UNLOCKING
THE POSSIBILITIES

THE KEY TO REGULATORY EXCELLENCE

PHILADELPHIA
AUG. 12 - 14, 2009

2009 ANNUAL MEETING

Table of Contents

Membership

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

Mission

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

Vision

Building regulatory expertise worldwide.

Values

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

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

Quality: Pursuing excellence in all endeavors.

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

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

Purpose

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

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

NCSBN ENVIRONMENTALLY CONSCIOUS MEETING COMMITMENT

As our Member Boards have requested, NCSBN is committed to holding environmentally friendly or green meetings. As part of our new policy, each hotel that is considered to host an NCSBN meeting will be given a green checklist to determine the property's environmental impact. As we move forward with our green meetings initiative, we will also ask you to contribute to the effort to decrease our carbon footprint and to help preserve our world.

How You Can Help

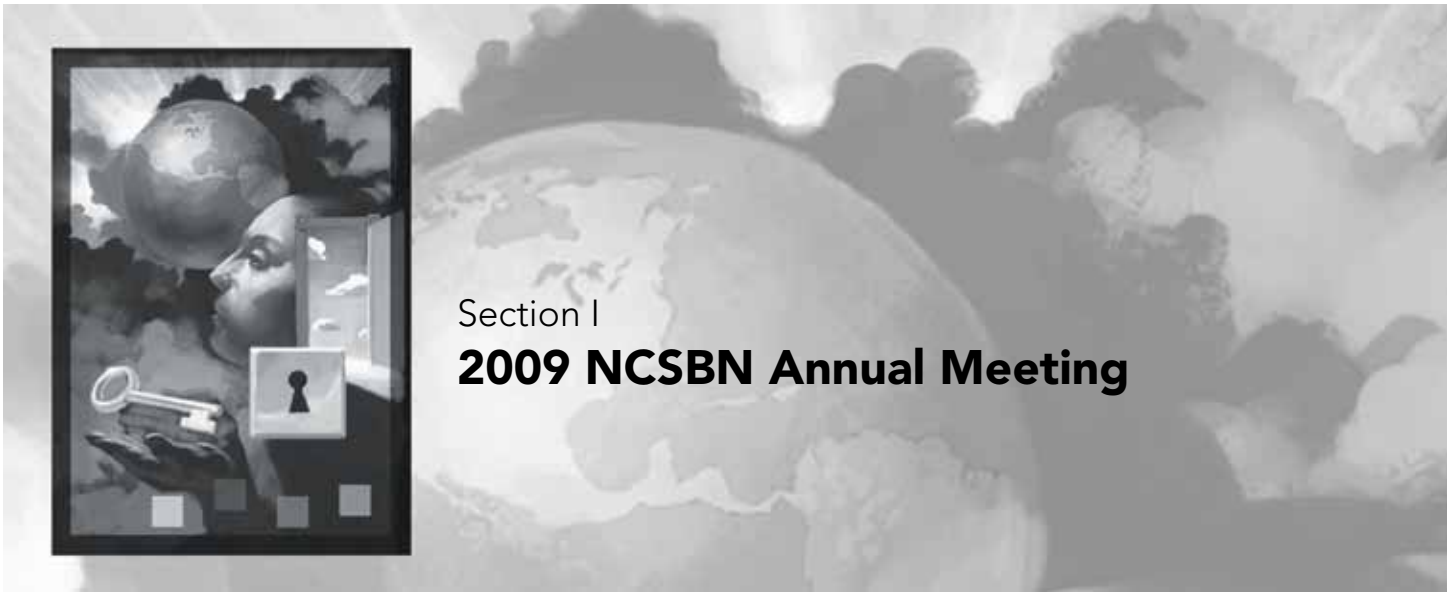
- Recycle all paper in the provided bins in the meeting rooms.
- Reuse the towels in your guest room by hanging them up after use.
- Request that housekeeping does not replace the sheets for the entire length of stay.
- Turn off all the lights in your room each time you leave.
- Place your badge in the provided recycle bin at the end of the meeting.

How the Loews Philadelphia Hotel is Helping

- Providing collection bins for the recycling of paper in meeting rooms.
- Participating in a glass and plastic recycling program.
- Providing condiments, beverages and other food items in bulk instead of individually packaged and assuring that the packaging of these items is recyclable and recycled.
- Using pitchers of water on tables instead of bottled water.
- Banning Styrofoam in any food/beverage functions or outlets.
- Providing all paper bathroom supplies with a minimum of 35 percent post-consumer recycled content paper.
- Using environmentally responsible cleaning products for carpets, floors, kitchens and bathrooms.
- Using china service or biodegradable disposable service.
- Avoiding the use of polystyrene #6 plastic.
- Using cloth napkins or post-consumer recycled paper napkins.
- Using sustainable food.
- Using compact fluorescent light bulbs in guest rooms.
- Instructing the housekeeping staff to leave all of the lights off and the air conditioning / heat on low.
- Using natural light in meeting rooms where available.

The National Council of State Boards of Nursing, composed of member boards, provides leadership to advance regulatory excellence for public protection.

Address inquiries in writing to NCSBN Permissions, 111 E. Wacker Drive, Suite 2900, Chicago, IL 60601-4277. Printed in the United States of America



Section I

2009 NCSBN Annual Meeting

SECTION I: 2009 NCSBN ANNUAL MEETING

Business Agenda of the 2009 Delegate Assembly

Wednesday, Aug. 12, 2009

8:30–10:00 am

OPENING CEREMONIES

- Introductions
- Announcements

OPENING REPORTS

- Credentials Report
- Adoption of the Standing Rules

ADOPTION OF AGENDA

REPORT OF THE LEADERSHIP SUCCESSION COMMITTEE

- Presentation of the 2009 Slate of Candidates
- Nominations from Floor
- Approval of the 2009 Slate of Candidates

PRESIDENT'S ADDRESS

CEO'S ADDRESS

Friday Aug. 14, 2009

9:00 am–12:00 pm

BOARD OF DIRECTORS' RECOMMENDATIONS

- Adopt the proposed revisions to the Education Model Rules.
- Adopt the College of Nurses of Ontario, the College of Registered Nurses of Manitoba and the College and Association of Registered Nurses of Alberta as Associate Members of NCSBN.

NCLEX® EXAMINATION COMMITTEE RECOMMENDATION

- Adopt the proposed 2010 NCLEX-RN® Test Plan.

NEW BUSINESS

CLOSING CEREMONY

ADJOURNMENT

Special Note

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

Standing Rules of the Delegate Assembly

1. Credentialing Procedures and Reports

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

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

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

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

2. Meeting Conduct

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

3. Agenda

   A. Business Agenda

      1. The Business Agenda is prepared by the President in consultation with the Chief Executive Officer 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 NCLEX® Examination Committee may present motions or resolutions to the Delegate Assembly. Resolutions or motions made by the NCLEX® Examination Committee are limited to those to approve test plans pursuant to Article X, Section 1(a) of the NCSBN Bylaws.

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

   C. The Resolutions Committee, according to its Operating Policies and Procedures, shall review motions and resolutions submitted before Thursday, Aug. 13, 2009, at 4:30 pm. Resolution or motion-makers are encouraged to submit motions and resolutions to the Resolutions Committee for review before this deadline.

   D. The Resolutions Committee will convene its meeting on Thursday, Aug. 13, 2009, at 4:30 pm and schedule a mutually agreeable time during the meeting to meet with each resolution or motion maker. The Resolutions Committee shall meet with the resolution or motion maker to prepare resolutions or motions for presentation to the Delegate Assembly and to evaluate the resolution or motion in accordance with the criteria in its operating policies and procedures. The Committee shall submit a summary report to the Delegate Assembly of the Committee's review, analysis, and evaluation of each resolution and motion referred to the Committee. The Committee report shall precede the resolution or motion by the maker to the Delegate Assembly.

   E. If a member of the Delegate Assembly wishes to introduce a non-procedural main motion or resolution after the deadline of 4:30 pm on Thursday, Aug. 13, 2009, the request shall be submitted under New Business; provided that the maker first submits the resolution or motion to the Chair of the Resolutions Committee. All motions or resolutions submitted after the deadline must be presented with a written analysis that addresses the motion or resolution's consistency with established review criteria, including, but not limited to, the NCSBN mission, purpose and/or functions, strategic initiatives and outcomes; preliminary assessment of fiscal impact; and potential legal implications. The member submitting such a motion or resolution shall provide written copies of the motion or resolution to all delegates. A majority vote of the delegates shall be required to grant the request to introduce this item of business. [The Resolutions Committee shall advise the Delegate Assembly where the required analyses have not been performed and/or recommend deferral of a vote on the motion pending further analysis.]

5. Debate at Business Meetings

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

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

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

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

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

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

6. Nominations and Elections

A. Any member who is intends to be nominated from the floor is required to submit their completed nomination form and is strongly encouraged to meet with the Leadership Succession Committee the day before adoption of the slate of candidates by the Delegate Assembly.

B. 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 Leadership Succession Committee at the time of the nomination from the floor.

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

D. The voting strength for the election shall be determined by those registered by 5:00 pm on Wednesday, Aug. 12, 2009.

E. Election for officers, directors, and members of the Leadership Succession Committee shall be held Thursday, Aug. 13, 2009, from 7:30 to 8:30 am.

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

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

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

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

7. Forums

A. Scheduled 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 may 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, Aug. 11, 2009

2:00–6:00 pm
2nd Floor Prefunction

Registration Opens
Visit the registration desk to receive your registration materials and name badge in order to enter the NCSBN Annual Meeting sessions.

2:00–5:00 pm
Jefferson Boardroom

New Candidate Interviews with the Leadership Succession Committee
Those candidates anticipating being nominated from the floor must submit a nomination form and meet with the Leadership Succession Committee.

3:00–6:00 pm
Washington A

Nurse Licensure Compact Administrators (NLCA) Meeting
Open to members of the NLCA and NCSBN only.

6:00–7:30 pm
Washington BC

Delegate Orientation
Open to all Annual Meeting attendees.

Wednesday, Aug. 12, 2009

7:15 am–8:30 am
2nd Floor Prefunction

Continental Breakfast

7:15 am–3:30 pm
2nd Floor Prefunction

Registration
Visit the registration desk to receive your registration materials and name badge in order to enter the NCSBN Annual Meeting sessions.

7:30 am–5:00 pm
2nd Floor Prefunction

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

8:30–10:00 am
Commonwealth

Delegate Assembly: Opening Ceremony
Welcome from the Pennsylvania State Board of Nursing

- Opening Ceremony
  - Introductions
  - Announcements
- Opening Reports
  - Credentials
  - Adoption of the Standing Rules
- Adoption of Agenda
- Report of the Leadership Succession Committee
  - Presentation of the 2009 Slate of Candidates
  - Nominations from Floor
  - Approval of the 2009 Slate of Candidates

President's Address
Laura Rhodes, MSN, RN, President, NCSBN Board of Directors

CEO's Address
Kathy Apple, MS, RN, CAE, NCSBN CEO

SCHEDULE AND LOCATIONS ARE SUBJECT TO CHANGE.

10:00–10:30 am
2nd Floor Prefunction

Break

10:30 am–12:00 pm
Commonwealth

Candidate Forum
Barbara Morvant, MN, RN, Chair, NCSBN Leadership Succession Committee

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

12:00–1:00 pm
Millennium

Lunch

1:00–1:20 pm
Commonwealth

Finance Committee Forum

Robert Clayborne, MBA, CPA, Director, Finance & Administrative Services

A report from the Finance Committee.

1:20–1:40 pm
Commonwealth

NCLEX® Examination Committee Forum
Sheila Exstrom, PhD, RN, Chair, NCLEX® Examination Committee

Discussion of the proposed 2010 NCLEX-RN® Test Plan and timeline for implementation.

1:40–2:20 pm
Commonwealth

Innovations In Education Regulation Committee Forum
Susan Odom, PhD, RN, CCRN, Chair, Innovations in Education Regulation Committee

Presentation and discussion of the work of the Innovations in Education Regulation Committee and the proposed model rule changes.

2:20–2:40 pm
2nd Floor Prefunction

Break

2:40–3:30 pm
Commonwealth

Board of Directors Forum
Laura Rhodes, MSN, RN, President, NCSBN Board of Directors

NCSBN President, Laura Rhodes, will present and discuss Board of Directors issues and recommendations to the Delegate Assembly.

6:00–8:00 pm

Pennsylvania State Board of Nursing Reception - Constitution Center

The Pennsylvania State Board of Nursing welcomes all attendees to Philadelphia for the 2009 Annual Meeting and Delegate Assembly. Please join us at the Constitution Center for a networking reception and take this opportunity to meet your candidates running for office.

Tickets will be included in the registration packets of those who opted to attend during online registration.

Thursday, Aug. 13, 2009

7:30 am–5:00 pm
2nd Floor Prefunction

Exhibit Showcase

7:30 am–12:00 pm
2nd Floor Prefunction

Registration

7:30–8:30 am
Adams Room

Election Voting

8:30–10:30 am

Area Breakfast Meetings: NCSBN Members Only

NCSBN Area Breakfasts I-IV are open to NCSBN members and staff only. Note that there is a breakfast meeting open to external organizations.

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

Washington A

- Area I members include: Alaska, American Samoa, Arizona, British Columbia, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Northern Mariana Islands, Oregon, Utah, Washington and Wyoming.

Washington C

- Area II members include: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, West Virginia and Wisconsin.

Millennium

- Area III members include: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and Virginia.

Washington B

- Area IV members include: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont and U.S. Virgin Islands.

Solstice

External Organizations Breakfast Meeting

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

10:30–11:00 am
2nd Floor Prefunction

Break

11:00 am –12:00 pm
Commonwealth

Keynote: The Croatian Regulatory Experience

Dragica Simunec, President of the Croatian Chamber of Nurses and Board Member of the European Council of Nursing Regulators

An inspiring look into the challenges and courage of nurse regulators as they developed a public protection model after Croatia was declared an independent sovereign state in 1991 after years of communist rule.

12:00–1:00 pm
Millennium

Lunch

1:00–2:30 pm

Knowledge Networks

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

Choose from the following options:

Washington B
- *NCSBN Executive Officers*

Washington A
- *NCSBN Board Presidents*

Commonwealth A1
- *NCSBN Board Members*

Commonwealth B
- *Discipline*

Commonwealth A2
- *Practice*

Commonwealth C
- *Education*

Washington C
- *Licensed Practical/Vocational Nurses*

2:30–3:00 pm

Break

Commonwealth Foyer

Washington Foyer

3:00–4:30 pm

Breakout Sessions

NCSBN is pleased to offer the following breakout sessions:

Washington A
- *NCSBN Research*
  Updates on new and ongoing research projects.

Commonwealth A2
- *Nursys®/Healthcare Integrity and Protection Data Bank (HIPDB)*
  This will be an interactive session focusing on various discipline and licensure data reports available to Member Boards. Attendees will learn how to audit data and how to compare with their licensure system to Nursys, leading to improved data integrity that can benefit all Member Boards.

Commonwealth A1
- *Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®)*

Washington B
- *Commitment to Ongoing Regulatory Excellence (CORE)*
  This session will cover three topics: (1) results from survey of boards of nursing indicating which CORE data have proven to be meaningful and of value; (2) what to expect from the 2010 survey; and (3) tips on using CORE.

Tubman Room
- *Institute of Regulatory Excellence (IRE) and Center for Regulatory Excellence Grant Program*
  IRE is a fellowship program that offers advanced education for nursing regulators. The Center for Regulatory Excellence Grant Program funds research projects related to nursing regulation. This session will describe the program, discuss how to apply for a grant and provide tips for getting a proposal funded. Come hear more about these exciting programs.

Commonwealth CD
- *Healing the Healer*
  Our expert speakers, Daniel H. Angres, MD, and Kathy Bettinardi-Angres, MS, RN, have worked with impaired professionals across the country. The session will cover all aspects of addiction in health professionals.

Adams Room
- *NCSBN and NLCA Relationship*

4:30–5:30 pm
Jefferson Boardroom

Resolutions Committee Meeting

6:00–9:30 pm
Regency Ballroom

Awards Dinner
Semi-formal attire. NCSBN is donating the centerpieces created for the Awards Dinner to the Philadelphia VA Medical Center.

Friday, Aug. 14, 2009

7:45–9:00 am
2nd Floor Prefunction

Pearson VUE Sponsored Breakfast

9:00–10:00 am
Commonwealth

Delegate Assembly

10:00–10:15 am
2nd Floor Prefunction

Break

10:15 am–12:00 pm
Commonwealth

Delegate Assembly Resumes

12:00 pm
2nd Floor Prefunction

Boxed Lunches
Remaining boxed lunches will be donated to the Philadelphia food bank.

SCHEDULE AND LOCATIONS ARE SUBJECT TO CHANGE.

Summary of Recommendations to the 2009 Delegate Assembly with Rationale

This document provides a summary of recommendations that the NCSBN Board of Directors, the NCLEX® Examination Committee (NEC) and the Leadership Succession Committee propose to the 2009 Delegate Assembly. Additional recommendations may be brought forward during the 2009 Annual Meeting.

