collection.

Data Analysis: Describe the statistical procedures that will be used to analyze data for each question or hypothesis. Describe how you will handle missing data. Identify the statistical package or program to be used to analyze the data.

VI. Final Product

What will be the final product? What will be submitted to NCSBN?

Attachment B

Institute of Regulatory Excellence Program Evaluation Plan

MBLDAP = Member Board Leadership Advisory Panel

Criteria	Method	Evaluators
1. Degree to which seminars met the objectives of the Institute a. Generate highly valued annual institutes of graduate level regulatory education b. Expand the body of knowledge related to regulation through research and scholarly work c. Develop the capacity of regulators to become expert leaders based on establishment of core competencies d. Develop a network of regulators to collaborate on research questions and improve regulatory practices and outcomes	Quantitative 5-point Likert scale	Attendees MBLDAP Staff
2. Degree to which seminars met individual offering objectives a. 2004 Public Policy Development & Role of Nursing Regulators i. Explain legal responsibilities and authority of boards of nursing ii. Discuss the factors that affect the policy development process in a regulatory environment iii. Compare and contrast the public policy elements of various health professions' Model Practice Acts iv. Illustrate the use of major ethical principles in the regulatory environment b. 2005 Nursing Practice Violations and Discipline i. Develop an awareness of the theoretical and legal basis for discipline ii. Discuss the value of regulation related to public safety iii. Articulate knowledge of disciplinary systems and distinguish among punishment, remediation and justice iv. Evaluate the tension between the need for consistency in board actions with the desire for individual consideration c. 2006 Nursing Competency, Evaluation & Remediation Strategies i. Develop an awareness of the theoretical basis for the evaluation of competency ii. Analyze existing and emerging models of competency evaluation iii. Identify strategies for remediation iv. Discuss evidence-based indicators of effectiveness in promoting public safety, education, regulation and remediation d. 2007 Nursing Regulatory Systems: Administration & Evaluation	Quantitative 5-point Likert scale	Attendees MBLDAP Staff

3. Participant Demographics a. # of attendees per year b. # of continuing attendees per year c. # projects initiated d. # projects completed	Raw Data	Staff
4. Individual presenter/topic evaluations a. 2004 b. 2005 c. 2006 d. 2007	Quantitative 5-point Likert scale	Attendees MBLDAP Staff
5. Evaluation of projects/evidence-based research a. Achievement of outcomes projected b. Poster evaluation c. Replication of research d. Acceptance of project report e. Use of mentors	Quantitative 5-point Likert scale Anecdotal	Delegate Assembly Attendees MBLDAP Staff
6. Feedback on influence of projects on policy decisions a. Valuable evidence-based information/background for board and regulatory issues b. Information triggers discussion of policy c. Information incorporates results into policy decisions	Quantitative Frequency Distribution Anecdotal	Executive Officers Member Board Presidents Attendees MBLDAP NCSBN Committees CORE
7. Evaluation of changes in individual attendee's practice a. Description of changes in: i. Practice ii. Policy iii. Regulation iv. Education v. Discipline.	Qualitative	Attendees Focus Group

Report of the Nursys® Advisory Panel

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

The Committee is charged with:

1. Enhancing the Nursys® database system;
2. Achieving the current Board strategy of 100% participation in disciplinary data and increased participation in licensure data;
3. Addressing Member Board day-to-day issues.

Highlights of FY05 Activities

- Increased participation in Nursys® by three Member Boards (Alaska, Virginia and West Virginia – PN), bringing the total number of Member Boards participating to 31.
- Increased the number of Member Boards submitting disciplinary data into Nursys® to almost 100%.
- Increased frequency of HIPDB data submission to monthly.
- Reviewed speed memo functionality and usage.
- Updated the Data Access Authorization and Restrictions Requirements form.
- Updated policies 1.5 and 1.7.
- Continued to strategize on increasing participation.

Future Activities

- Implement additional features to Nursys® including:
  - Exam information simplification
  - Nurse Imposter Alert
  - Nurse Workforce Data Collection
  - Acceptance of APRN licensure data
  - Reduction of duplicate records
  - Compact privilege to practice discipline enhancement.
- Review policies and procedures as needed.

Attachments

None

Members

Sheryl Meyer, Chair
Minnesota, Area II

Lanette Anderson, RN, BSN, JD
West Virginia – PN, Area II

Adrian Guerrero, IT Representative
Kansas, Area II

Adam Henricksen, IT Representative
Arizona, Area I

Lisa Ferguson Ramos, Enforcement Representative, Ohio, Area II

Board Liaison
Mark Majek, MA, PHR
Texas, Area III

Staff

Angela Diaz-Kay, MBA
Director, Information Technology

Debbie Hart, Administrative Assistant

Meeting Dates

- July 9, 2004
- September 13–14, 2004
- November 12, 2004, Conference Call
- January 24–25, 2005
- May 16, 2005
- July 11, 2005, Conference Call

Relationship to Strategic Plan

Strategic Initiative V
Advance NCSBN as the leading source of data, information and research regarding nursing regulation and related health care issues.

Strategic Objective 2
100% participation in Nursys® for both licensure and disciplinary data.

Report of the Practice Breakdown Advisory Panel

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

The Practice Breakdown Advisory Panel has continued the work begun in 2000 to tap into the rich source of data that has been collected in discipline cases, using that information to identify sources of nursing error. Boards of nursing are well positioned to add to the body of knowledge surrounding this aspect of medical errors. Working with consultant Dr. Patricia Benner, 20 pilot discipline cases submitted by boards of nursing were analyzed by delving deep into the factual content of cases, using information obtained from a variety of redacted materials ranging from the initial complaint to nurse narrative, other witness statements, investigation reports, hearing transcripts and staff interviews. When available, the analysis included the nurse's story in his or her own handwriting and/or transcripts of the nurse's interactions with the regulatory agency. Characteristics of various nursing errors were described and classified. The study of cases also involved analysis for root cause, system contributions and practice responsibility.

The audit instrument developed from the pilot cases is called TERCAP – *A Taxonomy of Error, Root Cause Analysis and Practice Responsibility*. This instrument was used to track case elements and recurring themes. The goal of the project was to learn from the experience of nurses who have had episodes of practice breakdown and to discover characteristics of nurses at risk. The overall aim is to promote patient safety by better understanding nursing practice breakdown and by improving the effectiveness of nursing regulation.

Highlights of FY05 Activities

- Final revision of TERCAP instrument and Coding Protocol.
- Launched electronic TERCAP on March 1, 2005.
- Provided training in use of electronic TERCAP to representatives of 40 Member Boards.
- Requested that each Member Board submit five discipline cases resolved from January 1, 2004 to April 30, 2005 via the electronic TERCAP.
- Distributed the TERCAP Toolbox, a CD with multiple resources, at Midyear Meeting (mailed to Member Boards not in attendance).
- Presented TERCAP information at Institute for Regulatory Excellence (January 2005, San Francisco) and the NCSBN Midyear Meeting (March 2005, Chicago).
- Drafted second article on development of tool.
- Conducted inter-rater reliability study of TERCAP.
- Wrote and edited book based on TERCAP Categories and pilot cases.