Board of Directors' Recommendations

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

   Rationale:
   One of the charges to the Innovations in Education Regulation Committee was to develop a regulatory model for innovative education proposals. In meeting this charge, the committee reviewed the literature and received feedback from Member Boards and educators. Because of today's complexities in health care delivery, nursing and health care leaders agree that there is a need to transform how we educate nurses. In their mission of public protection, boards of nursing (BONs) approve nursing programs across the U.S. and its territories. The committee concluded that this is the ideal time for the NCSBN Model Education Rules to be revised to include language that would foster innovative approaches to nursing education when the proposed strategy departs from the current rule structure. BONs are in an excellent position to create a favorable climate for innovative educational approaches and champion new strategies to educate nurses, while remaining diligent in regulating core education standards.

   Fiscal Impact:

   Publication costs incorporated into the FY10 budget.

2. ***Adopt the College of Nurses of Ontario, the College of Registered Nurses of Manitoba and the College and Association of Registered Nurses of Alberta as Associate Members of NCSBN.***

   Rationale:
   The NCSBN Bylaws state that an Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory. The bylaws require approval of membership by the full membership of the Delegate Assembly. The current applications for Associate Membership meet the qualifications as stated in the NCSBN Bylaws.

   Fiscal Impact:
   Upon acceptance, each new Associate Member will pay a $1,500 annual fee.

NCLEX® Examination Committee Recommendation

1. ***Adopt the proposed 2010 NCLEX-RN® Test Plan.***

   Rationale:
   The NEC reviewed and accepted the report of findings from the *2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* (NCSBN, 2009) as the basis for recommending revisions to the *2007 NCLEX-RN® Test Plan* to the Delegate Assembly. Empirical evidence from the practice analysis, feedback from the Members Boards and the professional judgment of the NCLEX® Examination Committee provide support for the recommendation to the Delegate Assembly to adopt the proposed 2010 NCLEX-RN® Test Plan.

   Fiscal Impact:

Incorporated into the FY10 budget.

Leadership Succession Recommendation

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

Rationale:
The Leadership Succession Committee has prepared the 2009 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of NCSBN. Full biographical information and personal statements for each candidate is posted in the Business Book under the Report of the Leadership Succession Committee. Candidates will present himself or herself at the Candidate's Forum on Wednesday, Aug.12, 2009.

Fiscal Impact:
Incorporated into the FY10 budget.

Report of the Leadership Succession Committee

Recommendation to the Delegate Assembly

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

   Rationale:
   The Leadership Succession Committee has prepared the 2009 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of NCSBN. Full biographical information for each candidate follows. Each candidate will present himself or herself at the Candidate's Forum on Wednesday, Aug. 12, 2009.

Background

Per the bylaws, the Leadership Succession Committee 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 Delegate Assembly, when additional nominations may be made from the floor. No name is placed in nomination without the written consent of the nominee.

FY09 Highlights and Accomplishments

- The committee reviewed the first charge related to recommending strategies for the ongoing sustainability and advancement of the organization through leadership succession planning. The committee reviewed the history of the bylaw revision resulting in the Leadership Succession Committee.
- The committee proposed a definition of leadership succession.
- Key leadership competencies were further discussed and ranked in order of importance.
- Consultant Nancy Hazard provided the history and experience of Sigma Theta Tau's work on implementing a Leadership Succession Committee.
- Activities regarding building the slate of candidates were discussed, including a discussion on interviewing potential candidates and how to get information on leadership competence. The committee reviewed and discussed possible interview questions related to essential competencies.
- The committee recommended strategies for the ongoing sustainability and advancement of the organization through leadership succession planning, per the committee's charge.
- The committee reviewed its second charge: present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors (BOD) and the Leadership Succession Committee.
- The committee finalized the call for nominations letter, nomination form and brochure, and reviewed recruitment strategies.
- The committee reviewed and edited Policies 1.1, 1.2 and 1.3.
- The 2009 Midyear Meeting presentation helped facilitate input from the membership, including opening dialogue at the Area meetings. Handouts at the Midyear Meeting included the essential competency framework and the newly revised policy.
- Committee members will speak with both executive officers and Member Board presidents at their networking sessions during the Midyear Meeting. Presidents can help identify possible board members and/or staff whom they believe are interested and qualified to serve in NCSBN office.

Members

Barbara Morvant, MN, RN
Louisiana-RN, Designated Member, Chair

Mary Kay Goetter, PhD, RNC, NEA-BC
Wyoming, Area I

Nancy Bohr, MBA, MSN, RN
South Dakota, Area II

Rick García, MS, RN, CCM
Florida, Area III

David Mangler, MS, RN
Delaware, Area IV

Mary Blubaugh, MSN, RN
Kansas, Designated Member

Paula Meyer, MSN, RN
Washington, Designated Member

Alexis Welch, EdD, RN
North Carolina, Designated Member

Staff

Kathy Apple, MS, RN, CAE
CEO

Kate Jones
Manager, Executive Office

Board Meeting Dates

- Nov. 3-4, 2008
- Dec. 18-19, 2008
- Jan. 15-16, 2009
- May 11, 2009

- The Midyear Meeting will be a time to identify members with potential who need to be nurtured and developed to provide input on NCSBN activities that can better prepare them for future candidacy.
- The committee reviewed and discussed the candidate forum focusing on how to keep candidates within the time limits. This was emphasized during the candidate call-in conferences and in the candidate acceptance letter.
- The committee reviewed and discussed the revised committee policy. There was a great deal of discussion regarding nominations from the floor. It was acknowledged that if the selection process is revised per the intent of the bylaws, the entire process is circumvented by the current nominations from the floor procedure. The committee would like to see members who want to be nominated from the floor meet with the Leadership Succession Committee the day before the adoption of the slate to undergo the same vetting process as all other candidates. This recommendation to the Standing Rules was presented at the Feb. 11-13, 2009, NCSBN BOD meeting.
- The committee developed an articulated conceptual framework, which was presented at the 2009 Midyear Meeting.

Attachments

A. 2009 Slate of Candidates

Attachment A

2009 Slate of Candidates

The following is the slate of candidates developed and adopted by the Leadership Succession Committee. Each candidate profile is taken directly from the candidate's nomination form. The Candidate Forum will provide the opportunity for candidates to address the 2009 Delegate Assembly.

Board of Directors

Vice President

Director-at-Large (two positions)

Area I Director

Area II Director

Area III Director

Area IV Director

Vacant

Leadership Succession Committee

Designated Member (Current or Former Committee Chair)

Designated Member (Board Member of Member Board)

Designated Member (Employee of Member Board)

Designated Member (Past Board of Directors Member)

Detailed Information on Candidates

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

1. Name, jurisdiction and area.
2. Present board position and board name.
3. Date of term expirations and eligibility for reappointment.
4. Describe all relevant professional, regulatory and community involvement, including service on NCSBN committee(s). (300 word limit)
5. What do you perceive as the top two challenges to nursing regulation (provide two or three strategies you would use to address those challenges)? (300 word limit)
6. What leadership competencies will you bring and what will you contribute to advance the organization? (300 word limit)

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Vice President (one-year term)

Myra Broadway, JD, MS, RN

Board Staff, Maine, Area IV

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Education: Franklin Pierce Law Center, JD 1990; University of Colorado, MS, 1973; Hunter College, BSN, 1967; Professional/Regulatory/Community Involvement: Executive Director, Maine State Board of Nursing; State of Maine Nursing Education Strategic Planning Group – 2008 – present; State of Maine Health Care Work Force 2005 – present; NCSBN: BOD – Vice president Dec 08 – Aug 09; Area IV director Nov-Dec 08; Area IV director – 2003-2007; Director at large 2000-2002; Finance Committee Aug 2007 – Nov 2008; Board Liaison to Member Board Leadership Development Task Force 2006-2007; Board Liaison to Examination Committee 2004-2007; Board Liaison to Commitment to Ongoing Regulatory Excellence 2003-2004; Commitment to Ongoing Regulatory Excellence 2002-2003; 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

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

Two significant challenges to nursing regulation include a limitation of resources and the changing dynamics of health care delivery. Within the limitation of resources are the scarcity of nursing workforce and faculty. Changing dynamics of health care delivery precipitate variations among professional organizations, nursing regulatory bodies, and jurisdictional governments. Strategies to address these challenges include: monitoring activities of national and international organizations as well as collaborating with them in defined efforts consistent with NCSBN's mission; supporting research that is planned, developed and performed to enable boards to embrace and implement evidence based decision making in nursing regulation; developing member board competencies to effectively regulate nursing practice; involving member board staff and board members on various committees to bring to the table a wealth of education and experience in order to reflect, discuss and address issues confronting us; exercising our collective imaginations in finding creative and innovative solutions/methodologies; working toward uniform licensure requirements in order to assure the public's protection and make regulation less burdensome. It is important to continue our work with entry level and continuing competence mechanisms in order to appropriately influence policy makers and lend assurance to them and the public that nursing is suitably regulated - allowing for the normal growth and development of a profession while protecting the public.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I believe that I can contribute to the advancement of the organization through commitment to its mission, vision and strategic initiatives and in being a participant in decision making that is consistent with the mission, compliant with the vision and in concert with the strategic initiatives. Being on the BOD requires listening well to all perspectives, deliberating and discussing openly the challenges and issues that confront us as a national organization and as individual boards. However, I also consider it important to maintain some flexibility in implementing the strategic initiatives so that as our environment changes we may respond appropriately and in kind by adapting strategy to meet the mission. My leadership competencies include: openness;

objectivity; enthusiasm; a desire to debate and understand others' points of view as well as my own; and a sprinkling of humor. I am neither afraid of asking nor of hearing the hard questions nor of doing things differently "from the way we have always done it" if it improves nursing regulation. In my jurisdiction I am considered a clear thinker and communicator; a responsible, reliable, and resourceful person who is fair. I believe these competencies will contribute to the advancement of NCSBN. I would consider it an honor and privilege to complete the term as your vice-president.

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Director-at-Large

Pamela Autrey, PhD, MBA, MSN, RN

Board Member, Alabama, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Dr. Pam Autrey has over 20 years of clinical and administrative experience in the healthcare setting with an emphasis in critical and emergent care. Her diverse background both in education and experience lend itself well to teaching a variety of courses in the undergraduate and graduate programs of business and nursing. Her teaching responsibilities include MBA, MSN, and Doctorate of Nursing Practice courses in health care marketing, advanced nursing practice issues, and health care policy and politics. Dr. Autrey is currently the Administrative Director for Medical Nursing at the University of Alabama at Birmingham Hospital. She has direct responsibility for 13 medical nursing units with 500 employees and a $110,000,000 operating budget. Her research interests include situation awareness and high reliability teams as they relate to hospital incident management systems and hand-off communication, as well as gaps in customer satisfaction, from both the patient and nursing perspective. She wrote and received an $850,000 HRSA grant for the UAB School of Nursing and assists her staff with grant writing and evidenced-based practice. Dr Autrey was appointed by Governor Riley to the Alabama Board of Nursing in 2007, currently serving in her third of four years. She served on the NCSBN Disaster Preparedness Committee 2008 and currently serves on the Continued Competency Committee. She was elected to the Governance Committee for the Honor Society of Nursing, Sigma Theta Tau International, 2008-2009 and is the past-President of the Birmingham Regional Organization of Nurse Leaders, as well as a technical advisor to the Health Subcommittee of the Governor's Commission for Action in the Black Belt and the Alabama Rural Action Committee.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

Challenge 1: Addressing not only competency of nurses throughout their profession, but of those who reenter after a long term of absence. The Continued Competency Committee is meeting the challenge yet the buy-in from all boards of nursing will be critical. Although a national model would provide consistency in terms of application and outcomes, practical issues associated with individual states such as legislation and resources is a huge barrier to overcome.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

My leadership competencies are extensive. Not only do I see the world of regulation from the practice side, but also from the educator and consumer viewpoints. I served in many leadership capacities; only a few are identified for this application. I am unbiased and use evidence to guide my decision making and see all sides of the issue from all stakeholder viewpoints, and not just that of my board in Alabama. Keeping the safety of the public as the core for our existence as boards guides what issues we must address and decisions that are made. I appreciate all viewpoints and treat all at the table as equals with collegiality, valuing the perspectives that are presented. I enjoy working as a team and do not have to be the designated leader although I take that responsibility and accountability seriously when I am in that position. The NCSBN plays an enormous role in refining, implementing, and evaluating the regulatory model for patient safety and nursing practice and I am honored to serve in any capacity, either as a committee member or an elected director-at-large. My employer values the work I do for the Alabama Board of Nursing and the NCSBN, allowing me the latitude of time and resources to be major player in nursing regulation.

Director-at-Large

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Debra Scott, MSN, RN, FRE

Board Staff, Nevada, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Nursing has been very good to me. In 2003-2004, I served on the NCSBN Practice, Regulation, and Education Model Revision Subcommittee. In 2006-2007, I was a member of the NCSBN Continued Competence Advisory Panel. Beginning in 2008 and presently, I am the chair for the NCSBN Continued Competence Committee. In 2008, I became a fellow of the NCSBN Institute of Regulatory Excellence.

Prior to coming to Nevada, I was a consultant for the California Board of Nursing's Diversion Program. From 1994-1996, I was a member of the Nevada State Board of Nursing (NSBN) Disability Advisory Committee until I began working for the Board, initially as the Associate Executive Director for Practice and in 2002, became the Executive Director. In 2001, I joined the Nursing Institute of Nevada as a charter member. In 2004, I formed the Nevada Health Professions Council, made up of the major healthcare boards to foster collaboration and find common ground on a variety of issues in our state.

In 2007, I served on the Nevada Legislative Healthcare Advisory Task Force, and in 2008, served on the Nevada Attorney General's Blue Ribbon Task Force. Since graduation from nursing school in 1985, I have been a member of Sigma Theta Tau International and a member of the Alumni Association, California State University, Fresno.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

The top two challenges to nursing regulation in the U.S. is the lack of uniform core (UCLR) licensure requirements across all jurisdictions and the need for a reliable measurement of continued competency as a component of maintenance of licensure. NCSBN has provided me the opportunity to be involved in activities which are addressing these challenges. My participation in focus groups, the UCLR survey, and attendance at the UCLR conference has given me beginning insight into how difficult the work will be. Realizing the need for uniformity, assessing the variance in requirements, identifying the importance of compromise, and addressing the real and perceived barriers has begun on a national level. Back at home, I have begun to evaluate how we can support finding a resolution for this barrier to nursing practice. My membership on the Continued Competency Advisory Panel, and now serving as chair of the Continued Competency Committee has given me a real appreciation for NCSBN's efforts to provide its members and our profession with a regulatory model, for ensuring continued competence in nursing practice. Initial assessment of nursing competence and providing a model for ongoing assurance of the competence of nurses is essential to meet our regulatory responsibility.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I bring a clear understanding of the role of the nursing regulator, with well-established principles and values as a premise for the work we do. I have an ability to foster collaboration and have just enough ego to be assertive while being respectful and open-minded. I have considerable insight about my own strengths and challenges, utilizing both to serve the greater good. I trust others and have learned to create an atmosphere of mutual trust, especially when confronted with difficult decisions. I have a pleasant sense of humor and believe in each person's right to make mistakes, learn and grow in becoming strong and capable. Because, if elected, I will be a

new board member, I will advance the organization by bringing a new perspective, commitment, and hard work in the consideration of the issues which are presented. I am steadfast in fairly and honestly supporting the NCSBN's goals and representing its members as we strive to protect the public.

Area I Director

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Kathy Malloch, PhD, MBA, RN, FAAN

Board Member, Arizona, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

I am honored to again be a candidate for the Area I Director position and grateful for the support of NCSBN members over the past three years. I have over thirty-five years of nursing experience in a variety of positions and levels of responsibility in healthcare including operations, education, regulation, and consulting. I continue my work as a leadership consultant with many clients across the country and in numerous organizations and associations. Recently, I extended my consulting as a Clinical Consultant to API Healthcare, software company specializing in healthcare systems. I have been a member of the Arizona State Board of Nursing since 1998. During this time, I have served as chair of the Scope of Practice Committee and an am current chair of the Education committee. I am serving my fourth term as president of the board. I have been involved in committee work for NCSBN for the past seven years. I served on the Practice Breakdown committee for four years and most recently on the Governance and Leadership Task Force. I was also a facilitator/presenter at the Institute of Regulatory Excellence 2003-2006. I was elected to the NCSBN Board of Directors in 2006 as a Director-at-Large and now serve as the Area I Director. I have served as board liaison to the Continued Competence and NCLEX Examination committees. In order to maintain an active role in the emerging issues in nursing, I have taught the course on Contemporary Issues in Health at Arizona State University, College of Nursing and Healthcare Innovation. Most recently, I consulted with the college to create the first multidisciplinary healthcare innovation leadership program in the country. I am a member of the American Organization of Nurse Executives, American Nurses' Association, Sigma Theta Tau, and the American Academy of Nursing.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

While there will always be many challenges for NCSBN, I believe board members face the two challenges of mission centrality and membership engagement in this work. Elected board members are expected to review and debate multiple policies and proposals. To be sure, there are far more ideas than there is capacity, time or staff to complete. The challenge for board members is to determine which ideas are the most consistent with the mission and will provide benefits for the greatest number of member boards. This requires skill to dialogue effectively with other board members and board staff to determine the essential nature of the proposed idea, the resource requirements, evaluation measures, and the probable impact on member boards. In addition, the impact on the nursing community at large and the greater healthcare community must also be considered. Knowing when to support other's ideas and when to push for new models and innovations requires consideration of the three critical areas: mission, members and the community. The second challenge for elected board members is to assure engagement and communication with all member boards on a regular basis. The engagement of all member boards –not just a small number of more communicative boards—is vital to the success of NCSBN. The importance of communicating regularly and openly with member boards is essential for the success of NCSBN. Understanding the needs of member boards and sharing the activities of the board of directors will support positive relationships between the board and member boards. It is through the processes of understanding and meeting member board needs that improvements in nursing regulation are made. Finally, as new needs emerge among member boards, new directions for the organization will also evolve. If these two challenges, mission focus and member board engagement are met successfully, NCSBN will thrive.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

As an experienced leader in multiple nursing roles in regulation, practice and education, I will bring the many leadership competencies including the facilitation of individuals and groups, expert collaboration skills, and partnership building with multiple teams, organizations, and healthcare associations. These competencies are often instrumental in helping others to consider current processes in more creative and ultimately more effective ways. Specific competencies include differentiating governance and operations work, posing challenging questions, and encouraging critical discussions of complex and difficult topics. As a recognized national nursing leader, I will bring not only my leadership competencies but also the knowledge and experience that I have gained from others in larger nursing community. Colleagues have recognized me as focused, dedicated, creative, thought provoking and dependable. Difficult and challenging issues do not discourage me; rather these situations energize me to find the best solution when others have not succeeded. I am an eternal optimist and work hard to empower others to gain a similar sense of optimism. The foundation and framework is an evidence-based approach; an approach that minimizes emotional decisions and optimizes objective, mission-driven actions. Of particular importance for me is the need to be respectful of the views of others as well as the importance of all individuals to be accountable for their actions and the consequences of these actions. Using these skills of facilitation to encourage and support effective discussions around difficult topics, challenging assumptions, being persistent, sustaining optimism, and creativity will be helpful for me to continue to be a good team member and collaborator with other members of the NCSBN Board of Directors. Finally, I believe my experience in creative processes will assist others to be the best they can be.

Area II Director

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Betsy Houchen, JD, MS, RN

Board Staff, Ohio, Area II

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY,AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

I have been Executive Director of the Ohio Board of Nursing since September 2005. Prior to that, I was Associate Executive Director and a Staff Attorney for Discipline. My involvement with NCSBN began by attending meetings and serving as an Alternate Delegate and a Delegate for Ohio at the NCSBN Annual Meeting and Delegate Assembly. For the last two years, I have served as Area II Director on the NCSBN Board of Directors and as the Board Liaison to the CORE Committee. I have also participated in NCSBN meetings and conferences: Compact Forum, Uniform Core Licensure Requirements; IRE Conference; Executive Officer Conferences; Mid-Year Meetings and Leadership Conferences. Through my work at the state board level and with NCSBN, I have demonstrated a commitment to NCSBN's mission, services, policies and programs. Prior to working for the Ohio Board of Nursing, I practiced as a health care attorney for two large law firms; served as Regulatory Counsel and legislative lobbyist for a state trade association; worked as a consultant for a national trade association; authored a health care compliance manual and contributed to an administrative law book; served as a Bureau Chief at the Ohio Department of Health with responsibilities of regulating adult care facilities, home health agencies, hospice care programs, and other health care providers; and was Executive Director of a large home health agency and hospice care program. During that time, I was elected to the Boards of the Ohio Council for Home Care and the National Association for Home Care.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

A current challenge to nursing regulation is the threat that the authority of state boards of nursing will be weakened due to budget cuts, consolidation, and non-nursing state boards seeking to regulate nursing. Strategies to address these challenges include: (1) developing an even stronger organization by making NCSBN not only an organization "of" state boards of nursing, but also an organization "for" state nursing boards; (2) focusing the valuable resources of NCSBN for research and data collection that will provide even more evidence and data that state boards of nursing have available to address the specific challenges in their states; and (3) conducting legal research and analysis regarding federal laws impacting state boards. NCSBN, by taking actions to become even more proactive for states by providing needed data, evidence, and legal analysis, can assist state boards of nursing in meeting these challenges and remaining strong in their mission of public protection. Another challenge important to nursing regulation is for state boards of nursing to remain unified as one national nursing regulatory organization. NCSBN is in a unique position to implement strategies to meet this challenge by: (1) structuring objectives and activities to build upon the "common threads" that unite all state boards of nursing so we are working toward uniform regulatory practices where possible; (2) reflecting member issues and concerns through NCSBN committees with clear direction and charges; (3) gathering input and feedback from member boards to establish a coordinated research agenda, setting research priorities, and coordinating research projects throughout the organization with the committees, the Center for Regulatory Excellence, and the Institute of Regulatory Excellence. These strategies help NCSBN remain united and strengthened in its representation of state boards. It helps assure NCSBN's inclusion in national policy making groups and committees whose work could impact states' regulation of nursing.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I have over thirty years of experience in leadership positions and distinguished service in the areas of nursing, health care, administration, regulation, and legislation. I have demonstrated an ability to both govern and to lead. My experience spans both the public and private sectors, providing a unique combination of experiences that have proven beneficial in understanding regulatory and legislative issues. My work on the NCSBN Board and on another national board has given me the opportunity to work with other states, various individuals, and differing points of view. These experiences have enabled me to develop a strong ability to facilitate and participate in processes that result in group consensus to advance organizational goals. I bring personal integrity, honesty, a tolerance and respect of differing viewpoints, and the ability to listen and work well with others. As a nurse attorney I also bring an analytical approach to nursing regulation. I am able to handle large amounts of information, identify the issues, and formulate strategies to reach the vision or objective. I have the ability to critically analyze, and think clearly and creatively. My work experience, education preparation, and skills will help me advance the mission, vision and strategic initiatives of NCSBN. By working with Board members, staff, and NCSBN members I can help assure the organization is meeting its strategic initiatives and objectives. I have a proven track record of successful work that advances the organization. It would be an honor to continue to serve on the Board of Directors.

Area III Director

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Julia George, MSN, RN, FRE

Board Staff, North Carolina, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

NCSBN Area III Director 2007-2009; Fellow-NCSBN Institute of Regulatory Excellence 2007; NCSBN PR&E Subcommittee on Delegation and Assistive Personnel 2003-2004; NCSBN Resolutions Committee 2002-2003; Presenter, International Council of Nurses Congress 2009; Presenter, National Federation of Physical Therapy Boards 2008; Moderator, Citizen Advocacy Center Annual Meeting 2008; Member, North Carolina Organization of Nurse Leaders; Member, North Carolina Nurses Association; Member, American Nurses Association; Member, Sigma Theta Tau

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

Possibly our most timely challenges are: (1) the need to remain strategic and relevant in this time of economic uncertainty and (2) to provide an active voice in healthcare reform. The North Carolina Board of Nursing uses Malcolm Baldrige criteria for continuous quality improvement. One of the things we have learned through Baldrige is the importance of listening to and learning from your customers. I believe that listening and learning from regulatory customers (providers, employers, patients, other disciplines and other countries) is essential in order to remain strategic and relevant. It can enable us to build a more diverse regulatory environment and identify opportunities for innovation. Regulators must remain focused on public protection, become engaged in legislative and policy reform, and continue to form collaborative relationships with others. As healthcare reform evolves, we must seize every opportunity to articulate the value of advanced practice nurses in providing safe, effective and affordable care. Cultivation of collaborative relationships and political partnerships will be essential for the voice of nursing regulation to be heard.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I will bring competence in regulation, having 14 years of regulatory experience and 12 consecutive years of attendance at Delegate Assembly and other NCSBN meetings. I am knowledgeable of the mission, vision, values and strategic initiatives of NCSBN. I am an engaged communicator and respectfully listen to diverse perspectives. I generally gravitate to the "big picture" and build consensus whenever possible. I believe I set a personal example of integrity and follow through with commitments. I am confident that I can continue to contribute to the organization through service on the Board of Directors. I will continue to model leadership behavior that encourages and challenges others. I will hold myself to the highest of standards in my stewardship and service to the organization. I would consider it an honor and privilege to serve a second term as Area III Director.

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Leadership Succession Committee Designated Member (Current or Former Committee Chair)

Barbara Morvant, MN, RN

Board Staff, Louisiana, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Committee on Nominations - 1991-1992 Chairman 1992; Finance Committee Member, 1992-2002, Chairman, 1999-2002; Board of Directors, Treasure 1999-2002, PR&E Model Revisiosons Subcommittee, 2004; Governance Task Force 2005-2006; IRE Committee 2008; Leadership Succession Committee, Chair, 2008, R.Louise Mc Manus Award, 2005

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

The two top challenges to nursing regulation today is the continued concern that we are effective in assuring the public safety and that the individuals licensed to practice at each level is competent. I believe that we must engage in on-going research regarding the competencies of our practitioners, particularly at entry level and engage in very significant dialogue with stakeholders surrounding competency issues. Another evolving challenge is that to the regulation of advanced practice nursing by boards of nursing. I believe we need to work collaboratively and with one vision regarding the scope and practice of APRNs.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

With 20 years of experience in nursing regulation, I bring an unique knowledge and understanding of regulation, its mission and purpose. As Treasurer of NCSBN, I have demonstrated an ability to work with the organizational leadership and staff to accomplish critical goals, resulting in financial security for this organization. I have a sincere commitment to contribute to the success of NCSBN for the good of nursing regulation and all of its Member Boards.

Designated Member (Board Member of Member Board)

Patricia Lane, MBA, BSN, RN, HCA

Board Member, Virginia, Area III

Date of expiration of term: June 30, 2012

Eligible for reappointment: Yes

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

Community Affiliations and Board of Work Since being on the board I have been on the following committees: Special Education Committee, CORE, Simulation Research Task Force, RFP Task Force for CNA's. Other activities in the community included: Member of Virginia Legislative Coalition, Board of Directors of National Black Nurses Association, Received the Magnet Leadership of Excellence award State of Virginia 2008, Member of ANA –Virginia confirmation 25579, District 8, President of Northern Virginia National Black Nurses Association 2007-2009, Member of American Association of Neuroscience Nurses, Ambassador for the Power to End Stroke Program Task Force Chair GWA, Member of Alpha Kappa Alpha Sorority Incorporated since 1982, Member of Mt. Zion United Methodist Church, Member of Sigma Theta Tau, GMU Alumni Association.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

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

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

My strengths incorporate project management, facilitation of groups, and comprehension of regulations. These skills were enhanced when I was in the role of a Quality Consultant and Director of Nursing Clinical Development. One of the things I would strive to do would be to share the work of NCSBN and their strategic initiatives with a plethora of stakeholders in nursing, health policy and community entities. I would take a grass roots approach to this methodology by creating quarterly updates of how strategic initiatives developed in NCSBN correlates to the success of nursing practice. The quality outcomes department for NCSBN is robust and I would like to see a stronger link to each state incorporating the initiatives of NCSBN. Furthermore I would like to see each state board member share the initiatives of NCSBN with their perspective area. I truly believe this would be a positive initiative for all to see the emphasis placed on patient safety.

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Leadership Succession Committee
Designated Member (Employee of Member Board)

Mary Blubaugh, MSN, RN

Board Staff, Kansas, Area II

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

NCSBN Area II Board of Directors 2003 to 2007, Committee on Nominations 2007 to 2009, Uniform Core Licensure Requirements and Portability Committee 2009, Core Committee 2007-2009, PR&E Committee 2002-2003, PERC Committee 2000-2002, Executive Administrator, Kansas State Board of Nursing, 1999-Present, Kansas ESAR/VHP Advisory/Planning Workgroup 2005 to Present, Kansas Strategic National Stockpile Planning Committee 2005 to Present, KSNA Educational Task Force 2004-2005, Kansas Nursing Work Force Partnership 2002-2005, Recruitment/Retention Strategies Workforce Council Team for Healthcare and Direct Care Classes 2001-2003, Kansas Small Agency Administrators 2000-Present, Health Resource Partnership 2000-2004, 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 State University 1992-Present, Fort Hays State University Nursing Honor Society 1991-Present

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

One of the newest challenges to nursing regulation is many boards of nursing are being required to do more with less. As the economy has changed so has the financial situation for boards of nursing. Several boards of nursing have seen their budgets decreased and their fee funds transferred to the state general fund. This has caused states boards of nursing to reevaluate what programs and services they can provide to continue to protect the public the most effective and efficient ways. NCSBN continues to support boards of nursing through sponsorship to meetings, reviewing and reporting best practices, and numerous workshops. NCSBN can develop best practice models for guidance for boards of nursing. We need to promote ongoing collaboration with state and national organizations to assist boards of nursing to achieve public protection effectively with decreased resources. Another issue that continues to be a challenge is the shortage of nurses. Although this shortage can be contributed to many things, two major problems are the lack of qualified faculty and lack of clinical sites. NCSBN can be the leader in identifying the barriers and help state boards of nursing to develop and implement strategies to ensure quality nursing education which will ensure nursing graduates who are competent as a novice nurse.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

I will bring the experience that I have as a past NCSBN board member, as a committee member, my role as an Executive Administrator and my commitment to the mission and vision of NCSBN. I will bring my desire for effective communication, honesty, accountability and the importance of regulatory excellence. As a member of the Leadership Succession Committee, I have worked and will continue to work to develop a slate of qualified candidates. I will continue to work with fellow committee members to develop core competencies and the leadership succession plan so this organization will continue to encourage and development leaders of the future.

Designated Member (Past Board of Directors Member)

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Paula Meyer, MSN, RN

Board Staff, Washington, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEE(S):

House of delegates member, ten years; Investigator Resources Committee, member and chair, 1999, 2000; Resolutions Committee, 2001; Area I Director, Board of Directors, 2001-2003; Nominations committee, 2006-2008; Leadership Succession Committee, 2008 to present. I have been the Executive Director of the WA Nursing Commission since 1998. In that time, I was also the Executive Director for five other professions within the Department of Health.

WHAT DO YOU PERCEIVE AS THE TOP TWO CHALLENGES TO NURSING REGULATION (PROVIDE TWO OR THREE STRATEGIES YOU WOULD USE TO ADDRESS THOSE CHALLENGES)?

While the nursing shortage continues to exist, addressing regulation of nursing personnel during our current economic crisis will be challenging. Identifying, implementing and evaluating every measure to improve regulation of not only nurses, but all health care providers is critical to public protection. We need to use our CORE data to identify best practices, work within NCSBN to communicate methods, and identify messages for boards working with their state legislatures. The second challenge continues to be the decreasing number of nursing faculty to prepare nurses. Boards need to articulate the roles of LPNs and RNs, determine critical need areas for RNS, identify barriers to nursing education, and implement innovations to nursing education that continue to protect the public and make the best use of public dollars.

WHAT LEADERSHIP COMPETENCIES WILL YOU BRING AND WHAT WILL YOU CONTRIBUTE TO ADVANCE THE ORGANIZATION?

Collaborative process to conflict resolution; financial management; lead change in the midst of economic crisis; innovative and creative; respond quickly and nimbly when needed while making progress on goals; aware of NCSBN strategic initiatives and experience with many of the committees and groups; familiarity with a variety of regulatory models; public speaking and presentations; commitment to the mission, goals and values of NCSBN.

2009 Report of the Board of Directors

Highlights of Business Activities Oct. 1, 2008 through May 31, 2009

NEW BEGINNINGS

The 2009 Board of Directors (BOD) began the year in a unique orientation session to ensure that the new BOD, consisting of 11 members for the first time in the history of NCSBN, would get off on the right foot for the good of the organization. To ensure continued governance, education and expertise, the BOD attended the annual BoardSource Leadership Forum in Washington, D.C. The BOD began its work by immediately approving the annual organizational budget for FY09, with due diligence regarding the economic environment and wise use of organizational resources. The BOD implemented governance performance improvement actions based on the 2008 Board Self Assessment to further governance efficiency and effectiveness.

Recommendation to the Delegate Assembly

1. ***Adopt the revision to the Education Model Rules.***

   Rationale:
   One of the charges to the Innovations in Education Regulation Committee was to develop a regulatory model for innovative education proposals. In meeting this charge, the committee reviewed the literature and received feedback from Member Boards and educators. Because of today's complexities in health care delivery, nursing and health care leaders agree that there is a need to transform how we educate nurses. In their mission of public protection, boards of nursing (BONs) approve nursing programs across the U.S. and its territories. The committee concluded that this is the ideal time for the NCSBN Model Education Rules to be revised to include language that would foster innovative approaches to nursing education when the proposed strategy departs from the current rule structure. BONs are in an excellent position to create a favorable climate for innovative educational approaches and champion new strategies to educate nurses, while remaining diligent in regulating core education standards.

   Fiscal Impact:
   Publication costs incorporated into the FY10 budget.