Future Activities

- Submit book for publication.
- Submit article for publication.
- Complete analysis of cases collected March 1 – April 30, 2005.
- Plan for presentation of the data analysis.

Members

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

Patricia E. Benner, RN, PhD, FAAN
Consultant

Karla Bitz, PhD, RN
ND, Area II

Karen Bowen, MS, RN
Nebraska, Area II

Lisa Emrich, MSN, RN
Ohio, Area II

Marie Farell, RN, PhD, FAAN
Consultant

Vicky Goettsche, RN, BSN, MBA
Idaho, Area I

Linda Patterson, RN, BSN
Washington, Area I

Kathryn Schwed, JD
New Jersey, Area IV

Kathy A. Scott, RN, PhD
Consultant

Mary Beth Thomas, MSN, RN
Texas, Area III

Board Liaison

Donna Dorsey, MS, RN, FAAN
Maryland, Area IV

Staff

Vickie Sheets, JD, RN, CAE
Director of Practice and Regulation

Kevin Kenward, PhD
Director of Research Services

Kelly Michale, Practice and Regulation
Administrative Assistant

Relationship to Strategic Plan

Strategic Initiative V
Advance NCSBN as the leading source of data, information and research regarding nursing regulation and related health care issues.

Strategic Objective 1
Conduct research that provides evidence regarding regulatory initiatives that supports public protection.

Strategic Initiative II
Promote evidence-based regulation that provides for public protection.

Strategic Outcome A
Support Member Board adaptation of best practices.

Meeting Dates

- September 27–29, 2004
- December 15–16, 2004
- January 24–25, 2005
- March 7–8, 2005
- May 12–13, 2005
- July 11–12, 2005

- Make recommendations to Board of Directors regarding next phase of research.
- Evaluate TERCAP tool.

Attachments

None

Report of the Resolutions Committee

Recommendations to the Delegate Assembly

None. This report is for information only.

Background

The Resolutions Committee is a standing committee responsible for reviewing, evaluating and reporting to the Delegate Assembly on all resolutions and motions submitted by the delegates of Member Boards. The Committee is also charged with reviewing the resolutions process and making recommendations for process improvement.

Highlights of FY05 Activities

- Reviewed the Delegate Assembly Resolutions meeting process.
- Reviewed the Resolutions Committee Operating Policies and Procedures, Motions Submission Form and Fiscal Form and determined there were no revisions.
- In April 2005, sent to the Membership the Resolutions Solicitation Letter, Resolutions Committee Operating Policies and Procedures, Motions Submission Form and Resolutions Fiscal Form. A web link to these documents posted on the Members Only side of NCSBN's Web site was also sent to the membership.

Future Activities

The Resolutions Committee is scheduled to meet at Annual Meeting on the following dates:

- Tuesday, August 2, 2005
- Wednesday, August 3, 2005

Attachments

A. Resolutions Solicitation Letter

B. Resolutions Committee Operating Polices and Procedures

C. Motions/Resolutions Submission Form

D. Resolutions Fiscal Form

Members

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

Gloria Damgaard, MS, RN
South Dakota, Area II

Sandra Evans, MAEd, RN
Idaho, Area I

Louise D. Hartz, Consumer Member
Virginia, Area III

Roberta L. Schott, LPN
Washington, Area I

Margaret Walker, MBA, BSN, RN
New Hampshire, Area IV

Staff

Alicia Byrd, RN
Member Relations Manager

Meeting Dates

- October 20, 2004 (Conference Call)
- April 12, 2005 (Conference Call)

Attachment A

Resolutions Solicitation Letter

NCSBN
National Council of State Boards of Nursing

National Council of State Boards of Nursing, Inc.
111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277
312.525.3600
312.279.1032
www.ncsbn.org

April 1, 2005

TO: Executive Officers
Member Board Presidents

FROM: The FY05 Resolutions Committee

Chairperson
Charlene Kelly, PhD, RN, Executive Director, Nebraska Department of Health and Human Services Regulation and Licensure, Area II

Committee Members
Gloria Damgaard, RN, MS, Executive Secretary, South Dakota Board of Nursing, Area II
Sandy Evans, MAEd, RN, Executive Director, Idaho Board of Nursing, Finance Committee, Area I
Louise D. Hartz, Board Member, Virginia Board of Nursing, Area III
Roberta Schott, LPN, Board Member, Washington State Nursing Care Quality Assurance Commission, Area I
Margaret Walker, MBA, BSN, RN, Executive Director, New Hampshire Board of Nursing, Area IV

RE: Call for Motions/Resolutions to the 2005 Delegate Assembly

The Resolutions Committee is seeking motions/resolutions for consideration by the Delegate Assembly at the 2005 NCSBN Annual Meeting, August 2-5, in Washington, D.C.

Use this link https://ncnet.ncsbn.org/about/governance_pgov_delegate_assembly.asp to access these key documents that will enable the maker to develop motions/resolutions that conform to the NCSBN Bylaws, 2005 Standing Rules (pending delegate approval) and the Resolutions Committee Operating Policies and Procedures.

- Resolutions Committee Operating Policies and Procedures
- Motions/Resolutions Submission Form
- Fiscal Impact Statement
- NCSBN Bylaws

The Resolutions Committee encourages you to submit motions/resolutions early. Please use the Motions form and Fiscal Impact Statement when submitting a motion. These forms are also available in a printable version on the NCSBN Web site.

Resolutions Committee Open Membership Call:
The Resolutions Committee will be hosting a call on **Tuesday April 12, 2005 @ 2:00 pm (CST)** to give the membership a chance to interact with the Committee members and ask questions or raise issues regarding the submission process or their particular motions/resolutions.

Motions/resolutions may be submitted at any time up to and through Delegate Assembly.

As a reminder, only delegates, the NCSBN Board of Directors and the Examination Committee (for approval of test plans) may make motions/resolutions at the Delegate Assembly.

Please contact Alicia E. Byrd if you have any questions at 312.525.3666 or abyrd@ncsbn.org. **All submission forms can be completed electronically, then print the form, sign and send via fax to 312.279.1032 to the attention of Alicia Byrd at the NCSBN office**.

cc: NCSBN Board of Directors
Kathy Apple, Executive Director

Attachment B

Resolutions Committee Operating Policies and Procedures

Purpose

The Resolutions Committee is a standing committee of the Delegate Assembly established under Article X (1)(e) of the NCSBN Bylaws to review, evaluate and report on all motions and resolutions submitted to the Committee by a delegate. The operating policies and procedures serve to guide the work of the Committee and the formulation of motions and resolutions by makers.

Policy

1. All resolutions and nonprocedural main motions unrelated to the election of officers and directors must first be submitted to the Chair of the Resolutions Committee before being presented to Delegate Assembly.

2. The Resolutions Committee will receive and analyze all motions and resolutions submitted to it by authorized motion makers. The analysis shall consist of:

   (a) Determination of consistency with NCSBN articles of incorporation, Bylaws, mission, purpose and functions, strategic initiatives, outcomes and policies;

   (b) Determination of relationship to ongoing programs;

   (c) Assessment for duplication with other proposed motions;

   (d) Legal implications;

   (e) Financial impact.