2. ***Adopt the College of Nurses of Ontario, the College of Registered Nurses of Manitoba and the College and Association of Registered Nurses of Alberta as Associate Members of NCSBN.***

   Rationale:
   The NCSBN Bylaws state that an Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory. The bylaws require approval of Associate Members by the full membership of the Delegate Assembly. The current applications for Associate Membership meet the qualifications as stated in the NCSBN Bylaws.

   Fiscal Impact:
   Upon acceptance, each new Associate Member will pay a $1,500 annual fee.

Members

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

Myra Broadway, JD, MS, RN Area IV Director (November 2008 - December 2008),
Vice President (December 2008 - August 2009), Maine, Area IV

Lepaine McHenry, MS, BSN, RN, CNS
Vice President, Arkansas, Area III (August 2008-December 2008)

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

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

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

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

Gino Chisari, MSN, RN
Area IV Director, Massachusetts (August 2007-November 2008)

Randall Hudspeth, MS, APRN-CNS/NP, FRE, FAANP
Director-at-Large, Idaho

Katherine Thomas, MN, RN
Director-at-Large, Texas

Catherine Giessel, MS, ANP, FAANP
Director-at-Large, Alaska

Gregory Howard, LPN
Director-at-Large, Alabama

Staff

Kathy Apple, MS, RN, CAE
CEO

Kate Jones
Manager, Executive Office

Board Meeting Dates

- Aug. 8, 2008 – Nashville, Tenn.
- Sept. 3-5, 2008 – Chicago
- Oct. 30, 2008 – Washington D.C.
- Dec. 3-5, 2008 – Chicago
- Dec. 16, 2008 – (Conference Call)
- Feb. 11-13, 2009 – Chicago
- May 4-6, 2009 – Chicago

FY09 Highlights and Accomplishments

COLLABORATION WITH EXTERNAL ORGANIZATIONS

Strategic Partnership Meeting Attendance by BOD and/or NCSBN Staff

- Colorado Board of Nursing
- European Council of Nursing Regulators (FEPI) President Meeting
- TriCouncil Meeting
- National League for Nursing (NLN) Education Summit
- The Council on Licensure, Enforcement and Regulation (CLEAR)
- National Quality Forum (NQF)
- American Association of Colleges of Nursing (AACN) Fall Meeting
- ANSI World Standards Week
- Citizens Advocacy Center (CAC)
- National Organization for Associate Degree Nursing (N-OADN) Convention
- Nursing Organizations Alliance (NOA) Fall Summit
- FEPI International Conference
- Rhode Island Board of Nursing
- National Academy of State Health Policy (NASHP) Annual Meeting
- First Philippine Nursing Competitiveness Conference
- Association of Academic Health Centers (AAHC) Workforce Data Conference
- American Board of Nursing Specialties (ABNS) Meeting
- Alliance for Nursing Accreditation Meeting
- Minnesota Board of Nursing
- Emergency Nurses Association Consensus Meeting
- National Student Nurses Association (NSNA) Conference
- American Medical Association (AMA) 2008 Interim Meeting
- International Council of Nurses (ICN) Credentialing Forum
- Commission on Graduates of Foreign Nursing Schools (CGFNS) Building Global Alliances
- AACN Baccalaureate Meeting
- Council of State Governments (CSG)
- National Council of State Legislatures: Trade Policy Meeting
- AACN Spring Meeting
- Federation of State Medical Boards
- National Association of Clinical Nurse Specialists
- American Board of Nursing Specialties Spring Meeting
- National Governors Association Meeting
- Centers for Nursing Workforce Meeting
- Florida Board of Nursing

- South Carolina Board of Nursing
- American Organization of Nurse Executives (AONE)

FINANCE

- The BOD met with the auditors and approved the financial statements and the report of the independent auditors for the year ended Sept. 30, 2008.
- The BOD reviewed the 2008 IRS 990 Form.
- The BOD approved the engagement of Legacy to audit the financial statements for the fiscal years ending Sept. 30, 2009, Sept. 30, 2010, and Sept. 30, 2011.
- The BOD approved the proposed budget for the fiscal year beginning on Oct. 1, 2008, and ending on Sept. 30, 2009.
- The CEO of NCSBN was authorized, directed and empowered to establish and maintain banking investment and brokerage accounts in the name of NCSBN with certain financial institutions (each, a "Bank"); that the officers of NCSBN be, and each of them hereby is, authorized to prepare, execute, and deliver in the name and on behalf of NCSBN such resolutions, designations, applications, certificates and other documents or instruments as may be necessary to open such account; and that the secretary of NCSBN shall deliver to the Bank a certified copy of such resolutions.
- The BOD approved the Finance Committee's recommended revisions to Policy 8.2. (Financial Planning).
- The BOD approved the Finance Committee's recommended revisions to Policy 8.6. (Purchasing and Contractual Commitments).
- The BOD accepted the financial statements for the period ending Dec. 31, 2008.
- The BOD approved the selection of JP Morgan Asset Management to manage the NCSBN bond portfolio.
- The BOD accepted the financial statements for the period ending March 31, 2009.
- The BOD approved the revisions to Policy 8.5. (Investments).

GOVERNANCE AND POLICY

- The BOD began a comprehensive review of historical BOD and Delegate Assembly positions. The BOD is currently revising its internationally educated nurses position and the nursing shortage statement in order to reflect 2008 information and citations.
- The BOD conducted an environmental scan at each meeting.
- The BOD endorsed the Advanced Practice Registered Nurse (APRN) Consensus Paper.
- The BOD set meeting dates for FY10.
- The BOD assigned board members to attend various external organizational meetings.
- The BOD established a Uniform Core Licensure Requirements and Portability Committee, articulated committee charges and appointed members to the committee.
- The BOD approved the proposed revisions to Policy 4.1. (Committees).
- The BOD reviewed and discussed the 2008 Delegate Assembly Evaluations and made changes to the 2009 Annual Meeting schedule based on member feedback.
- The BOD appointed a chair to the Leadership Succession Committee and filled a vacancy on the committee by appointment.

- The BOD reviewed and discussed Policy 1.2. (Organizational Planning) specific to the direction to review the mission and vision every six years. The current mission and vision were developed and adopted by the Delegate Assembly and BOD respectively in 2003. The BOD began preliminary discussions of the current mission, vision and values, and sought initial membership input during the 2009 Midyear Meeting.
- The BOD reviewed Policy 2.1. (Distribution of Members).
- The BOD approved funding of two members from each jurisdiction to attend the Midyear Meeting and revised Policy 5.12. (Funding of NCSBN Members to Annual Meeting) accordingly.
- The BOD approved the concept and launch of the *Journal of Nursing* regulation.
- The BOD reviewed recommendations for regulatory interventions related to medical errors.
- The BOD reviewed and discussed the scope of practice of licensed practical/vocational nurses (LPN/VNs) working in dialysis units.
- The BOD approved three two-hour Webinars for Member Board Operations staff.
- All BOD policies were reviewed and revised to reflect the inclusion of Associate Members.
- The BOD reviewed and discussed the National Governors Association E-health Report and the implications for licensing boards.
- The BOD approved a full-time employee for the purpose of providing professional support activities needed for multistate jurisdiction licensure implementation and compliance. The BOD further approved that in conjunction with the Nurse Licensure Compact Administrators (NLCA) to move forward with a plan to review and redefine the relationship between the NLCA and NCSBN to establish the presence of a unified regulatory organization with a conclusion and implementation by July 2009.
- The BOD approved applying for Associate Membership in FEPI.
- The BOD approved the proposed revision to the 2009 Standing Rules.
- The BOD approved a donation of $50,000 in one lump sum to the Foundation of NSNA.
- The BOD approved the revised Awards Criteria and Eligibility.
- The BOD approved the revised Institute of Regulatory Excellence (IRE) Policy.
- The BOD approved NCSBN recognition of Charlene Kelly and her many contributions to NCSBN by donating $10,000 to the Charlene Kelly Scholarship Fund.
- The BOD approved the committees for FY10, including appointing committee chairs and determining committee charges.
- The BOD reviewed an evaluation and recommendations regarding the Center for Regulatory Excellence Program.
- The BOD approved an organizational research agenda and policy.
- The BOD completed appointments to fill vacancies of the Area IV director and vice president positions.
- The BOD approved a future conference for presentation of initial research from the Center for Regulatory Excellence Program.
- The BOD reviewed a report on the duty to report to law enforcement.
- The BOD reviewed a report on the European Tuning Project, identifying core nursing education competencies.
- The BOD routinely reviewed progress regarding the strategic initiatives, strategic objectives and performance measures for FY09.

- The BOD reviewed the outcome of the Committee Chair Orientation and annual conference call.
- The BOD reviewed a report on regulatory trends.
- The BOD began discussion of proposed strategic objectives for FY10.
- The BOD reviewed and discussed the annual continuous quality improvement membership satisfaction survey results.
- The BOD participated in a conference call with the Leadership Succession Committee to discuss the needs of the BOD for the future.
- The BOD discussed the NCSBN meeting with the Canadian Nurses Association, who are exploring the move to computer-based testing.
- The BOD reviewed the evaluations of the annual IRE conference.
- The BOD reviewed quarterly E-Learning Productions update reports.
- The BOD reviewed the annual committee evaluations.
- The BOD reviewed the 2009 Midyear Meeting evaluations.
- The BOD reviewed the first Operations Webinar evaluations.
- The BOD reviewed a report on legislative trends regarding nursing education approval authority.
- The BOD reviewed recommendations regarding health care reform and drafted a letter to President Obama regarding a regulatory perspective.
- The BOD filled the Area I vacancy on the Leadership Succession Committee by appointment.

TESTING

- The BOD reviewed quarterly NCLEX® performance reports.
- The BOD reviewed the current progress on NCLEX innovative items.
- The BOD reviewed progress on the Pearson VUE response to test deployment.
- The BOD reviewed the *2008 Knowledge of Newly Licensed Registered Nurses Survey*, the NCLEX-RN® Practice Analysis Report and the preliminary recommendations to the 2010 NCLEX-RN® Test Plan.
- The BOD reviewed the evaluations of the 2008 NCLEX® Invitational.

PRACTICE, EDUCATION AND REGULATION

- The BOD reviewed the report of the Advanced Practice (APRN) Committee.
- The BOD reviewed the report of the Chemical Dependency Program Review Committee.
- The BOD reviewed the report of the Continued Competence Committee.
- The BOD reviewed the report of the Disciplinary Resources Committee.
- The BOD reviewed the report of the Institute for Regulatory Excellence Committee.
- The BOD reviewed the report of the Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®) Committee.
- The BOD reviewed the report of the Transition to Practice Committee.
- The BOD reviewed the report of the Innovations in Education Regulation Committee.

INFORMATION TECHNOLOGY

- The BOD routinely reviewed performance and enhancements regarding Nursys®.
- The BOD approved direct assistance to the following Member Boards for technology support, per Policy 2.9.: Virgin Islands, Maine, Ohio, Louisiana-RN, District of Columbia, Iowa, Guam, Massachusetts, Wyoming, North Carolina and Kentucky.
- The BOD approved a policy for emergency access to Nursys.
- The BOD reviewed a report on barriers to participation in Nursys licensure verification.
- The BOD reviewed and discussed a proposal for a comprehensive licensure data management system.
- The BOD reviewed a proposal for a one time determination of an unduplicated count of nurses in the U.S.
- The BOD reviewed updates regarding the Data Integrity Project.

RESEARCH

- The BOD approved the following new research projects: continuation of the remediation study; continuation of the simulation study; advanced practice; medication assistants; transition programs; continued competency; and alternative programs.
- The BOD reviewed the current status of data analysis for TERCAP.
- The BOD reviewed the current status of data analysis for Workforce Data Project.
- The BOD reviewed the report of the *Post-Entry Competence Study*.
- The BOD reviewed the report of the Commitment to Ongoing Regulatory Excellence Committee.

Attachment

A. Annual Progress Report, October 2008 – May 2009

Attachment A

Annual Progress Report, October 2008 - May 2009

Background

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

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

STRATEGIC OBJECTIVE 1

Identify and develop patient safety recommendations for nurse regulators.

A comprehensive literature review related to patient safety and medical errors was completed. Issues related to patient safety initiatives and nursing regulation will be researched through the 2009 Professional and Practice Issues Survey. The potential for nursing regulation involvement regarding the Patient Safety Education Project is being explored. Information and education on regulatory and public safety implications of proposed legislation was shared with various public stakeholders on topics such as the education approval authority of Member Boards, advanced practice registered nurse (APRN) scope of practice and verification of nurse credentials in the federal system.

STRATEGIC OBJECTIVE 2

Promote patient safety initiatives.

NCSBN continued its membership in the National Quality Forum and the National Patient Safety Foundation. Collaboration with various federal agencies was facilitated with the Federal Nursing Services Council, Department of Homeland Security, Office for Advancement of Telehealth and the Health Resources Services Administration.

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

STRATEGIC OBJECTIVE 1

Recognize Member Board excellence.

A clearly articulated and objective process for soliciting and identifying outstanding contributions to the organization has been communicated to the membership and enacted through the NCSBN Awards Program.

STRATEGIC OBJECTIVE 2

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

Throughout the fiscal year, NCSBN conducted numerous activities, such as seminars, Webinars and workshops aimed at communicating information to its membership. Members were invited to participate in the Institute for Regulatory Excellence (IRE) Fellowship Program, Executive Officers Seminar, the Midyear Meeting Leadership Conference for executive officers and Member Board presidents, Investigator and Attorney Symposium, Information Technology Summit, NCLEX® Invitational, two NCLEX® Regional Workshops, as well as Member Board Operations Webinars. In addition, several NCSBN Interactive courses were identified and developed.

Leader to Leader, Council Connector, Policy Perspectives, *Directory of Nurse Aides Registry* and *LINK* were published as scheduled. The NCLEX® Fact Sheet was updated and posted on the NCSBN Web site. New collateral materials educating consumers and nurses on nursing regulation

were produced. Networking opportunities such as the APRN Roundtable and the networking sessions at Midyear Meeting were available for Member Boards to attend. Information sharing and networking was made easy through conference calls in areas such as education, policy and practice. Conference calls for APRN consultants and Taxonomy of Error, Root Cause Analysis and Practice-Responsibility (TERCAP®) users were also held. Additionally, the Continuous Quality Improvement Survey was conducted. Results of the survey were later analyzed for program and service improvements.

NCSBN also introduced its new E-push technology, which allows for newsletters, news releases and information surrounding NCSBN's products and services to be communicated via e-mail.

STRATEGIC OBJECTIVE 3

Maintain and protect a substantial internal financial reserve.

Financial statements were reviewed on a quarterly basis in an effort to assure cash and invested securities have ready market values that ensured available internal funding to support NCSBN activities in perpetuity. An analysis of the long-range forecast was also completed. Through the development and approval of the FY09 budget, financial resources were prioritized and allocated to strategic initiatives that supported the mission of NCSBN. Certified public accountants (CPAs) from the firm Legacy Professionals audited NCSBN's financial policies to ensure adequate financial statements and internal controls were in place. Investment, policy, strategy, asset allocation and returns on investment were reviewed quarterly. NCSBN's investment manager and consultant performances were evaluated. As a result, JP Morgan Asset Management was selected to manage NCSBN's core bond investments. The Finance Committee, along with legal counsel, met with insurance brokers from USI Midwest to review the property and liability coverage for insurable losses. NCSBN received an unqualified opinion from an independent CPA firm attesting to the accuracy of the financial statements for FY08. After conducting an audit in accordance with generally accepted standards, in the opinion of the auditors, the statements fairly presented the financial position of the organization.

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

STRATEGIC OBJECTIVE 1

Promote ongoing regulatory excellence.

The Commitment to Ongoing Regulatory Excellence (CORE) research process was reviewed and refined to meet the needs of Member Boards. Strategies were developed and implemented to increase the understanding and use of CORE reports by Member Boards. TERCAP data collection has increased and data were periodically reviewed. Education sessions and other resources were provided to Member Boards to increase participation and data collection in the TERCAP project.

The 2009 IRE Fellowship participants and mentors were selected and the fellowship project proposals are under review for approval. Ongoing assistance with project development and completion continues for the members of the 2006, 2007 and 2008 IRE cohorts. The 2009 Annual IRE Conference was also held.

STRATEGIC OBJECTIVE 2

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

Implementation strategies for the new APRN regulatory model were developed. An outreach toolkit to inform the public of the board of nursing (BON) discipline process is near completion. Alternatively, early intervention programs related to practice including advantages and disadvantages were identified. The Sexual Misconduct Resource Manual was revised. An evidenced based regulatory model for transition to practice continues to be developed with

Member Board and stakeholder input and feedback. Model rules for the transition to practice regulatory model were drafted. Guiding principles and a regulatory model with multiple options for demonstration of continued competence were addressed. Further input by the Board of Directors (BOD) and Member Boards have been identified for additional development.