3. The Resolutions Committee Chairperson will present to the Delegate Assembly oral and/or written reports of all motions and resolutions submitted to it. The report for each motion and resolution shall include the following analyses performed by the Resolutions Committee:

   (a) Determination of consistency with NCSBN articles of incorporation, Bylaws, mission, purpose and functions, strategic initiatives, outcomes and policies.

   Consistent

   Not Consistent (with rationale)

   (b) Determination of relationship to ongoing programs

   Not in current Strategic Plan

   In current Strategic Plan (site identified)

   (c) Assessment for potential duplication with other proposed motion or ongoing programs

   No duplication

   Duplication (area of duplication specified)

   (d) Legal implications

   None

   Implications identified

   (e) Financial impact

   None

   Impact identified

In the event a motion or resolution is submitted too late for the Resolutions Committee to perform its analysis, the Committee will report to Delegate Assembly the absence of any review.

Procedures

1. Motions and resolutions must be submitted by a delegate in accordance with the Bylaws and the Standing Rules. The person seconding the motion must also sign all motions. A fiscal impact statement must accompany the motion or resolution.
2. It is desirable to have the motion or resolution submitted in time to include in the mailing to Member Boards 45 days before the Annual Meeting. However, motions and resolutions not submitted in time to meet the 45-day mailing deadline prior to the Annual Meeting should be submitted to the Resolutions Committee by the time and date proscribed in the Standing Rules.
3. The Resolutions Committee may schedule a conference call and/or an informal meeting with members wanting to make a motion at Delegate Assembly to enable makers an opportunity to receive assistance in the formulation of the motion/resolution.
4. Makers may submit motions to the Resolutions Committee until the Delegate Assembly concludes its business at the Annual Meeting to allow for all matters to be addressed. However, motions and resolutions not submitted to the Committee by the established deadline may not be reviewed and analyzed by the Resolutions Committee.
5. The deadline for submitting motions and resolutions to the Resolutions Committee shall appear in the Standing Rules for the Delegate Assembly.
6. The Resolutions Committee will meet with each maker in accordance with the schedule and guidelines established. This meeting shall occur as close to the session at which new business will be considered as is consistent with the orderly transaction of the Committee's business. Once discussion is concluded, the Committee will meet in executive session to prepare the motion or resolution for submission to the Delegate Assembly.
7. Courtesy resolutions are proposed directly by the Resolutions Committee.

Motions and Resolutions for Publication

1. Motions and resolutions must be submitted to the Resolutions Committee by the deadlines published in NCSBN's newsletter, *Council Connector*, Member mailings, NCSBN Web site, or other form of notice, in order to be reviewed by the Resolutions Committee and mailed to Member Boards 45 days before the Annual Meeting.
2. Motions and resolutions submitted in advance of the Annual Meeting will be presented at the Resolutions Forum.
3. The person(s) submitting a motion or resolution must be prepared to attend and discuss the motion or resolution with Resolution Committee at its scheduled meeting and speak to the motion or resolution to the Delegate Assembly.

Motions and Resolutions Received After the Resolutions Committee Meeting

1. A motion or resolution not submitted to the Resolutions Committee by the established deadline at the Delegate Assembly may be presented directly to the Delegate Assembly as new business, provided that the maker first submits the resolution to the Chair of the Resolutions Committee. The Resolutions Committee may make a reasonable attempt to meet with the motion maker to discuss any such motions and resolutions, time permitting, but the Committee may report to the Delegate Assembly that it was unable to perform its analysis and review of the motion.
2. The maker is responsible for duplication of the resolution for distribution to members of the Delegate Assembly. Each resolution or motion should be accompanied by a written analysis

of consistency with NCSBN mission, purpose and functions, strategic initiatives, outcomes, assessment of fiscal impact and potential legal implications. 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.

Attachment C

Motions/Resolutions Submission Form

National Council of State Boards of Nursing
Motions/Resolutions Submission Form

PLEASE TYPE OR PRINT CLEARLY

Name of Motion/Resolution:

Maker:

Date: **Phone #:** **E-mail Address:**

I move that:

Rationale for Motion:

Signature of Maker: _____

Member Board: _____

Signature of Second: _____

Member Board:

I. Describe the relationship of the motion/resolution to NCSBN's:
(a) Bylaws, mission, strategic initiatives and outcomes (see NCSBN Web site and/or current Delegate Assembly business book)

(b) Ongoing programs and policies

II. Identify potential legal implications.

III. Attach a completed Fiscal Impact Statement.

Attachment D

Fiscal Impact Statement Form

National Council of State Boards of Nursing
Fiscal Impact Statement

PLEASE TYPE OR PRINT CLEARLY

Title of Motion/Resolution: _____

Proposed by:

I. PROJECTED DATES

A) Beginning: _____

B) Completion: _____

II. RESOURCES ANTICIPATED

Check those resources needed to accomplish motion/resolution

A) Does this proposal require a committee? ❑ Yes ❑ No ❑ Unsure

1. Number of members anticipated including the Chair? ❑ Unsure
2. How many meetings anticipated?
3. Time span of resources: ❑ 1 year ❑ 2 years ❑ 3 or more years ❑ Unsure

B) Does this proposal require printings, mailings, or electronic access (e.g., Web)?

❑ Yes ❑ No

1. Please describe any expected surveys.
2. Please describe other expected printings (special reports, mailings).
3. Please describe any expected electronic resources (e.g., Web site).

C) Will this proposal require outside consultation? ❑ Yes ❑ No

If yes, please select all that apply:

Legal Counsel
Nursing
Testing/Psychometric
Policy/Regulation
Technical (including computer)
Other (please describe) _____

D) Will this proposal require other resources? ❑ Yes ❑ No

If yes, please complete the following:

1. Please describe expected travel (other than committee meetings).
2. Other (please describe).

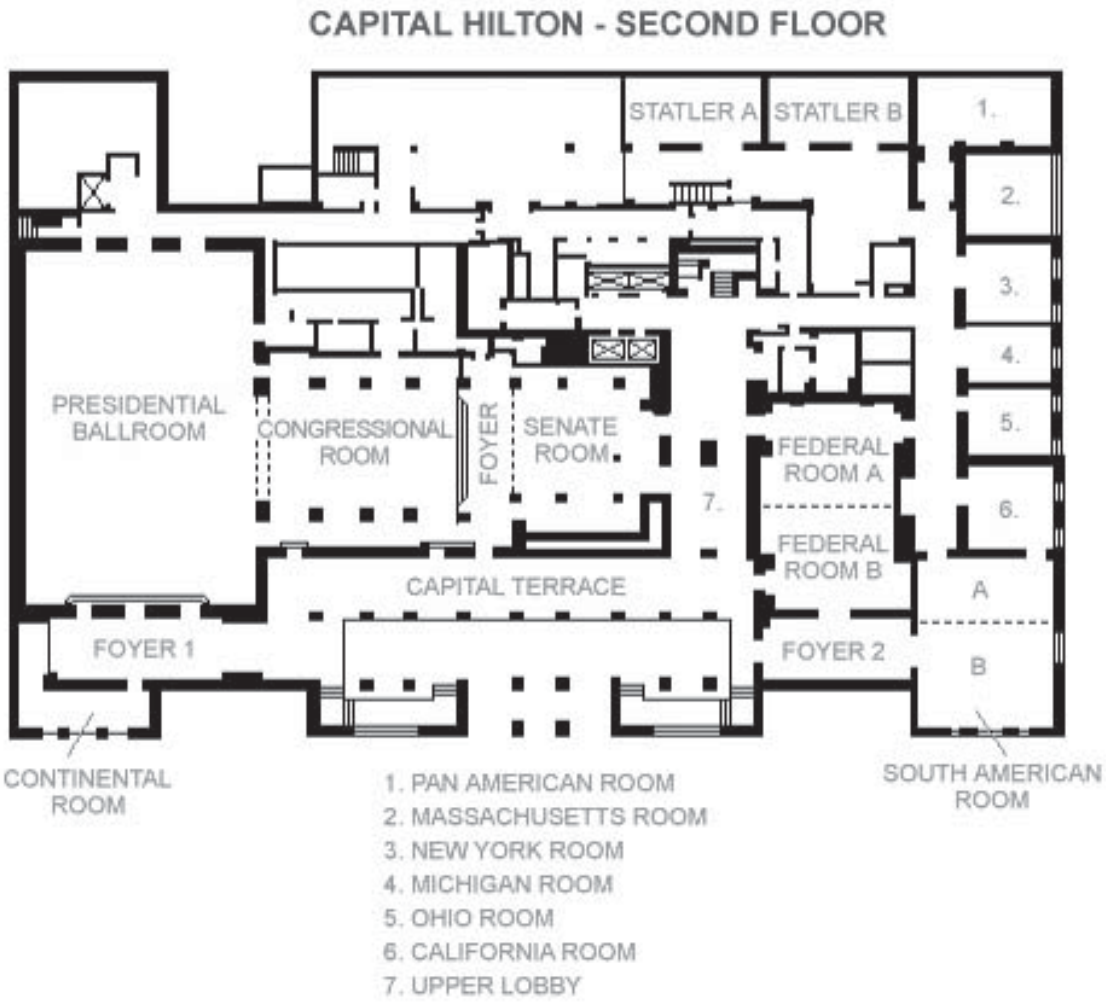
III. OTHER COMMENTS REGARDING FISCAL IMPACT.

Section III

2005 NCSBN Annual Meeting

For Resolutions policy & procedures and forms, see the Resolutions Committee Report and attachments, page 327.

Capital Hilton Hotel – Second Floor 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.

The Strategic Iniatives for 2005-2007, adopted by the 2004 Delegate Assembly, are:

1. Facilitate Member Board excellence through individual and collective development. (Member Boards)
2. Promote evidence-based regulation that provides for public protection. (Regulatory Excellence)
3. Enhance the organizational culture to support change and innovation. (PERC)
4. Position NCSBN as the premier organization to measure entry and continuing competence of nurses and related health care providers. (Competence)
5. Advance NCSBN as the leading source of data, information, and research regarding nursing regulation and related health care issues. (Data)
6. Advance NCSBN as a key partner in nursing and health care regulation in the U.S. and internationally. (U.S./International Partner)

To achieve its strategic initiatives, NCSBN identifies expected outcomes, under which tactics 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 outcomes 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 60 Member Boards, including those from the District of Columbia, the U.S. Virgin Islands, Puerto Rico, 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.

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.

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. (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 late July/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 Committee on Nominations by majority and plurality vote respectively. They also receive and respond to reports from officers and committees and to receive a copy of the annual audit report. 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 and strategic initiatives of NCSBN and approves the substance of all NCLEX® examination contracts between NCSBN and Member Boards, and adopts test plans to be used for the development of the NCLEX examination and the NCLEX examination test service 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. 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.

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, consists of the nine 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 the adoption of personnel policies for all staff, 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. Board officers and directors are asked to submit reports and other materials for the meeting at least three weeks prior to each meeting so that they can be copied and distributed with other meeting materials. 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. A summary of the Board's major decisions is provided for dissemination prior to the release of approved minutes following the next Board 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 Executive Director communicates weekly with the President regarding major activities and confers as needed with the Treasurer about financial matters. In most instances, the Executive Director is the person responsible for communicating with NCSBN consultants about legal, financial and accounting concerns.

This practice was adopted primarily as a way to monitor and control the costs of consultant services. Conference calls can be scheduled, if so desired by the President. Written materials are generally forwarded to Board Members in advance of the call. These materials include committee or staff memos detailing the issue's background as well as Board action required. Staff prepares minutes of the call and submits them at the next regularly scheduled Board meeting.

Board Members use NCSBN letterhead when communicating as representatives of NCSBN.

Committee on Nominations

NCSBN delegates elect representatives to the Committee on Nominations. The committee consists of four people, one from each area, who may be either Board Members or staff of Member Boards. Committee members are elected to two-year terms. One half of the committee members are elected in even-numbered years and one half in odd-number years. They are 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 Committee on Nominations' function is to consider the qualifications of all candidates

for Board of Director officers and for the committee itself and to prepare a slate of qualified candidates. During the Delegate Assembly, additional nominations may be made from the floor.

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 five standing committees: Examination; Finance; Practice, Regulation, and Education; Bylaws; and Resolutions. 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.

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; and consumers. Nonmembers may be appointed to special committees as consultants to provide specialized expertise to committees. 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 can advise the committee regarding the strategic or operational impact of decisions and recommendation.

Description of Standing Committees

EXAMINATION COMMITTEE

The Examination Committee is 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 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 Examination Committee provides general oversight of National Council Licensure Examination (NCLEX®) 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 is comprised of 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.

PRACTICE, REGULATION AND EDUCATION COMMITTEE

The Practice, Regulation and Education Committee is comprised of at least six members. The committee's purpose is to provide general oversight of nursing practice, regulation and education issues. It periodically reviews and revises the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*, and recommends white papers, guidelines or other resources to the Board of Director for Member Board use. It also reviews NCSBN research data, conducts membership surveys and disseminates information to Member Boards and other interested parties. In the past, the committee has utilized subcommittees to study various issues (e.g., continued competence,

foreign nurse issues and accreditation/approval in nursing education).

RESOLUTIONS COMMITTEE

The Resolutions Committee is comprised of at least four members generally representing each of the four NCSBN geographic areas and also includes one member of the Finance Committee. The committee's purpose is to review, evaluate and report to the Delegate 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 bylaws 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's and Board of Directors' policy directives and provide assistance to committees.