Discipline, alternative programs and regulatory practices for chemically dependent licensees were reviewed. Real and perceived regulatory barriers to innovations in education were identified. A regulatory model for innovative education proposals was developed and is being presented to the Delegate Assembly for review and consideration. APRN stakeholders and NCSBN communicated and collaborated regarding APRN issues. A committee was established to evaluate the currency and relevance of the 1999 Uniform Core Licensure Requirements (UCLRs), including initial, renewal, endorsement and international requirements. Actions regarding variances to core licensure requirements will be reviewed and recommended. A strategic plan for assisting Member Boards to implement the UCLRs will be developed. Solutions for issues identified regarding the interface between the two licensure models will be recommended.

STRATEGIC OBJECTIVE 3

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

The Center for Regulatory Excellence Program continued and four proposals were funded. An index was added to the *Member Board Profiles*. The NCLEX candidate projections and the licensure statistics research projects were completed.

The *Report of Findings from the 2009 Employers Survey* is being developed. The *Progress Report Phase I Study of North Carolina Evidence-based Transition to Practice Initiative* and the *Remediation Program Outcomes* were completed. *The Effect of High-Fidelity Simulation on Nursing Students' Knowledge and Performance: A Pilot Study, Effectiveness of Negotiation Training* and *Post-Entry Competence Study*, were completed as well. New research projects regarding APRNs, simulation, medication aides, transition programs and alternative programs are being designed and implemented.

STRATEGIC OBJECTIVE 4

Support single state and multistate licensure initiatives.

Licensure information was provided to Member Boards and other entities as requested regarding both the single state and multistate licensure models. Assistance was provided to the Missouri Board of Nursing on data related to the Nurses Licensure Compact (NLC) in relation to pending legislation. A UCLR Conference was conducted in November 2008 to begin addressing issues related to all licensure models.

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

STRATEGIC OBJECTIVE 1

Maintain a comprehensive national nurse licensure database.

Enhancements were made to Nursys® that included Reports at Your Fingertips and a user-friendly interface for inputting discipline data. In addition, Nursys.com, which provides online license verification for nurses, employers and the general public, was released. The new Falsified Identity Tracking System (FITS) was also deployed. NCSBN continues to support Member Board reporting of disciplinary actions to federal databanks and has been 100 percent compliant with federal reporting requirements.

STRATEGIC OBJECTIVE 2

Maintain a national nurse workforce data repository.

Workforce data from four states is now being collected through online renewal. Staff is currently collecting information from all BONs to determine what is needed in order to contribute data to the workforce project and therefore, increase the numbers of participating states.

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

STRATEGIC OBJECTIVE 1

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

Sufficient items for four operational pools were developed. Only valid NCLEX examinations were administered and scored. All candidates were seated in compliance with the 30/45 day contractual obligation for both domestic and international test centers. In addition, all examinations were administered in accordance with security policies and procedures. Registered nurse (RN) and practical nurse (PN) practice analyses were conducted, and an NCLEX-RN® test plan was recommended to the Delegate Assembly. Areas of innovation continue to be explored and reported to the BOD. A practice analysis study of RNs in Ontario and British Columbia was initiated. The NCLEX® Examination Committee is recommending a minimum score requirement for the Test of English as a Foreign Language Internet-Based Test that measures the minimum degree of English proficiency among foreign nurses. New item types were researched and a tentative plan for the introduction of new item types into the NCLEX examinations was devised.

STRATEGIC OBJECTIVE 2

National Nurse Aide Assessment Program (NNAAP™) and Medication Aide Certification Examination (MACE™) development, security, psychometrics, administration, and quality assurance processes are consistent with Member Boards' examination needs.

The transfer of NNAAP and MACE intellectual property was finalized. Sufficient items and skills were built to populate required number of test forms. Item writing and review workshops were conducted for both the NNAAP and MACE examinations. Psychometric properties of items, skills and test forms were evaluated.

F. NCSBN advances the development of regulatory excellence worldwide.

STRATEGIC OBJECTIVE 1

Develop and maintain collaborative working relationships with key national and international organization.

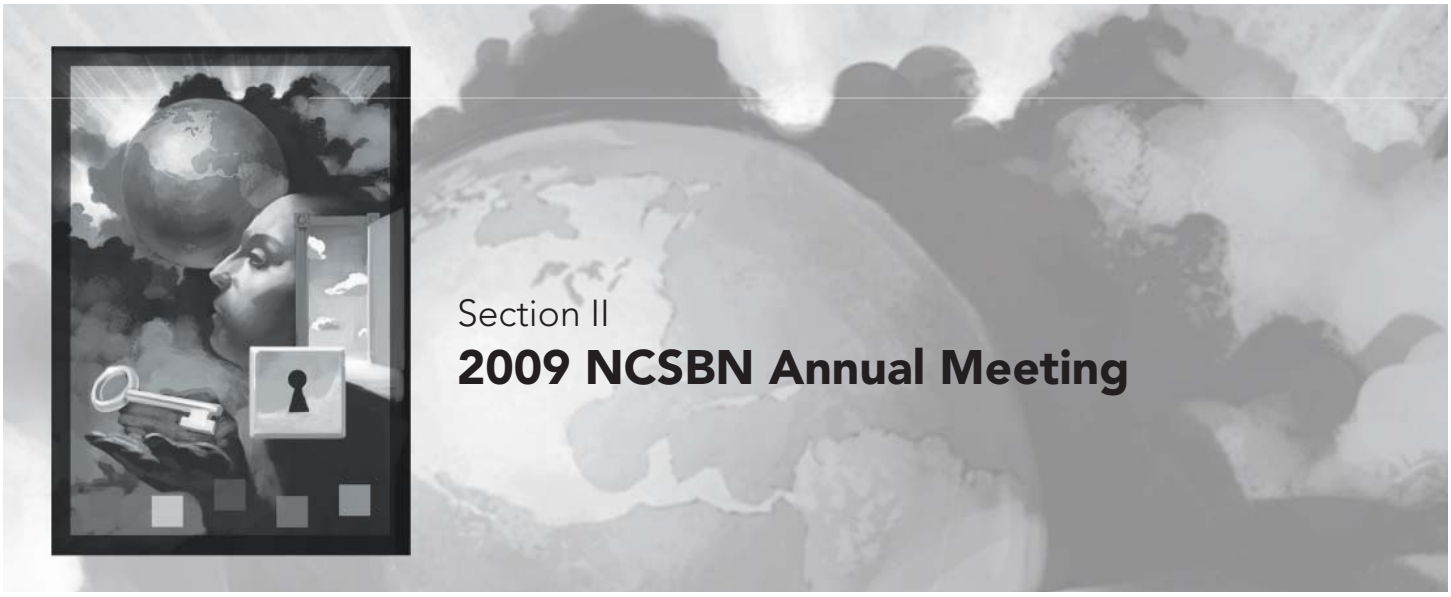
NCSBN has advanced the visibility and mission of the organization through various presentations and participation at national and international meetings, as listed in the Board of Directors Business Book Report. Additionally, NCSBN has actively participated in the American Nursing Shortage Relief Coalition, the Coalition for Patients Rights, the AcademyHealth Workgroup on Ethical International Recruitment Monitoring, CLEAR's policy and knowledge transfer committees, the annual nursing community meeting on congressional budget priorities, the National Governors Association Health Committee and state nursing workforce centers meetings. President Laura

Rhodes and CEO Kathy Apple met in Chicago with the President of the European Council of Nursing Regulators (FEPI). The BON moved to become an associate member in FEPI as one method of staying abreast of nurse regulator issues globally.

STRATEGIC OBJECTIVE 2

Disseminate information regarding international nursing regulatory issues.

International regulatory information notices were shared with Member Boards as received.



Section II

2009 NCSBN Annual Meeting

SECTION II: COMMITTEE REPORTS

Reports with Recommendations

Informational Reports

Innovations in Education Regulation Committee

Recommendation to the Delegate Assembly

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

   Rationale:
   One of the charges to the Innovations in Education Regulation Committee was to develop a regulatory model for innovative education proposals. In meeting this charge, the committee reviewed the literature and received feedback from Member Boards and educators. Because of today's complexities in health care delivery, nursing and health care leaders agree that there is a need to transform how we educate nurses. In their mission of public protection, boards of nursing (BONs) approve nursing programs across the U.S. and its territories. The committee concluded that this is the ideal time for the NCSBN Model Education Rules to be revised to include language that would foster innovative approaches to nursing education when the proposed strategy departs from the current rule structure. BONs are in an excellent position to create a favorable climate for innovative educational approaches and champion new strategies to educate nurses while remaining diligent in regulating core education standards.

Background

Because of the complexities in nursing and health care delivery, and a national focus on patient safety, there has been a call across nursing and health care organizations for more innovation in nursing and health care education. Therefore, on March 25, 2008, NCSBN hosted an invitational roundtable where leaders in nursing gathered to discuss the implications of implementing innovations in nursing education. The next day, March 26, 2008, NCSBN hosted a national conference where the regulatory implications of nursing education innovations were presented. To continue with this endeavor to foster nursing education innovation, the Board of Directors (BOD) established the Innovations in Education Regulation Committee. A more comprehensive report can be found in Attachment A.

The BOD charged the committee with:

1. Identify real and perceived regulatory barriers to innovations in education.

As a foundation for this work, members of the committee reviewed the literature and developed definitions and premises. They also hosted a collaborative call with the following organizations to gain their input about perceived regulatory barriers:

- American Association of Colleges of Nursing (AACN);
- Commission on Collegiate Nursing Education (CCNE);
- National Association for Practical Nurse Education and Service (NAPNES);
- National League for Nursing (NLN); and
- National League for Nursing Accrediting Commission (NLNAC). (They were not able to attend.)

The members of the committee then developed a conceptual model to visualize the regulatory influences (processes, rules/law and communication) on nursing education innovations (Attachment A). They also developed flyers for the BONs (Attachments B and C). Attachment B describes the real and perceived regulatory barriers and makes some recommendations to BONs for creating a favorable environment for innovative education approaches. Another flyer (Attachment C) was designed for BONs to distribute to educators who are contemplating an innovative approach in nursing education. This handout will provide an opportunity for faculty and BONs to dialogue about innovations in nursing education.

Members

Pamela Randolph, MS, RN
Arizona, Area I

Susan Odom, PhD, RN
Idaho, Area I, Chair

Mary Beth Stepans, PhD, RN
Wyoming, Area I

Joyce Zurmehly, PhD, RN
Ohio, Area II

Cyndy Haynes, MSN, RN
West Virginia-RN, Area II

Nora Steele, DNS, RN, APRN
Louisiana-RN, Area III

Linda Burhans, PhD, RN
North Carolina, Area III

Janice Hooper, PhD, RN
Texas, Area III

Staff

Nancy Spector, PhD, RN
Director, Regulatory Innovations

Qiana Hampton, MBA, MHRM
Administrative Assistant,
Regulatory Innovations

Meeting Dates

- Oct. 13-14, 2008
- Jan. 29-30, 2009
- March 19-20, 2009
- March 30, 2009 (Conference Call)

Relationship to Strategic Plan

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

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

2. Develop a regulatory model for innovative education proposals.

The members of the Innovations in Education Regulation Committee decided that developing model rules (see Attachment D) would be an excellent way to foster innovation in education. These would provide BONs with regulatory language to allow for innovative approaches to nursing education that are outside the current rule structure. This language would be particularly effective for those BONs that don't have a lot of flexibility in their practice act or rules. As with any model rules, BONs can adapt the language for their particular jurisdictions.

Highlights of FY09 Activities

Besides reviewing the literature and holding conference calls with nursing education organizations, committee members dialogued with the membership at NCSBN's Midyear Meeting and through e-mail, conducted a survey on regulatory simulation limitations, and reviewed the *Member Board Profiles*. With that background, the committee developed a conceptual model for describing the influences of regulatory parameters on innovation. It is, however, clear that other hindrances exist as well. Educational institutions, practice administrators and the students themselves can all set up barriers for implementing innovative educational approaches.

The committee also developed model rule language for BONs to adopt that will allow educators to develop innovations outside the current rule structure. If a jurisdiction adopts the model rules on innovations, evaluation data on the innovative approaches will be reported to the BON and these data will provide the nursing community with evidence for nursing education innovations.

Specific highlights from this year's committee include:

- Sought input from our membership on the model rules that foster innovative approaches to nursing education and on perceived or real regulatory barriers.
- Hosted a collaborative conference call with five nursing education organizations to gain insight on their perceptions of regulatory barriers.
- Developed model rules that foster innovations in nursing education.
- Developed a conceptual model that describes the three major regulatory influences on innovative approaches in nursing education: laws/rules, processes and communication.
- Conducted an online survey on the use of simulation in BONs.
- Designed a flyer for BONs that makes recommendations for creating a favorable environment for innovative education approaches.
- Designed a flyer for BONs to distribute to nursing education programs that provides some tips on what to think about before developing an innovative approach.

Future Activities

- NCSBN will create a Web site to serve as a clearinghouse for those innovative education approaches that BONs approve.
- If the model rules are adopted at the 2009 Delegate Assembly, NCSBN will disseminate that information in NCSBN's new journal, *Leader to Leader* and *Council Connector*, for the purpose of encouraging innovative approaches.
- NCSBN will establish a plan to evaluate whether BONs have adopted the innovation model rules and if they have been effective in fostering innovations in nursing education.

Attachments

A. Full Report of Innovations in Education Regulation Committee

B. Recommendations for Boards of Nursing for Fostering Innovations in Education

C. Tips for Planning Nursing Education Innovative Approaches

D. Model Rules for Innovative Approaches in Nursing Education Programs

Attachment A

Full Report of Innovations in Education Regulation Committee

April 6, 2009

To supplement the work done by the Innovations in Education Regulation Committee, a history of the committee, the definitions and premises for their recommendations, a synopsis of the literature, a full report from the collaborative call held with education leaders, and a discussion of the influences that affect regulation, particularly regulatory influences, are presented below.

Background

Because of the complexities in nursing and health care delivery, and a national focus on patient safety, there has been a call across nursing organizations and health care organizations for more innovation in nursing and health care education (Greiner and Knebel, 2003; IHI, 2003; NLN, 2003; NCSBN, 2005; AACN, 2008). Therefore, NCSBN held an invitational roundtable on March 25, 2008, where leaders in education, practice and regulation gathered to discuss how nursing can collaborate to innovatively enhance nursing education for the next generation of nurses. This meeting was facilitated by NCSBN staff and included representatives from seven organizations related to nursing education, three boards of nursing (BONs), the American Nurses Association, and the Robert Wood Johnson Foundation. The group discussed the meaning and implications of innovation in nursing education. Perceived barriers to educational innovations were discussed; not only those related to regulation, but also the barriers set up by education systems, practice environments and the students themselves. A vision for the future was presented, which focused on improved communication and forming partnerships between education, regulation and practice.

The following day, March 26, 2008, NCSBN's Faculty Qualifications Committee hosted a conference on the faculty shortage that attracted educators, practitioners and regulators from around the country, as well as internationally. At this meeting, some exemplar innovations were presented and nurse regulators discussed how these could be implemented in their jurisdictions.

In May 2008 the NCSBN Board of Directors established a new committee for 2008-2009 to continue with this endeavor of fostering innovation in education, the Innovations in Education Regulation Committee, which was charged with:

- Identifying real and perceived regulatory barriers to education innovations; and
- Developing a regulatory model for innovative education proposals.

Definitions and Premises

Committee members began by developing the following definitions and premises as a foundation to their work. When devising the definition for innovation, the group recognized that the etymology of the word derives from the Latin word "innovare," which means "to renew or change" (Online Etymology Dictionary, 2001). Therefore, while an innovation is something very new and different, it doesn't necessarily mean that an innovation is better. Oftentimes, that nuance is not understood.

- Definitions
  - Innovation - a dynamic, systematic process that envisions new approaches to nursing education.
  - Regulatory barrier - real or perceived regulatory parameters that hinder innovation in nursing education.
- Premises
  - The mission of BONs is public protection.

- Factors other than BON regulations may constrain innovation and therefore limit the scope of this report.
- As knowledge and complexity in health care increase exponentially, newer models of nursing education are necessary.
- Collaboration and partnerships often are required for innovation in nursing education.
- Innovation can occur at all levels of nursing education.
- Nursing regulation recognizes the value of evidence based innovation in meeting nursing education program outcomes.
- Quality can be maintained amidst innovative changes.
- The ultimate responsibility and accountability of any innovation rests with the nursing program.
- Advances in technology may influence innovation in nursing education.
- Nursing is a practice discipline requiring supervised clinical instruction.
- Regulation criteria for nursing programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection.

Selected Literature Review

The members of the committee reviewed the literature, with an emphasis on reports related to regulatory issues and concerns. Please see Appendix C for a list of suggested references.

The literature clearly calls for more innovation in nursing education (Bellack, 2008; Benner, Sutphen, Leonard-Kahn & Day, 2008; Coonan, 2008; Dreher, 2008; Gabrud-Howe and Schoessler, 2008; Tanner, 2008; Unterscheutz, Hughes, Nienhauser, Weberg and Jackson, 2008), even though Ironside and Valiga (2007) found that 77 percent of their survey respondents reported that faculty in their program have made a commitment to implementing innovative, evidence based approaches to teaching and learning. Further, Clarke and Cheung (2008), in reporting workforce statistics in nursing, predict that faculty shortages will stay high and that there will be "heavy pressure" (p. 24) for innovations in nursing education to increase the numbers of new graduates. For nursing to advance through the 21st century, education, practice and regulation will all need to work together to foster innovative approaches in the education of nurses.