GENERAL DELEGATE ASSEMBLY INFORMATION

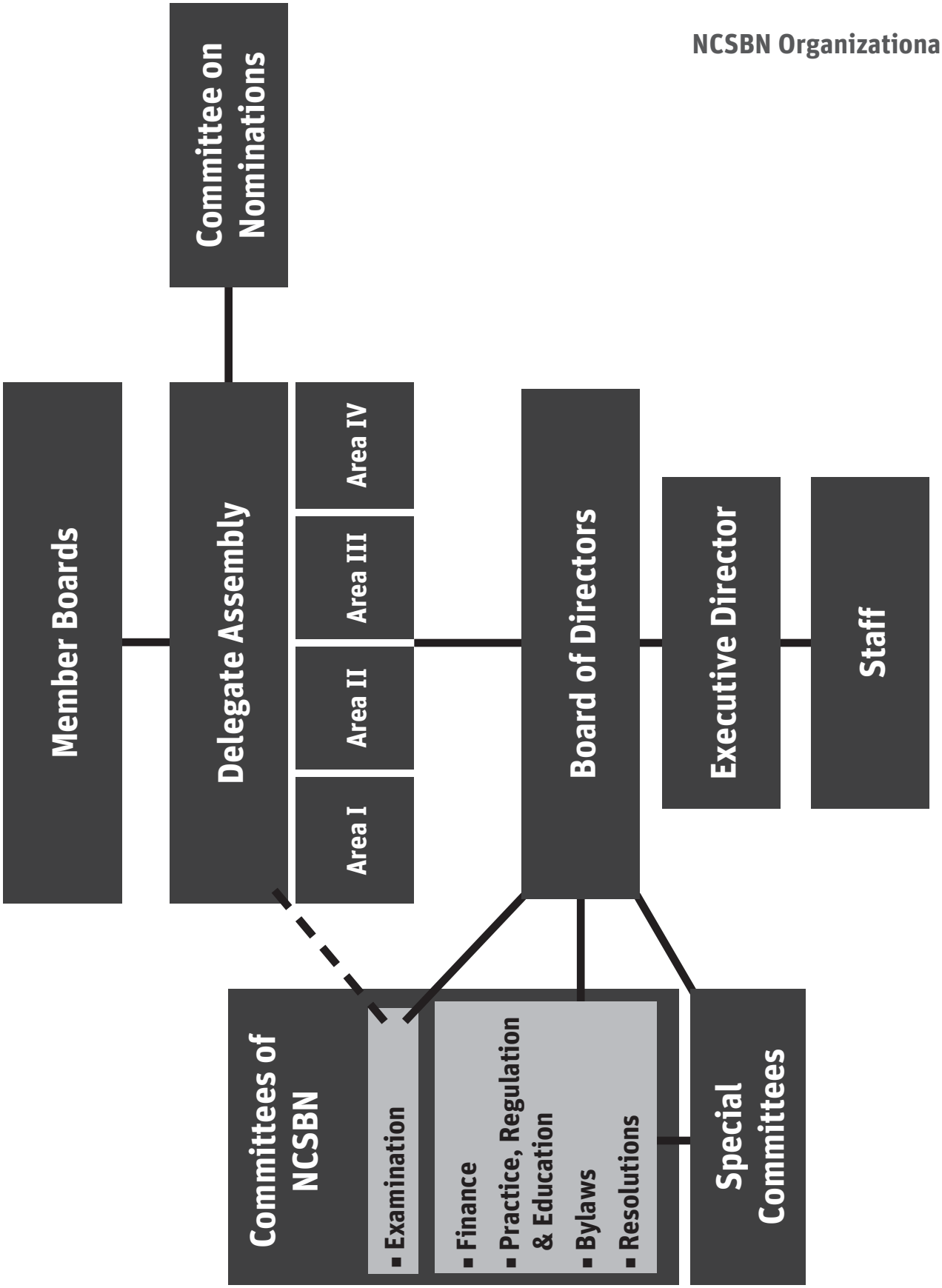
Agendas for each session of the Delegate Assembly are prepared by the President in consultation with the Board of Directors and Executive Director and approved by the Board of Directors. At least 45 days prior to the Annual Meeting, Member Boards are sent the recommendations to be considered by the Delegate 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

Article I

NAME

The name of this organization shall be the National Council of State Boards of Nursing, Inc. (the "National Council").

Article II

PURPOSE AND FUNCTIONS

Section 1. Purpose. The purpose of the National Council 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 National Council'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 National Council 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 is the governmental agency empowered to license and regulate nursing practice in any state, territory or political subdivision of the United States of America.

Section 2. Qualifications. Any state board of nursing that agrees to use one or more National Council Licensing Examinations (the "NCLEX® examination") under the terms and conditions specified by the National Council and pays the required fees may be a member of the National Council ("Member Board").

Section 3. Admission. A state board of nursing shall become a member of the National Council 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.

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 National Council issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. Fees. The annual member fees, as set by the Delegate Assembly, shall be payable each October 1.

Section 6. Privileges. Membership 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 Board whose fees remain unpaid after January 15 is not in good standing. Any Member Board which does not comply with the provisions of the bylaws and contracts of the National Council 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 Board 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 that 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 National Council 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 secretary of the National Council or a delegate of another Member Board to cast its votes.

Section 3. Authority. The Delegate Assembly, the membership body of the National Council, shall provide direction for the National Council 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 National Council memberships; approve the substance of all NCLEX® examination contracts between the National Council and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; approve the NCLEX® examination test service; and establish the fee for the NCLEX® examination.

Section 4. Annual Meeting. The National Council 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 National Council.

Section 5. Special Session. The Board of Directors may call and, upon written petition of at least 10 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 10 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 National Council shall be a President, a Vice President and a Treasurer.

Section 2. Directors. The directors of the National Council shall consist of two Directors-at-Large and a Director from each Area.

Section 3. Qualifications. Members and employees of Member Boards shall be eligible to serve as National Council 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 National Council 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 and Area Directors shall be elected for a term of two years or until their successors are elected. Directors-at-Large shall be elected for a term of one year or until their successors are elected. The President, Vice President and Treasurer shall be elected in even numbered years. The Area Directors 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 National Council, as determined by the Committee on Nominations before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors stand for 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 National Council.

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 National Council.

Section 2. Authority. The Board of Directors shall transact the business and affairs and act on behalf of the National Council 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.

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 24 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. The Board of Directors may remove any member of the Board of Directors from office upon conviction of a felony, gross misconduct, failure to perform, dereliction of duties or conflict of interest by a two-thirds vote of 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

NOMINATIONS AND ELECTIONS

Section 1. Committee on Nominations.

(a) *Composition.* The Committee on Nominations shall be comprised of one person from each Area. Committee members shall be members or employees of Member Boards within the Area.

(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. 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 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.

(d) *Limitation.* A member elected or appointed to the Committee on Nominations 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 Area in which the vacancy occurs, in order of votes received. If no remaining candidates from an Area can serve, the Board of Directors shall fill the vacancy with an individual from the Area who meets the qualifications of Section 1(a) of this Article. If the vacancy is the Chair, the other person serving the second year of a two-year term shall be the Chair. If the vacancy is the Vice Chair, the other person serving the first year of a two-year term shall become the Vice Chair. The person filling the vacancy shall serve the remainder of the term.

(f) *Duties.* The Committee on Nominations shall consider the qualifications of all nominees for officers and directors and the Committee on Nominations and present a slate of qualified candidates for vote at the Annual Meeting. 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.

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.* National Council, 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 National Council 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

EXECUTIVE DIRECTOR

Section 1. Appointment. The Executive Director shall be appointed by the Board of Directors. The selection or termination of the Executive Director shall be by a majority vote of the Board of Directors.

Section 2. Authority. The Executive Director shall serve as the agent and Chief Administrative Officer of the National Council and shall possess the authority and shall perform all duties incident to the office of Executive Director, including the management and supervision of the office, programs and services of National Council, the disbursement of funds and execution of contracts (subject to such limitations as may be established by the Board of Directors). The Executive Director shall serve as Corporate Secretary and oversee maintenance of all documents and records of the National Council 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 Executive Director, and shall set the Executive Director's annual salary.

Article X

COMMITTEES

Section 1. Standing Committees. National Council shall maintain the following standing committees.

(a) *Examination Committee.* The 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 Examination Committee shall provide general oversight of 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 approve item development panels and 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 National Council's investments and the audit. The Committee shall recommend a budget to the Board of Directors and advise the Board on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

(c) *Practice, Regulation, and Education Committee.* The Practice, Regulation and Education Committee shall be comprised of at least six members. The Committee shall provide general oversight of nursing practice, regulation and education issues.

(d) *Bylaws Committee.* The Bylaws Committee shall be comprised of at least four members. The Committee shall review and make recommendations on proposed bylaws amendments as directed by the Board of Directors or the Delegate Assembly.

(e) *Resolutions Committee.* The Resolutions Committee shall be comprised of at least four members, including one member from the Finance Committee. The Committee shall, in accordance with the Standing Rules, review, evaluate and report to the Delegate Assembly on all resolutions and motions submitted by Member Boards.

Section 2. Special Committees. The Board of Directors may appoint special committees as needed to accomplish the mission of the National Council 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. Standing committees shall include only current members and employees of Member Boards. Special committees may also include consultants or 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 delegate, shall be an ex-officio member of all committees except the Committee on Nominations.

(b) *Term.* The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for reappointment 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.

(d) *Committee Duties*.

1. *Budget*. Standing committees shall operate within the assigned budget for the fiscal year. Special committees will be assigned a budget to use in accomplishing the charge. Committees shall not incur expenses in addition to the approved budgeted amount without prior authorization of the Board of Directors.
2. *Policies*. Each standing committee shall establish policies to expedite the work of the committee, subject to review and modification by the Board of Directors. Special committees shall comply with general policies established by the Board of Directors.
3. *Records and Reports*. Each committee shall keep minutes. Special committees shall provide regular updates to the Board of Directors regarding progress toward meeting their charge. Standing committees shall submit quarterly reports to, and report on proposed plans as requested by, the Board of Directors. Special committees shall submit a report and standing committees shall submit annual reports to the Delegate Assembly.

Article XI

FINANCE

Section 1. Audit. The financial records of the National Council 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 National Council in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the National Council.

Article XIV

AMENDMENT OF BYLAWS

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.

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 National Council. The plan shall provide, among other things, that the assets of the National Council be applied as follows:

Firstly, all liabilities and obligations of the National Council shall be paid or provided for.

Secondly, any assets held by the National Council that 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 Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. Seventy-five percent (75%) 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 National Council 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

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 Nursing School Accrediting Agency

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 Assessment Strategies: Assessing Higher-Level Thinking
Online course offered through NCSBN Learning Extension for nursing educators. Users earn 15.6 contact hours for completing the course.

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 26 boards. NCSBN Member Boards continue to share discipline data through Nur*sys*®. 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.

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

References

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2. The ACNM Certification Council Web site. (n.d.) *The ACNM certification council*. Retrieved 4 April 2005, from http://www.accmidwife.org/misc_aboutacc.php.
3. Dictionary.com Web site. s.v. *Alternative dispute resolution*. (n.d.) Retrieved 18 April 2005, from http://dictionary.reference.com/search?q=Alternative%20Dispute%20Resolution

4. American Academy of Nurse Practitioners Web site. (n.d.) *American academy of nurse practitioners fact sheet*. Retrieved 4 April 2005, from http://www.aanp.org/About+AANP/AANP+Information/About+AANP.htm
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
13. ANA Nursing World Web site. (n.d.) *About the American nurses association*. Retrieved 4 April 2005, from http://www.nursingworld.org/about/

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, and 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 over 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 United States. AILA members also represent thousands of U.S. businesses and industries which sponsor highly skilled foreign workers seeking to enter the United States in 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 registered nurses (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 the Congress and regulatory agencies on health care issues affecting nurses and the public.[13]

American Nurses Credentialing Center (ANCC)
A subsidiary of 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 by the reconceptualization of certification and 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 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	N. Carolina	New Jersey
Montana	N. Dakota	Oklahoma	New York
Nevada	Ohio	S. Carolina	Pennsylvania
New Mexico	S. Dakota	Tennessee	Puerto Rico
N. Mariana Islands	W. Virginia	Texas	Rhode Island
Oregon	Wisconsin	Virginia	Vermont
Utah			U.S. Virgin Islands
Washington			
Wyoming			

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

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 Strategies
Test service for Canadian Nurses Association.

Assessment Strategies for Nursing Educators: Test Development and Item Writing
Online course offered through NCSBN Learning Extension for nursing educators. Users earn 19.5 contact hours for completing the course.

B

Blueprint
The organizing framework for an examination that includes the percentage of items allocated to various categories.

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.

Breaking the Habit: When Your Colleague Is Chemically Dependent
Video and facilitation package within NCSBN's "Professional Challenges of Nurses" series, released in 2001.

Bylaws
The rules that govern the internal affairs of an organization.

C

Canadian Nurses Association
A federation of 11 provincial and territorial nursing associations representing more than 123,000 registered nurses.

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 & 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 Examination for Practical Nurses in Long-Term Care (CEPN-LTC)
The first large-scale, national certification examination available to licensed practical/vocational nurses. Developed by NCSBN's Special Services Division, in conjunction with the National Association for Practical Nurse Education and Service Inc., to enhance the level of licensed practical/vocational nurses working in long-term care settings.

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 registered nurses 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*.

Certified Registered Nurse Anesthetist (CRNA)
Nurse anesthesia is an advanced clinical nursing specialty. As anesthesia specialists, CRNAs administer approximately 65% of the 26-million anesthetics given to patients in the United States each year.[19]

See also *Advanced Practice Registered Nurse*.

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 twenty-first 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 registered nurse who has graduate preparation (Master's or Doctorate) in nursing as a Clinical Nurse Specialist.

See also *Advanced Practice Registered Nurse*.

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 con-tinuing 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 United States are eligible and qualified to meet licensure, immigration and other practice requirements in the United States. 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 questions 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.

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/objective. It is an expected activity of all licensed nurses to reflect upon lifelong learning activities and their application to daily practice. The profile was, in essence,

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19. American Association of Nurse Anesthetists Web site. (n.d.) *Questions and Answers: A Career in Nurse Anesthesia*. Retrieved 23 May 2005, from http://www.aana.com/crna/careerqna.asp
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21. American Association of Colleges of Nursing (AACN) Web site. (n.d.) *CCNE accreditation*. Retrieved 4 April 2005, from http://www.aacn.nche.edu/Accreditation/
22. Commission on Graduates of Foreign Nursing Schools (CGFNS) Web site. (n.d.) *Who we are*. Retrieved 4 April 2005, from http://www.cgfns.org/about-who.shtml

23. The Council of State Governments Web site. (n.d.) *Frequently asked questions*. Retrieved 4 April 2005, from http://www.csg.org/CSG/About+CSG/faq/default.htm
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

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 registered nurse 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.