There are myriad examples of innovations reported in the nursing literature. *The Journal of Nursing Education* has a section in each issue reporting on innovations. Some examples of innovative approaches to nursing education include a recent report using the Schumacher Model to recruit and groom new faculty (Schumacher, Risco & Conway, 2008). Given the current faculty shortage, this model shows promise. Moscato, Miller, Logsdon, Weinberg and Chorpenning (2007) report on the University of Portland's very positive experience with the innovative dedicated education unit approach to clinical education. Brown, Kirkpatrick, Mangum and Avery (2008) report on their work with transforming traditional nursing education by implementing the emerging narrative pedagogy approach. With this approach, the student becomes a more self-directed, participative learner and the faculty role shifts from being teacher-dominated to being more learner-centered. Goodin and Stein (2008) discuss the implication of the deliberate discussion teaching strategy in nursing. This method has been used in other disciplines for more than 25 years and offers some real benefits to nursing. These innovations are just a few examples of what is available in the literature.

Yet sometimes there are barriers that prevent these innovations from being implemented. Higher education itself, with its time-consuming curriculum committees and administrative hierarchies, can get in the way of innovators (Bellack, 2008; Coonan, 2008). Coonan (2008) says two barriers cited by educators are not having enough time and not having enough money. However, he disputes these reasons as being shortsighted. Coonan particularly suggests that when educators partner with practice, there are potential benefits.

Similarly, practice can be a barrier to innovation, partly because the power is so centralized, and there is often linear thinking and vertical hierarchies in health care organizations (Unterschuetz et al., 2008). Coonan (2008) asserts that state and federal policy makers have failed to support innovation in nursing education as a priority, thereby setting up barriers. Regulation, including national nursing accreditors and BONs, have also been cited as barriers to innovation (Bellack, 2008; Coonan, 2008; Dreher, 2008). Dreher (2008) states that the regulatory entities are not in the position to drive innovation as they must ensure adherence to standards. While the Innovations in Education Regulation Committee agrees with this, they also think that regulators can champion innovative approaches in education and can act as a conduit for them.

Hargreaves (2008) presents an interesting perspective in innovation for regulators. She discusses the importance of balancing the risk with the expected outcome. She also presents an excellent decision tree for thinking through the consequences of the innovation, as well as looking at whether the innovation will make a difference. Please see Attachment C for more detail on Hargreaves' decision tree.

There is also literature about implementing innovations. Murray (2007) presents an excellent review of how to make choices in adopting trends in nursing education using the diffusion theory of innovation (Rogers, 2003). She also discusses the adopter categories from the diffusion theory, which includes innovators, early adopters, early majority, late majority and laggards. The tipping point occurs, she says, when the early majority adopts the innovation. Van Achterberg, Schoonhoven & Grol (2008) provide some evidence based guidelines for implementing innovations, though they acknowledge that further research is needed in implementation science, particularly in nursing.

Tanner (2008) suggests that our next generation of innovations in nursing education will be pedagogies of integration where students will learn through experience and evidence based practice. Similarly, Benner et al. (2008), in their Carnegie study of nursing education, propose that educators should shift from using curricular threads and competencies to the integration of cognitive knowledge, practice know-how and ethical formation. Benner et al., found in their study that clinical and classroom study in nursing education was often separate and distinct, and they'd like to see clinical and classroom teaching integrated into a "seamless whole" (p. 475). It is likely the Carnegie study, when published, will stimulate innovative pedagogies integrating clinical and didactic approaches to nursing education.

Collaborative Conference Call with Educators

At their January meeting, Innovations in Education Regulation Committee members held a collaborative call with nursing education organizations[1] to learn their perspectives about some of the regulatory barriers that BONs have in place that hinder innovation in nursing education. Committee members had sent representatives from the organizations their definitions, premises and some objectives for the meeting. The following were the themes from that call:

- There are issues about specialization of faculty. In some states, programs are required to have content specialists.
- Educators are wondering about how much simulation can be used to replace clinical experiences.
- There are concerns about full-time/part-time percentages of faculty.
- There was a concern that BONs are monitoring distance learning programs more than other programs, though the guests did understand that all programs are regulated equally.
- The faculty shortage is a problem for BON rules on faculty qualifications. Similarly, the use of preceptors is sometimes limited by BONs, causing barriers.

[1]American Association of Colleges of Nursing (AACN); Commission on Collegiate Nursing Education (CCNE); National Association for Practical Nurse Education and Service (NAPNES); and National League for Nursing (NLN). The National League for Nursing Accrediting Commission (NLNAC) was invited, but no one from that organization was able to participate at that time.

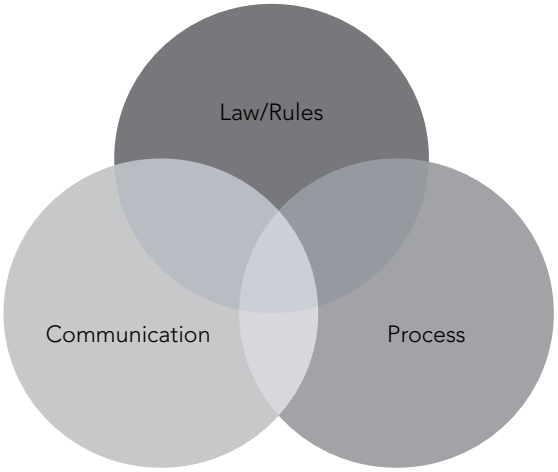
- The education organizations would like to see more piloting of innovations and might encourage more partnering with BONs.
- NCLEX® first-time pass rates are barriers, as discussed by NLN.
- The dedicated education unit (DEU) is an excellent way to work with the faculty shortage, though some BONs might have difficulty incorporating them in their rules.
- Educators need access to the data. For example, it is believed that some states don't inform programs about which students have failed the NCLEX.
- There was discussion about disseminating the committee's findings, including bundling with brochures; Webinars; YouTube videoclips; *Leader to Leader*, and appearances at each others' conferences and conference calls. Getting the word out about the model rules fostering innovations would be particularly important.
- One participant said that the BON is often feared by educators. The group talked about developing relationships between the BON and educators in each jurisdiction. Suggestions included the BON sending a representative to the deans' and directors' meetings.
- The group suggested that BONs need to communicate which innovations are working and which ones are not. State Web sites could report this, as is done in Texas.
- Outcomes are very important in measuring the strength of a program and they should include more than just the NCLEX pass rates.
- One of the committee members reminded the group about the NCLEX program reports and how valuable they can be for the programs.
- The group expressed willingness to review model rules that the committee is developing.

Generally, participants on the collaborative call were very grateful that NCSBN had asked for their input and were eager to continue the dialogue about how to foster innovation in nursing education.

Fostering Innovation

After reviewing the literature and listening to input from educators and BONs, the Innovations in Education Regulation Committee decided that developing model rules (see Attachment D) would be an excellent way to foster innovation in education. These would provide BONs with regulatory language to allow for innovative approaches to nursing education that are outside the current rule structure. This language would be particularly effective for those BONs that don't have a lot of flexibility in their practice act or rules. As with any model rules, BONs can adapt the language for their particular jurisdictions.

Related to regulatory influences that prevent innovation, the committee devised the following model to describe these influences:



The laws/rules, processes in the BONs and communication with educators are all regulatory processes that can hinder innovation. When the three regulatory influences overlap, the barrier might be even harder to overcome. Please see Attachment B for an identification of possible regulatory barriers and for recommendations to BONs for promoting a favorable climate for innovation. Attachment C will be available to BONs to provide to educators who are interested in implementing innovations. This document gives the educators tips to consider when planning an innovation and also contains a suggested reading list.

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Attachment B

Recommendations for Boards of Nursing for Fostering Innovations in Education

April 2009

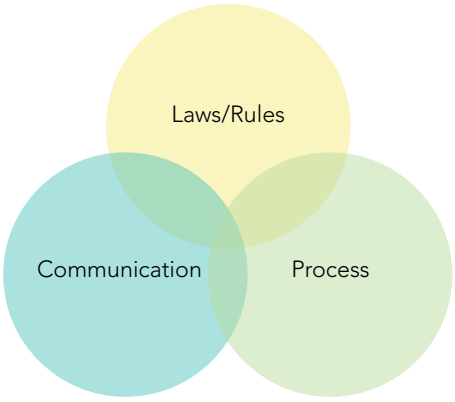
Innovations in Education Regulation Committee

Recommendations for Boards of Nursing for Fostering Innovations in Education

Because of today's complexities in health care delivery, there is a need to transform how we educate nurses (AACN, 2008; Greiner & Knebel, 2003; NLN, 2003). Some of these complexities include increasing technologies, the need for systems thinking, a more diverse population that is living longer with multiple chronic illnesses, and a national focus on patient safety and preventing errors. Therefore, the NCSBN Board of Directors asked the Innovations in Education Regulation Committee to identify ways for Boards to foster innovation[1] in nursing education. In their mission of public protection, Boards of Nursing approve nursing programs across the U.S. and its territories and are in an excellent position to act as a conduit for innovative educational approaches. However, as Boards of Nursing champion innovative approaches in nursing education, they must also assure that the approaches conform to the core education criteria as established by the individual Boards. A full report of this committee work can be found on the NCSBN Web site.

Through their research of reviewing the literature, dialoging with the NCSBN membership at NCSBN's Midyear meeting and through e-mail, conducting a survey[2], and holding a conference call with the educational organizations[3], NCSBN's Innovations in Education Regulation Committee members developed the following conceptual model for describing the influences of regulatory parameters on innovation. It is, however, clear that other hindrances exist as well. The educational institutions can set up barriers for innovations, for example with institutional hierarchies or lengthy committee processes to approve curricular changes (Bellack, 2008; Coonan, 2008). Practice similarly can set up barriers with its centralized power bases and linear thinking (Unterschuetz et al. 2008). Students even may set up barriers because they desire the comfort of traditional teaching methodologies.

The model below describes three major regulatory influences on innovative approaches in nursing education: laws/rules, communication, and process. The barriers may be real, though many perceived regulatory barriers[4] also exist. That is, while educators think the rules are too prescriptive to allow their innovative strategy, oftentimes they are not. A barrier to innovation could exist independently in any of these areas but may be more likely where there is an overlap of the regulatory influences.



1 Innovation is defined by the Innovations in Education Regulation Committee as a dynamic, systematic process that envisions new approaches to nursing education.

2 On March 27, 2009, a Web survey request was sent to all Education Consultants on their rules and regulations with simulation.

3 This conference call was held on January 29, 2009, and participants were from the following organizations: American Association of Colleges of Nursing; Commission on Collegiate Nursing Education; National Association for Practical Nurse Education and Service; and National League for Nursing. The National League for Nursing Accrediting Commission was invited but no one from that organization was able to participate at that time.

4 The Innovations in Education Regulation Committee defines a regulatory barrier as a real or perceived regulatory parameter that hinders innovation in nursing education.

Communication
Much of the feedback obtained from educators and regulators indicated that lack of communication between the two groups affects the implementation of innovative approaches in nursing education. For example, the NCSBN Member Boards reported that most innovations can be implemented through the current laws/rules and Board processes, but that the educators, often mistakenly, perceive the rules to be too prescriptive. Before embarking on an innovative approach, educators should first review the Practice Act and administrative rules, which are available online in most jurisdictions. If the proposed innovation is outside the rules and regulations, the faculty should then contact the Board of Nursing and consult with the education consultant about the possibility of carrying out the innovation. Of the states with rules that specifically address education innovations, most of the innovative approaches were allowed under the current rules and didn't need a specific application or rule exemption.

Some educators report that they are fearful to go before their Boards to request permission for an innovative approach because their program will be watched more carefully. They would rather stay as "part of the crowd." This again demonstrates the need for communication between educators and the Boards of Nursing. By working together, education and regulation can facilitate the transformation of nursing education that must take place in nursing.

Process
The Boards of Nursing and educators both cited the regulatory process as sometimes limiting how quickly innovation can take place in nursing education. For example, some Boards report that it can take up to two years just to change rules, though in most Boards this process takes up to a year. Faculty members report that Board time lines create a lengthy and difficult process when they attempt to make curricular changes.

Laws/Rules
The education practice acts and rules vary somewhat across jurisdictions, though there are some core standards such as the requirement in prelicensure programs for supervised clinical experiences with actual patients (NCSBN, 2005). NCSBN also has published a model education practice act and rules for the Boards of Nursing to use as guidelines (NCSBN, 2008), and many Boards have adopted those guidelines.

Table 1 contains a list of the regulatory barriers perceived by the educators, along with the realities (NCSBN, 2007). For example, while faculty members often identify simulation limitations as a barrier for implementing innovations, a 2009 survey of the Member Boards (48/59 prelicensure Boards of Nursing have responded) found that only five Boards limit simulation to non-clinical courses. Most Boards of Nursing are waiting for more research in order to determine how simulation might be used to complement clinical experiences. Similarly, oftentimes faculty members report that Boards of Nursing have stricter regulations for online programs than for traditional programs, but the Boards have the same laws and rules for traditional and online programs.

Table 1. Myths and Realities about Perceived Regulatory Barriers[5] Related to Rules	
Perceived Regulatory Barriers	Reality
Specific number of clinical hours are mandated	Required in: PN programs (certificate/diploma) – 17 Boards PN programs (associate degree) – 8 Boards RN diploma – 3 Boards RN ADN – 8 Boards RN BSN – 7 Boards
Specific number of didactic hours are mandated	Required in: PN programs (certificate/diploma) – 19 Boards PN programs (Associate degree) – 9 Boards RN diploma – 6 Boards RN ADN – 8 Boards RN BSN – 7 Boards
Distance learning nursing programs are approved differently from traditional programs	All Boards approve distance/online programs using the same approval criteria as with traditional programs.
Faculty-student ratios	Required in 46 Boards (ranging from 1:4 to 1:15)
Full and part-time ratios of faculty	Required in 9 Boards (ranging from 1:2 to 1:10)
Simulation limitations	▪ 5 Boards limit simulation to non-clinical courses. ▪ Most Boards don't have simulation specified in their rules and/or are awaiting further research on the use of simulation.

5 Based on 59 prelicensure Boards of Nursing, which include the Boards of Nursing in the 50 states, the District of Columbia, four LPN/VN Boards (Louisiana, Georgia, California, and West Virginia), and four territories (Guam, Northern Mariana Islands, Virgin Islands and American Samoa).

Recommendations to Boards of Nursing

One of the cautions from experts in nursing education innovations is that not all educators are innovators and it is not expected that all faculty or all nursing programs will implement innovations. However, the Boards of Nursing can create a favorable climate for innovation for those programs that are ready for it. The following are some recommendations for Boards of Nursing that might promote innovations:

- Boards of Nursing might consider critically analyzing their education rules, particularly related to those listed in Table 1, with an eye toward fostering innovation in education.
- Boards of Nursing may contemplate evaluating their approval processes for the purpose of streamlining them.
- Related to communication, Boards of Nursing could think about:
  - Representing the Board of Nursing at deans and director meetings.
  - Convening education advisory committees including representation from educators, employers, and consumers.
  - Developing Power Point presentations for faculty related to the role of the Board's education consultant.
  - Developing online orientation courses for deans and directors.
  - Sending out regular e-mails and/or newsletters to programs.
  - Informally communicating with faculty.
  - Developing an innovations Web site[6] to serve as a statewide clearinghouse for innovations in nursing education.
  - Hosting conferences with educators on regulatory issues and providing question and answer sessions.
  - Posting a frequently asked questions (FAQ) handout on the Web site.

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6 See this example from the Texas Board of Nursing: http://www.bon.state.tx.us/nursingeducation/innovative.html

Attachment C

Tips for Planning Nursing Education Innovative Approaches

April 2009

Tips for Planning Nursing Education Innovative Approaches

Health care delivery in the U.S. is becoming increasingly complex, requiring the use of sophisticated technologies and the need for systems thinking in order for nurses to practice safely. Further, more than ever before nurses are caring for sicker, older, and more diverse patients with myriad chronic conditions. In order to keep up with this these changes, innovative approaches in nursing education are being encouraged. However, before educators begin to plan innovative approaches to nursing education, they might consider the following:

Hargreaves (2008) suggests that it is important to think about consequences (intended and unintended) before beginning to plan an innovative instructional strategy. Answering questions such as those listed below will provide guidelines as decisions are made:

- What are the likely outcomes of a given learning and teaching strategy?
- Will it work for all students/staff/the institution?
- What is the intention?
- What is the worst possible outcome?
- What is the best possible outcome?
- On balance, how great is the likelihood that positive consequences will outweigh negative ones?

When the consequences are identified, then think about:

- Would greater support make a difference?
- Which assessment tasks ensure students can complete the course/education without being compromised by uncertain outcomes?

If the decision is made to go ahead with the innovative strategy, review your jurisdiction's nurse practice act and administrative rules. If your innovation constitutes a significant departure from the way a nursing education program currently functions under the rule structure, contact your Board of Nursing about implementing an innovative approach. Early consultation with your Board is highly recommended.