Crossing the Line: When Professional Boundaries Are Violated
Video and facilitation package within NCSBN's "Professional Challenges of Nurses" series, released in 1998.

D

Delegate Assembly (DA)
The voting body of NCSBN that comprises 60 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: Working Through and With Assistive Personnel
Video and facilitation package within NCSBN's "Professional Challenges of Nurses" series, released in 2002.

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: direct mail, 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. Users 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 Nur*sys*®, 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. Users earn 6.0 contact hours for completing the course.

E

English as a Second Language (ESL)

Ethics of Nursing Practice
Online course offered through NCSBN Learning Extension for practicing nurses. Users 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)
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)
October 1 to September 30 at 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 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 accommodations 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

25. Institute of Medicine of the National Academies Web site. (n.d.) *About*. Retrieved 4 April 2005, from http://www.iom.edu/about.asp
26. International Council of Nurses Web site. (n.d.) *About ICN*. Retrieved 4 April 2005, from http://www.icn.ch/abouticn.htm

policy to policy-makers, professionals, 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)
Member organization that meets to discuss data collection issues.

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 London, Seoul or Hong Kong: $150 plus a Value Added Tax (VAT) where applicable. These non-refundable fees must be paid by credit card and will be charged when a candidate calls to schedule their examination appointment.

International Testing Centers
The Pearson Professional test center locations in Hong Kong, London and Seoul 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
An examination 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*.

Item Reviewers
Individuals who review newly written 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 test questions for the NCLEX-RN® and NCLEX-PN® examinations. Item reviewers must meet specific criteria in order to participate on a panel.

Item Writing
Process by which examination items are created.

J

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
Evaluates and accredits more than 15,000 health care organizations and programs in the United States. It is the nation's predominant standard-setting and accrediting body in health care. The Joint Commissions' 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 three NCSBN and

three test service staff members as well as four 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

Kable News
Fulfillment vendor for NCSBN publications and "Professional Challenges of Nurses" series of video and facilitation packages. Orders can be made through NCSBN's Web site under Resources or calling 800.765.3944.

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 registered nurse (RN), licensed practical nurse (LPN) or advanced practice registered nurse (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, usually working under direction of a licensed physician or a registered nurse.

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, usually working under direction of a licensed physician or a registered nurse.

Licensing Board
A state's regulatory body responsible for issuing 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.

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

Machine Scorable Format
Format in which an examination is scored via an automated process.

Master Pool Items
NCLEX® operational items. The bank of test items from which examinations are developed.

Member Board
A jurisdiction that is a member of NCSBN.

Model Nursing Administrative Rules (MNAR)
Served 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. 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

27. Joint Commission on Accreditation of Healthcare Organizations Web site. (n.d.) *Facts about the Joint Commission on Accreditation of Healthcare Organizations*, Retrieved 4 April 2005, from http://www.jcaho.org/about+us/index.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 3 June 2005, from http://www.opm.gov/qualifications/SEC-II/s2-c-d.asp

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 which allows a nurse licensed in his or her state of residency to practice in other 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 *Nurse Licensure Compact* for more information.

N

National Association for Practical Nurse Education and Service (NAPNES)
Advocates 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 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 policymakers 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 licensed practical nurses, licensed vocational nurses and practical/vocational nursing students in the United States.[36]

29. National Association for Practical Nurse Education & Services, Inc. (NAPNEP) Web site. (n.d.) *About NAPNES*. Retrieved 5 April 2005, from http://www.napnes.org/about.htm

30. National Association of Hispanic Nurses Web site. (n.d.) *Philosophy*. Retrieved 4 April 2005, from http://www.thehispanicnurses.org/

31. National Black Nurses Association, Inc. (NBNA) Web site. (n.d.) *Who Are We?* Retrieved 4 April 2005, from http://www.nbna.org/whoarewe.htm›

32. National Certification Board of Pediatric Nurse Practitioners and Nurses Web site. (n.d.) *Welcome*. Retrieved 3 June 2005, from http://www.people.virginia.edu/~sep3y/certification.htm.

33. National Certification Corporation for the Obstetric, Gynecologic & Neonatal Nursing Specialties (NCC) Web Site. *What is NCC?* Retrieved 3 June 2005, from http://www.nccnet.org/public/pages/index.cfm?pageid=61

33. The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Web site. (n.d.) *About NCC MERP*. Retrieved 15 April 2005, from http://www.nccmerp.org/aboutNCCMERP.html

35. National Conference of State Legislatures (NCSL) Web site. (n.d.) *About NCSL*. Retrieved 15 April 2005, 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 15 April 2005, from http://www.nflpn.org/allaboutnflpn.htm

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; 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.

National Practitioner Data Bank (NPDB)
A federally mandated program for collecting data regarding health care practitioners. The 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).

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 clearinghouses and health care providers.

National Student Nurses' Association (NSNA)
Organizes, represents and mentors students preparing for initial licensure as registered nurses, 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 NCSBN Testing Services 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 by 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.

37. National League for Nursing (NLN) Web site. (n.d.) *Bylaws*. Retrieved 3 June 2005, from http://www.nln.org/aboutnln/Bylaws/index.htm
38. National League for Nursing Accrediting Commission (NLNAC) Web site. (n.d.) *About NLNAC*. Retrieved 15 April 2005, from http://www.nlnac.org/About NLNAC/whatsnew.htm
39. National Student Nurses Association (NSNA) Web site. (n.d.) *NSNA Mission Statement*. Retrieved 15 April 2005, from http://www.nsna.org/

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-PN® Examination
NCSBN's licensure examination for practical nurses. NCSBN's Licensure Examinations for Practical Nurses is used in the United States and its territories to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.

NCLEX-RN® Examination
NCSBN's licensure examination for registered nurses. NCSBN's Licensure Examinations for Registered Nurses is used in the United States and its territories to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.

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
Branded name for the online campus located at www.learningext.com where NCSBN promotes educational products and provides online course access to users.

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'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 United States 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 licensed practical/vocational nurses (LPN/VNs) and registered nurses (RNs). In August 2002, NCSBN delegates voted to expand the compact to include advanced practice registered nurses (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. Users earn 2.0 contact hours for completing the course.

Nurse Practitioner (NP)
A registered nurse (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 nurse practitioner 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. Nurse practitioners 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*.

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. 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.

Nursys® Advisory Panel (NAP)
An NCSBN committee.

Nursys®
A database developed by NCSBN containing demographic information on all licensed nurses (in the United States) and an unduplicated count of licensees. Nursys® serves as a foundation for a variety of services, including the disciplinary tracking system, licensure verification, interstate compact functions and research on nurses.

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

40. American College of Nurse Practitioners Web site. (n.d.) *NP Facts*. Retrieved 3 June 2005, from http://www.nurse.org/acnp/facts/whatis.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

42. 4 Patient Safety Web site. (n.d.) *Home Page*. Retrieved 6 June 2005, from http://www.4patientsafety.net/

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. Users earn 5.4 contact hours for completing the course.