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Attachment D

Model Rules for Innovative Approaches in Nursing Education Programs

Latest revision: 3/30/09

Model Rules for Innovative Approaches in Nursing Education Programs

Placement:

(Left side – Act: Language for Boards that will need to change the Act) Article IX. **Section 3.** *Provision for innovative approaches in nursing education programs.*

The Board shall, by administrative rule, identify the process for implementing innovative approaches in nursing education programs.

(Current Section 3 will change to Section 4 and the current Section 4 will change to Section 5)

Definitions – Chapter 3

Innovative approach – A creative nursing education strategy that departs from the current rule structure and requires Board approval for implementation.

(Right side – Rules)

9.3. Innovative approaches in nursing education programs

A nursing education program may apply to implement an innovative approach by complying with the provisions of this section. Nursing education programs approved to implement innovative approaches shall continue to provide quality nursing education that prepares graduates to practice safely, competently, and ethically within the scope of practice as defined in <jurisdiction's> statutes.

9.3.1. Purposes

a. To foster innovative models of nursing education to address the changing needs in health care.

b. To assure that innovative approaches are conducted in a manner consistent with the Board's role of protecting the public.

c. To assure that innovative approaches conform to the quality outcome standards and core education criteria established by the Board.

9.3.2. Eligibility

a. The nursing education program shall hold full Board approval without conditions.

b. There are no substantiated complaints in the past 2 years.

c. There are no rule violations in the past 2 years.

9.3.3. Application

The following information (no longer than < > pages with a 1-page executive summary) shall be provided to the Board at least <> days prior to a Board meeting:

a. Identifying information (name of nursing program, address, responsible party and contact information).

b. A brief description of the current program, including accreditation and Board approval status.

c. Identification of the regulation(s) affected by the proposed innovative approach.

d. Length of time for which the innovative approach is requested.

e. Description of the innovative approach, including objective(s).

f. Brief explanation of why you want to implement an innovative approach at this time.

g. Explanation of how the proposed innovation differs from approaches in the current program.

h. Rationale with available evidence supporting the innovative approach.

i. Identification of resources that support the proposed innovative approach.

j. Expected impact innovative approach will have on the program, including administration, students, faculty, and other program resources.

k. Plan for implementation, including timeline.

l. Plan for evaluation of the proposed innovation, including measurable criteria/outcomes, method of evaluation, and frequency of evaluation.

m. Additional application information as requested by the Board.

9.3.4. Standards for approval

a. Eligibility criteria in 9.3.2. and application criteria in 9.3.3. are met.

b. The innovative approach will not compromise the quality of education or safe practice of students.

c. Resources are sufficient to support the innovative approach.

d. Rationale with available evidence supports the implementation of the innovative approach.

e. Implementation plan is reasonable to achieve the desired outcomes of the innovative approach.

f. Timeline provides for a sufficient period to implement and evaluate the innovative approach.

g. Plan for periodic evaluation is comprehensive and supported by appropriate methodology.

9.3.5. Review of application and board action

a. Annually the Board may establish the number of innovative approach applications it will accept, based on available Board resources.

b. The Board shall evaluate all applications to determine if they meet the eligibility criteria in 9.3.2.and the standards established in section 9.3.4.

c. The Board shall inform the education program of the approval process timeline within <> days of the receipt of the application.

d. If the application meets the standards, the Board may:

1) Approve the application, or

2) Approve the application with modifications as agreed between the Board and the nursing education program.

e. If the submitted application does not meet the criteria in 9.3.2.and 9.3.4., the Board may deny approval or request additional information.

f. The Board may rescind the approval or require the program to make modifications if:

1) The Board receives substantiated evidence indicating adverse impact.

2) The nursing program fails to implement the innovative approach as presented and approved.

9.3.6. Periodic Evaluation

a. The education program shall submit progress reports conforming to the evaluation plan annually or as requested by the Board.

b. The final evaluation report shall conform to the evaluation plan, detailing and analyzing the outcomes data.

c. If any report indicates that students were adversely impacted by the innovation, the nursing program shall provide documentation of corrective measures and their effectiveness.

d. Nursing education program maintains eligibility criteria in 9.3.2.

9.3.7. Requesting continuation of the innovative approach

a. If the innovative approach has achieved the desired outcomes and the final evaluation has been submitted, the program may request that the innovative approach be continued.

b. Request for the innovative approach to become an ongoing part of the education program must be submitted < > days prior to a regularly scheduled Board meeting.

c. The Board may grant the request to continue approval if the innovative approach has achieved desired outcomes, has not compromised public protection, and is consistent with core nursing education criteria.

Report of the NCLEX® Examination Committee

Recommendation to the Delegate Assembly

1. ***Adopt the proposed 2010 NCLEX-RN® Test Plan.***

   Rationale:
   The NCLEX® Examination Committee (NEC) reviewed and accepted the *Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* (NCSBN, 2009) as the basis for recommending revisions to the *2007 NCLEX-RN® Test Plan* to the Delegate Assembly. Empirical evidence from the practice analysis, feedback from Member Boards and the professional judgment of the NEC provide support for the recommendation to the Delegate Assembly to adopt the 2010 NCLEX-RN® Test Plan.

Background

As a standing committee of NCSBN, the NEC is charged with providing psychometrically sound and legally defensible entry level nurse licensure assessments to NCSBN Member Boards. In order to accomplish this, 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 profession. The NEC investigates potential future enhancements to the NCLEX examinations, evaluates additional international testing locations for the Board of Directors (BOD), and monitors all aspects of the NCLEX examination process, including item development, examination security, psychometrics, and examination administration to ensure consistency with Member Boards' need for examinations. The NEC approves item development panels and recommends test plans to the Delegate Assembly.

Additionally, the committee oversees the activities of the NCLEX® Item Review Subcommittee (NIRSC), which assists with the item development and review processes. Individual NEC members act as chair of the subcommittee on a rotating basis. Highlights of the activities of the NEC and NIRSC activities follow.

Highlights of FY09 Activities

ENTRY LEVEL NURSE COMPETENCE ASSESSED

2010 NCLEX-RN® Test Plan

At the October 2008 meeting, the NEC reviewed the results of the *Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*. Empirical data from the 2008 registered nurse (RN) practice analysis was used to evaluate the *2007 NCLEX-RN® Test Plan* to determine if changes were needed. After in-depth discussion and careful deliberation, the committee decided to retain the client needs framework. Based on data from the practice analysis and psychometric considerations, the percentage of test items allocated to the subcategory of "Management of Care" was increased from 13-19 percent to 16-22 percent, and the subcategory of "Reduction of Risk Potential" was reduced from 13-19 percent to 10-16 percent. Minor revisions were made in the document to provide clarity.

A draft of the proposed 2010 NCLEX-RN® Test Plan was sent to all Member Boards in November 2008 for feedback on these changes. During its April 2009 business meeting, the committee discussed all comments from the Member Boards and approved a final draft of the proposed 2010 NCLEX-RN® Test Plan as noted in Attachments A and B, as well as approved the timeline for implementation (Attachment C).

Members

NCLEX® Examination Committee

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Arizona, Area I, Board Liaison

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California-VN, Area I

Louise Bailey, MEd, RN
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NCLEX® Item Review Subcommittee

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Ada Woo, PhD
Psychometrician, NCLEX® Examinations

Meeting Dates

- Oct. 21-23, 2008 (NCLEX® Examination Committee Business Meeting)
- Dec. 2-5, 2008 (NCLEX® Item Review Subcommittee Meeting)
- Jan. 20-22, 2009 (NCLEX® Examination Committee Business Meeting)
- Feb. 10-13, 2009 (NCLEX® Item Review Subcommittee Meeting)
- March 17, 2009 (NCLEX® Examination Committee Conference Call)
- April 15-17, 2009 (NCLEX® Examination Committee Business Meeting)
- April 28, 2009 (NCLEX® Examination Committee Conference Call)
- April 28-May 1, 2009 (NCLEX® Item Review Subcommittee Meeting)
- June 9, 2009 (NCLEX® Examination Committee Conference Call)

IMPROVEMENTS TO THE DEVELOPMENT AND ADMINISTRATION OF THE NCLEX® EXAMINATIONS

2009 Licensed Practical/Vocational Nurse (LPN/VN) Practice Analysis

An LPN/VN panel of subject matter experts (SMEs) was selected to develop a comprehensive list of nursing activity statements that will be used to inform the test plan. At the January 2009 meeting, the committee reviewed and approved the list of LPN/VN activity statements and the survey form that will be used for the 2009 LPN/VN practice analysis. The practice analysis is anticipated to be completed in August 2009.

2009 LPN/VN Knowledge Survey

A second LPN/VN panel of SMEs created a comprehensive list of knowledge statements to survey new graduates, faculty and supervisors. The knowledge survey, which will be completed in July 2009, will be used to inform item development.

Joint Research Committee (JRC)

The JRC is a small group comprised of NCSBN and Pearson VUE testing staff, along with a selected group of testing and measurement experts, which reviews and conducts psychometric research to provide empirical support for the use of the current NCLEX examination, as well as to investigate possible future enhancements.

Several new pieces of research have either been completed or are near the final draft stage. Examples include: an investigation into the cognitive processing and memorability of various innovative item types; the comparability of item quality indices from sparse data matrices that result from computerized adaptive tests; the effects of item position on response time and the probability of a correct response; stability of item parameters over time; estimation of item difficulty of pretest items; establishing pretest statistical criteria specific for alternate item types; and developing item variants and the impact of item compromise on the probability of passing the NCLEX.

The JRC has also approved, in some cases tentatively, research to be conducted on an optimal item pool design; the effect of sample sizes on differential item functioning analyses; the feasibility of various approaches to situated tasks as a format for new item types; and an analysis of how candidates interact with alternate item types.

Item Pool Rotation Plan

NCSBN has been working to reduce the amount of time that it takes to bring examination items from conception to operational usage. Rather than having operational item pools deployed for six months, a three month deployment could reduce the amount of time it takes to place new items into operational usage. Security could also be enhanced by reducing the window of availability for any given operational item pool. Moving toward these goals, the JRC has approved a study to investigate the optimal item pool design for quarterly deployments.

Revise Performance Benchmarks for Test of English as a Foreign Language – internet-Based Test (TOEFL-iBT)

TOEFL is a test of English proficiency commonly used by boards of nursing (BONs) as one of the requirements for obtaining licensure to practice. The current NCSBN-endorsed TOEFL standard was set in 2004 with TOEFL Computer Based Test (TOEFL-CBT). As of 2006, Educational Testing Service (ETS), owner and developer of the TOEFL, has discontinued the use of TOEFL-CBT and replaced it with TOEFL-iBT, which includes a speaking component. Unlike the CBT, the iBT is made up of four sections: reading, listening, speaking and writing. As a result of changes in test format from CBT to iBT, the committee has been working to establish an empirically based passing standard for the TOEFL-iBT. This standard is intended to reflect the minimum level of English proficiency required in the U.S. to practice nursing safely at the entry level.

On Nov. 10-12, 2008, a panel of 22 SMEs met in Chicago to participate in a criterion-referenced standard setting exercise for TOEFL-iBT. ETS staff members, Susan Nissan, assessment director,

and Eileen Tyson, director of client relations, facilitated the panel. Using retired TOEFL-iBT items, the panel made preliminary recommendations for performance benchmarks on the examination. Results from this criterion-referenced standard setting exercise were presented to the NEC for consideration. Using the score interpretation guide published by ETS, the expert panel recommended a fair to intermediate mastery as the minimum level of English needed to practice entry level nursing safely and effectively for the four exam components.

After reviewing the standard setting process and recommendations from the standard setting panel, historical data from the 2004 TOEFL passing standard and other available evidence, such as comparability and impact data, the committee recommended that a total score of 84 and a minimum score of 26 be required for the speaking component on the TOEFL-iBT in order to demonstrate the minimum degree of English proficiency necessary to be a safe and effective entry level nurse. Making this legally defensible standard available to Member Boards will be beneficial. In addition to being legally defensible, the use of this passing standard by Member Boards would allow TOEFL scores to be portable across jurisdictions. However, the final decision of whether to adopt the recommended passing standard rests on each individual BON. Each BON should carefully consider the applicability of the recommended standard to circumstances unique to their jurisdiction. This recommendation regarding the TOEFL-iBT passing standard will be communicated to Member Boards, as well as other stakeholders. Additional information regarding the TOEFL-iBT standard setting will be made available on the NCSBN Web site.

As part of the NCSBN initiative to establish standards for minimally acceptable English language proficiency for entry level nurses, the committee anticipates continuing similar criterion-referenced standard setting exercises in FY10 with the Pearson Test of English (PTE). The standard setting workshop will be followed by a recommended passing standard of English proficiency that can be used by Member Boards.

NCLEX® Alternate Item Types

The committee consistently reviews the present and future of the NCLEX examinations with an eye towards innovations that would maintain the examination's premier status in licensure. In keeping with this plan, the NCLEX examinations content staff and Pearson VUE content staff finalized a strategy for the development and delivery of alternate item types that can include multimedia.

NCLEX® Administration Enhancements

Pearson VUE has implemented a user interface on the NCLEX® Administration Web site that gives Member Boards the ability to select an option on the printed score reports and Education Program Summary, to either show or conceal the candidate's Social Security Number (SSN) and date of birth (DOB). This change was initiated by Member Boards' requests to ensure the privacy of candidate information.

Beginning Jan. 1, 2009, candidates were able to register for the NCLEX examination online and pay by check (cashiers/certified) or money order. This option was introduced to assist those candidates or candidate sponsors that are unable to utilize the credit card option.

Pearson VUE has begun to phase-in palm vein technology at test centers. This technology is very accurate and allows NCSBN to more accurately identify people trying to take the NCLEX under assumed testers' identities. By preventing proxy testers, the technology helps NCSBN maintain the integrity of the NCLEX examination. NCSBN will potentially start using the palm vein device in FY10. The palm vein device would serve as a second level of security; it would not be replacing fingerprinting for the NCLEX program.

Additionally, the NEC has approved the use of an optional reader service from Pearson VUE's subcontractor for NCLEX candidates seeking a reader accommodation. The criteria and procedures for the optional Pearson VUE reader service will remain the same and there is no charge to Member Boards for this service.

- June 24-26, 2009 (NCLEX® Item Review Subcommittee Meeting)
- July 21, 2009 (NCLEX® Examination Committee Conference Call)
- July 28-31, 2009 (NCLEX® Item Review Subcommittee Meeting)
- Sept. 15-18, 2009 (NCLEX® Item Review Subcommittee Meeting)

Relationship to Strategic Plan

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

Strategic Objective 1
NCLEX development, security, psychometrics, administration and quality assurance processes are consistent with Member Boards examination needs.

Pearson VUE will be opening 10 new Pearson Professional Centers (PPCs) and expanding seating capacity at 13 other centers during 2009. Member Boards are notified of these PPC changes prior to implementation. Information on PPC updates are featured in NCSBN's *Council Connector* newsletter.

Evaluated and Monitored NCLEX® Examination Policies and Procedures

The committee evaluated the efficacy of the BOD examination-related policies and procedures, as well as the NEC policies and procedures.

MONITORED ALL ASPECTS OF EXAMINATION DEVELOPMENT

Conducted NEC and NIRSC Sessions

To ensure consistency regarding the manner in which NCLEX examination items are reviewed before becoming operational, members of the committee continue to chair subcommittee meetings. The committee and the subcommittee: (1) reviewed RN and PN operational and pretest items; (2) provided direction regarding RN and PN multiple-choice and alternate format items; and (3) made decisions addressing revisions to content coding, operational definitions for client needs, cognitive codes, integrated processes and the NCLEX® Style Manual. In addition, the subcommittee and staff currently evaluate 100 percent of all validations for pretest items and 100 percent of all validations of master pool items scheduled for review.

Assistance from the subcommittee continues to reduce the committee's item review workload, facilitating its efforts toward achieving defined goals. As the item pools continue to grow, review of operational items is critical to ensure that the item pools reflect current entry level nursing practice. At this time, the number of volunteers serving on the subcommittee is 14, with representation from all four NCSBN geographic areas. Orientation to the subcommittee occurs annually and at each meeting.

Monitored Item Production

Under the direction of the NEC, 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. As part of the contractual requirements with the test service, items that use alternate formats (i.e., any format other than multiple-choice) 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*, candidate tutorial and on the NCSBN Web site.

NCSBN Item Development Sessions Held at Pearson VUE

Table 1. RN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Written	Review Sessions	Items Reviewed
April 02 – March 03	4	47	2611	7	1542
April 03 – March 04	2	23	1097	5	1446
April 04 – March 05	1	12	301	4	1415
April 05 – March 06	5	66	2514	7	2885
April 06 – March 07	3	47	1835	6	3195
April 07 – March 08	3	47	1815	5	2556
April 08 – March 09	3	39	1724	5	3036

Table 2. PN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Written	Review Sessions	Items Reviewed
April 02 – March 03	3	33	1476	6	1547
April 03 – March 04	2	24	968	5	1611
April 04 – March 05	1	11	430	3	2124
April 05 – March 06	4	50	1938	5	3682
April 06 – March 07	3	45	2453	4	1661
April 07 – March 08	3	48	2378	6	3304
April 08 – March 09	1	16	551	6	2829

Pearson VUE continues to work to improve item development sessions and increase the quality and quantity of the NCLEX items.