Pearson Professional Testing Network
Network of Pearson Professional Test Centers (PPCs) where candidates take the NCLEX® examinations. There are over 200 domestic and three international PPCs that administer the NCLEX.

See also *Pearson Professional Testing/Pearson VUE*.

Pearson Professional Testing/Pearson VUE
Contracted test service provider for NCSBN since 2002 to assist with the NCLEX® program; the contract with Pearson Professional Testing/Pearson VUE is valid through 2009.

Pew Taskforce on Health Care
Charged by the Taskforce 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 NCSBN Testing Services 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, Education, and Regulation Congruence Task Force (PERC)
This task force no longer exists, but its recommended action plan was approved at the 2002 Delegate Assembly and will be implemented through 2010 by staff and existing committees.

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 non-punitive 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 multi-state 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.

Professional Accountability & Legal Liability for Nurses
Online course offered through NCSBN Learning Extension for practicing nurses. Users earn 5.4 CEUs 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 materials available from NCSBN.

Professional Challenges of Nurses Series
NCSBN's branded name for the group of educational video and facilitation packages offered for sale at Kable News.

See also *Kable News*.

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 for purchase through NCSBN's Web site.

Promissor™
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 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 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.

Request for Proposal (RFP)

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. Users 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 conducted every three years for each NCLEX® examination and each time the test plan/blueprint changes for the NNAAP™.

Standard Setting Panel of Judges
A group of individuals that contribute 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 be 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 Center Administrator (TCA)
Test service staff that 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 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*.

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 & 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 & Transportation Security; Emergency Preparedness & Response; Science & Technology; Information Analysis & 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 the United States and bring to the criminal and civil justice system of the United States, 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 United States; and to recommend and support non-enforcement 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.

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.

VCampus Corporation
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 trademark product of CGFNS and currently is the only federally accepted organization to perform screening on nurses immigrating to the United States.

See also *Commission on Graduates of Foreign Nursing Schools (CGFNS)*.

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.

43. U.S. Department of Education Web site. (n.d.) Overview," Retrieved 6 June 2005, 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 6 June 2005, 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. National Council Position Paper, 1995.

NCSBN Glossary Acronyms

A

AACN
American Association of Colleges of Nursing

AACN
American Association of Critical Care Nurses

AANA
American Association of Nurse Anesthetists

AANP
American Academy of Nurse Practitioners

ACC
ACNM Certification Council Inc.

ACNM
American College of Nurse Midwives

ADA
American Dental Association

ADA
American Dietetic Association

ADA
Americans with Disabilities Act

ADR
Alternative Dispute Resolution

AILA
American Immigration Lawyers Association

AMA
American Medical Association

ANA
American Nurses Association

ANCC
American Nurses Credentialing Center

ANSR
Americans for Nursing Shortage Relief

AONE
American Organization of Nurse Executives

APRN
Advanced Practice Registered Nurse

B

BOD
NCSBN Board of Directors

BON
Board of Nursing

C

CAC
Citizen Advocacy Center

CAT
Computerized Adaptive Testing

CCAP
Continued Competence Accountability Profile

CCNA
Council on Certification of Nurse Anesthetists

CCNE
Commission on Collegiate Nursing Education

CEPN-LTC
Certification Examination for Practical Nurses in Long-Term Care

CEU
Continuing Education Unit

CGFNS
The Commission on Graduates of Foreign Nursing Schools

CLEAR
Council on Licensure, Enforcement and Regulation

CM
Certified Midwife

CMS
Centers for Medicare & Medicaid Services

CNM
Certified Nurse Midwife

CNS
Clinical Nurse Specialist

CORE
Commitment to Ongoing Regulatory Excellence

CPR
Candidate Performance Report

CRNA
Certified Registered Nurse Anesthetist

CRNE
Canadian Registered Nurse Examination

CSG
Council of State Governments

D

DA
Delegate Assembly

DDB
Disciplinary Data Bank

DEA
U.S. Drug Enforcement Administration

DHS
U.S. Department of Homeland Security

DIF
Differential Item Functioning

DOE
U.S. Department of Education

E

EC
Examination Committee

EO
Executive Officer

EPR
Examinee Performance Record

ESL
English as a Second Language

F

FARB
Federation of Associations of Regulatory Boards

FY
Fiscal Year

H

HHS
U.S. Department of Health & Human Services

HIPAA
Health Insurance Portability and Accountability Act

HIPDB
Healthcare Integrity and Protection Data Bank

HRSA
Health Resources and Services Administration

I

ICHP
International Commission on Healthcare Professions

ICN
International Council of Nurses

ICONS
Interagency Collaborative on Nursing Statistics

IIRIRA
Illegal Immigration Reform and Immigration Responsibility Act of 1996

IOM
Institute of Medicine

IRE
Institute of Regulatory Excellence

IRs
Incident Reports

IRT
Item Response Theory

IWHPR
Interprofessional Workgroup on Health Professions Regulation

J

JCAHO
Joint Commission on Accreditation of Healthcare Organizations

JRC
Joint Research Committee

K

KR20
Kuder-Richardson Formula 20

KSA
Knowledge, Skill and Ability statement

L

LPN
Licensed Practical Nurse

LVN
Licensed Vocational Nurse (also VN)

M

MNAR
Model Nursing Administrative Rules

MNPA
Model Nursing Practice Act

N

NAFTA
North American Free Trade Agreement

NAHN
National Association of Hispanic Nurses

NAP
Nursing Assistive Personnel

NAP
Nur*sys*® Advisory Panel

NAPNES
National Association for Practical Nurse Education and Service

NBNA
National Black Nurses Association

NCBPNP/N
National Certification Board of Pediatric Nurse Practitioners and Nurses

NCC
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties

NCC MERP
National Coordinating Council for Medication Error Reporting and Prevention

NCSBN
National Council of State Boards of Nursing

NCSL
National Council of State Legislatures

NFLPN
National Federation of Licensed Practical Nurses

NLC
Nurse Licensure Compact

NLCA
Nurse Licensure Compact Administrators

NLN
National League for Nursing

NLNAC
National League for Nursing Accrediting Commission, Inc.

NNAAP™
National Nurse Aide Assessment Program

NNAs
National Nursing Associations

NP
Nurse Practitioner

NP&E
Nursing Practice and Education Committee

NPDB
National Practitioner Data Bank

N-PEC
Nursing Practice and Education Consortium

NPI
National Provider Identifier

NSNA
National Student Nurses' Association

O

OBRA 1987
Omnibus Budget Reconciliation Act of 1987

P

PERC
Practice, Education, and Regulation Congruence Task Force

PPC
Pearson Professional Test Centers

PPI
Practice and Professional Issues Survey

PR&E
Practice, Regulation and Education Committee

PreP
Practitioner Remediation and Enhancement Partnership

R

RFP
Request for Proposal

RN
Registered Nurse

T

TCA
Test Center Administrator

TERCAP
Taxonomy of Error, Root Cause Analysis and Practice Responsibility

U

UAP
Unlicensed Assistive Personnel

V

VAT
Value Added Tax

VN
Licensed Vocational Nurse (also LVN)