Monitored Item Sensitivity Review

NCLEX® Item Sensitivity Review procedures are designed to eliminate item wording that could be elitist, stereotypical, have different meaning for different ethnic or geographic groups, or have an inappropriate tone. Review panels are composed of members who represent the diversity of NCLEX candidates. Prior to pretesting, items are reviewed by sensitivity panels and any items identified by the group are referred to the NEC for final disposition.

Evaluated Item Development Process and Progress

The NEC evaluated reports provided at each meeting on item development sessions conducted by the test service. Committee representatives continue to oversee each panel whenever possible and, alternately, NCLEX staff monitors the panels when needed. Overall, panelists and committee representatives in attendance have rated item development sessions favorably.

Monitored the Development of Operational NCLEX® Item Pools

The NEC monitored the configuration of RN and PN operational item pools. The process of configuring operational item pools involves only a few critical variables; however, the quality control checks performed afterward are based upon both nursing content and psychometric variables. The resulting operational item pools were evaluated extensively with regard to these variables and were found to be within operational specifications. To ensure that operational item pools and the item selection algorithm were functioning together as expected, simulated examinations were evaluated. Using these simulated examinations, the functioning of the algorithm was scrutinized with regard to the distribution of items by test plan content area; it was concluded that the operational item pools and the item selection algorithm were acting in concert to produce exams that were within NCSBN specifications and were comparable to exams drawn from previous NCLEX item pool deployments. These conclusions were reinforced by replicating the analyses using actual candidate data. The committee will continue to monitor performance of the NCLEX examinations through these and other psychometric reports and analyses.

Member Board Review of Items

BONs are provided opportunities to conduct reviews of NCLEX pretest items twice a year and items are referred to the NEC. No items from the April 2008 Member Board Review were referred to the committee. In April 2009, the committee reviewed the items referred from the October 2008 Member Board Review. BONs referred items to the NEC for one of the following reasons: not entry level practice, not consistent with the nurse practice act or for other reasons. The committee provided direction on the resolution of each Member Board item and staff gave Member Boards feedback on the committee's decisions on all referred items. The NEC encourages each Member Board to take advantage of the semi-annual opportunities to review NCLEX items.

Item Related Incident Reports (IRs)

Electronically filed IRs may be submitted at PPCs when candidates question item content. Pearson VUE and NCSBN staff investigates each incident and reports their findings to the NEC for decisions related to retention of the item.

Americans with Disabilities Act (ADA) Implications of Alternate Item Formats

The NEC reviewed information from NCSBN's psychometrician regarding the psychometric impact of adding alternate items. NCSBN's legal counsel offered a legal opinion and questions for the committee regarding alternate items and the ADA. In particular, legal counsel noted that the introduction of new item types that require hand/eye coordination and visual or auditory acuity will likely lead to additional requests for ADA accommodations and for different types of accommodations, including the use of assistive devices. After a thorough discussion and deliberation, the committee determined that such alternate items are measuring essential psychomotor, audio or visual abilities identified in the practice analysis as part of the nursing competencies being measured by NCLEX. The committee directed staff to continue to investigate new item types.

MONITOR EXAMINATION ADMINISTRATION

Monitored Procedures for Candidate Tracking: Candidate Matching Algorithm

The committee continued to monitor the status and effectiveness of the candidate-matching algorithm. On a semi-annual 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 January 2008 through June 2008 and compared over 173,000 candidate records. The result of that check revealed that there were no duplicate candidate records and that no repeat candidate records were treated by the system as separate individuals.

Monitored the Security of the NCLEX® Examination Administrations and Item Pools

In the last year, the NEC has continued to approach security proactively. It has worked to develop formal procedures to describe how certain categories of security-related investigations and actions are executed.

In addition to providing mechanisms and opportunities for people to inform NCSBN about issues, NCSBN utilizes two security firms to search the Internet for Web sites and Internet forums that might attempt to trade in NCLEX items. Also, NCSBN staff continues to visit many of the domestic test centers and several of the international test centers to review the physical and procedural security measures that are in place. NCSBN staff, Pearson VUE staff and the NEC continues to be vigilant regarding the administration and the security of the NCLEX examination in domestic and international test centers.

Compliance with the 30/45 Day Scheduling Rule for Domestic PPCs

The NEC monitors compliance with the 30/45 day scheduling rule. For the period of Jan. 1, 2008, to Dec. 31, 2008, all candidates were able to be tested in compliance. 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 exceed 80 percent capacity levels.

Responded to Member Board Inquiries Regarding NCLEX® Examination Administration

As part of its activities, the committee and the NCSBN NCLEX® Examinations Department staff responded to Member Boards' questions and concerns regarding administration of the NCLEX examinations.

More specific information regarding the performance of the NCLEX test service provider, Pearson

VUE, can be found in the Annual Report of Pearson VUE for the NCLEX, available in Attachment D of this report.

ADA Amendment

An amendment to the ADA was approved by the U.S. legislature and enacted in January 2009. The new ADA language includes a broader definition of a disability with the addition of "inability to think and concentrate" labeled as disabilities. The committee reviewed a staff report on the ADA amendment and noted that this amendment may increase the number of requests for accommodations from Member Boards. Pearson VUE has been alerted to this issue and is proactively making plans for this potential.

NCSBN staff consulted with NCSBN legal counsel who did not anticipate that any significant programmatic changes in the NCLEX will be needed as a result of the new ADA amendment, nor will changes to policies and procedures be necessary.

ADMINISTER NCLEX® AT INTERNATIONAL SITES

The international test centers meet the same security specifications and follow the same administration procedures as the professional centers located in Member Board jurisdictions. Please see Attachment D of this report for the 2008 candidate volumes and pass rates for the international testing centers.

EDUCATE STAKEHOLDERS

NCLEX® Research Presentations

At the 2008 American Educational Research Association (AERA) annual meeting, a paper, "Development and Evaluation of Innovative Test Items for a Computerized Nursing Licensure Exam," was presented. AERA is an internationally recognized professional organization with the primary goal of advancing educational research and its practical application. In collaboration with test service, two papers, "Limiting Item Exposure for Key-difficulty Ranges in a High-stakes CAT" and "Developing Item Variants: An Empirical Study," have been selected for presentation at the 2009 Graduate Management Admission Council (GMAC®) Conference on Computerized Adaptive Testing (CAT). The GMAC Conference on CAT provides a venue where researchers and practitioners come together to improve practice and advance the field of CAT. Acceptance in these programs not only helps NCSBN share expertise on best testing practices worldwide, but also allows NCSBN to move ahead in psychometric testing solutions through the collective strength of internal and external stakeholders. Furthermore, collaborating on psychometric testing issues with external communities allows NCSBN to remain at the forefront of the testing industry.

Presentations and Publications

NCSBN NCLEX® Examinations Department staff conducted numerous NCLEX informational presentations, Webinars and workshops. This included a presentation entitled, "Filipino Nurses and the NCLEX Examination: Trends and Test Performance," at the 2008 First Philippine Nursing Competitiveness Conference in Manila, Philippines. In order to ensure NCSBN membership was kept current on the NCLEX program, the NCLEX® Examinations Department hosted three informational Webinars for Member Boards.

Additionally, as part of the departments outreach activities, content staff conducted two BON sponsored NCLEX® Regional Workshops. Regional workshops are presented for the purpose of providing information to educators preparing students to take the NCLEX examination. The BONs that hosted a regional workshop were Kansas and Wyoming. These opportunities assist NCSBN's NCLEX® Examinations Department with educating stakeholders about the examination, as well as recruiting for NCSBN item development panels.

The committee continues to oversee development of various publications that accurately reflect the NCLEX examination process. This year the *2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* and the *2008 Knowledge of Newly Licensed Registered Nurses Survey*

were published, distributed to Member Boards and made available to the public at no charge on the NCSBN Web site.

Eight other articles were written and accepted for publication by NCSBN staff:

- "Readability of licensure examinations," *CLEAR Exam Review*, 20(1);
- "Memorability of innovative items," *CLEAR Exam Review*, 20(1);
- "NCLEX fairness and sensitivity review," *Nurse Educ*, September/October 2009;
- "Evaluating innovative items for the NCLEX: Part I," *Nurse Educ*, 34(2);
- "Developing and evaluating innovative items for the NCLEX: Part II," *Nurse Educ*, 34(3);
- "NCLEX pass rates: An investigation into the effect of lag time and retake attempts," *JONAS Healthc Law Ethics Regul*, 11(1);
- "Alternate item types: Continuing the quest for authentic testing," *J Nurs Educ*, 48(3); and
- "Setting a passing standard for English proficiency on the Internet-based Test of English as a Foreign Language (TOEFL®-iBT)," *JONAS Healthc Law Ethics Regul*.

NCLEX® Member Board Manual

NCSBN updates the *NCLEX® Member Board Manual* on a quarterly basis. Changes included updates on the notification process for test center changes; the process to request a new test center in a Member Board jurisdiction; option to mask a candidate's SSN and DOB; the online pay by check registration option; instructions on how to order additional candidate bulletins; correcting program code errors; expanded definition of a ADA disability; the new optional reader process and NCSBN's process for handling candidates suspected of violating NCLEX rules.

NCLEX® Invitational

Historically, the NCLEX® Examinations Department 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 2008 NCLEX® Invitational was held in San Diego, on Sept. 8, 2008, with approximately 200 participants. The 2009 NCLEX® Invitational is scheduled for Sept. 21, 2009, at the Hyatt Regency in Chicago.

NCLEX® Program Reports

The committee monitored production of the NCLEX® Program Reports. Program reports can be ordered, paid for and downloaded via a Web-based system that permits program directors to receive reports quickly and in a more portable, electronic format. Now subscribers will have the ability to e-mail the reports to those people who need it most–faculty and staff that design curriculum and teach students. Subscribers will have the ability to copy and paste relevant data, including tables and charts, into their own reports and presentations. This will be particularly beneficial if the program uses these reports to supplement the academic accreditation process.

NCLEX® Unofficial Quick Results Service

BONs, through NCSBN, offer candidates the opportunity to learn their unofficial results (official results are only available from BONs) through the NCLEX® Quick Results Service. A candidate may call or use the Internet to access their unofficial result two business days after completing their examination. Currently, 46 BONs participate in offering this service to their candidates. In 2008, approximately 152,000 candidates utilized this service.

Future Activities

- Conduct a continuous online RN practice analysis.
- Evaluate the NCLEX-PN test plan.
- Conduct a PN Standard Setting Workshop.

- Continue to monitor all administrative, test development and psychometric aspects of the NCLEX examination program.
- Evaluate all aspects of the NCLEX program and initiate additional quality assurance processes as needed.
- Evaluate NCLEX informational initiatives such as the NCLEX® Invitational, NCLEX® Regional Workshops and other presentations.
- Evaluate ongoing international testing.
- Host the 2010 NCLEX® Invitational.
- Introduce additional alternate format item types, which may include multimedia, such as sound and video for the NCLEX examinations.
- Explore additional item writing strategies for the NCLEX.
- Conduct a study of U.S. nursing education competencies using an international nursing survey.
- Recommend a passing standard to Member Boards for the Pearson Test of English (PTE).
- Conduct practice analysis comparability studies with British Columbia and Ontario.

Attachments

A. Proposed 2010 NCLEX-RN® Test Plan-Strikethrough Copy

B. Proposed 2010 NCLEX-RN® Test Plan-Clean Copy

C. Timeline for Implementation of the 2010 NCLEX-RN® Test Plan

D. Annual Report of Pearson VUE for the NCLEX

Attachment A

Proposed *2010 NCLEX-RN® Test Plan*-Strikethrough Copy

Comparison of 2007 to the proposed 2010 NCLEX-RN® Test Plan
(Track Changes: Strikethroughs represent deletions; underscore represents additions)

National Council Licensure Examination for Registered Nurses

(NCLEX-RN® EXAMINATION)

Introduction

Entry into the practice of nursing is regulated by the licensing authorities within each of the National Council of State Boards of Nursing (NCSBN®) member board jurisdictions (state, commonwealth, and territorial boards of nursing). To ensure public protection, each jurisdiction requires candidates for licensure to pass an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level registered nurse. NCSBN develops a licensure examination, the National Council Licensure Examination for Registered Nurses (NCLEX-RN®), which is used by member board jurisdictions to assist in making licensure decisions.

Several steps occur in the development of the *NCLEX-RN® Test Plan*. The first step is conducting a practice analysis that is used to collect data on the current practice of the entry-level nurse (*Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*, NCSBN, 2009). Twelve thousand newly licensed registered nurses are asked about the frequency and importance of performing 155 nursing care activities. Nursing care activities are analyzed in relation to the frequency of performance, impact on maintaining client safety and client care settings where the activities are performed. This analysis guides the development of a framework for entry-level nursing practice that incorporates specific client needs as well as processes fundamental to the practice of nursing. The second step is the development of the *NCLEX-RN® Test Plan,* which guides the selection of content and behaviors to be tested.

The *NCLEX-RN® Test Plan* provides a concise summary of the content and scope of the licensing examination. It serves as a guide for examination development as well as candidate preparation. Each NCLEX-RN® examination is based on the test plan. The NCLEX examination assesses the knowledge, skills and abilities that are essential for the nurse to use in order to meet the needs of clients requiring the promotion, maintenance or restoration of health. The following sections describe beliefs about people and nursing that are integral to the examination, cognitive abilities that will be tested in the examination and specific components of the *NCLEX-RN® Test Plan*.

Beliefs

Beliefs about people and nursing underlie the *NCLEX-RN® Test Plan*. People are finite beings with varying capacities to function in society. They are unique individuals who have defined systems of daily living reflecting their values, motives and lifestyles. Additionally, people have the right to make decisions regarding their health care needs and to participate in meeting those needs.

Nursing is both an art and a science, founded on a professional body of knowledge that integrates

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concepts from the liberal arts and the biological, physical, psychological and social sciences. It is a learned profession based on an understanding of the human condition across the life span and the relationships of an individual with others and within the environment. Nursing is a dynamic, continually evolving discipline that employs critical thinking to integrate increasingly complex knowledge, skills, technologies, and client care activities into evidence-based nursing practice. The goal of nursing for client care in any setting is preventing illness; alleviating suffering; protecting, promoting and restoring health; and promoting dignity in dying. The registered nurse provides a unique, comprehensive assessment of the health status of the client (individual, family or group), and then develops and implements an explicit plan of care. The nurse assists clients in the promotion of health, in coping with health problems, in adapting to and/or recovering from the effects of disease or injury, and in supporting the right to a dignified death. The registered nurse is accountable for abiding by all applicable member board jurisdiction statutes related to nursing practice.

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Classification of Cognitive Levels

Bloom's taxonomy for the cognitive domain is used as a basis for writing and coding items for the examination (Bloom, et al., 1956; Anderson & Krathwohl, 2001). Since the practice of nursing requires application of knowledge, skills and abilities, the majority of items are written at the application or higher levels of cognitive ability, which requires more complex thought processing.

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Test Plan Structure

The framework of Client Needs was selected for the examination because it provides a universal structure for defining nursing actions and competencies, and focuses on clients in all settings.

Client Needs

The content of the *NCLEX-RN® Test Plan* is organized into four major Client Needs categories. Two of the four categories are divided into subcategories:

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Safe and Effective Care Environment

- Management of Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

Physiological Integrity

- Basic Care and Comfort
- Pharmacological and Parenteral Therapies
- Reduction of Risk Potential
- Physiological Adaptation

Integrated Processes

The following processes are fundamental to the practice of nursing and are integrated throughout the Client Needs categories and subcategories:

- *Nursing Process* – a scientific, clinical reasoning approach to client care that includes assessment, analysis, planning, implementation and evaluation.

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- *Caring* – interaction of the nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the nurse provides encouragement, hope, support and

compassion to help achieve desired outcomes.

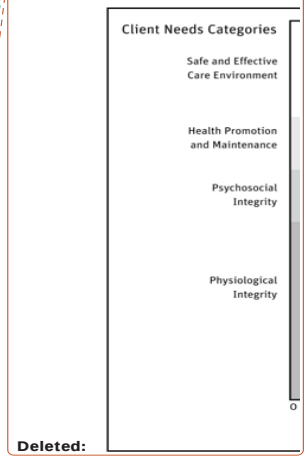
- *Communication and Documentation* – verbal and nonverbal interactions between the nurse and the client, the client's significant others and the other members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.
- *Teaching/Learning* – facilitation of the acquisition of knowledge, skills and attitudes promoting a change in behavior.

Distribution of Content

The percentage of test questions assigned to each Client Needs category and subcategory of the *NCLEX-RN® Test Plan* is based on the results of the *Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* NCSBN, 2009), and expert judgment provided by members of the NCSBN Examination Committee.

Client Needs	Percentage of Items From Each Category/Subcategory
Safe and Effective Care Environment	
▪ Management of Care	16-22%
▪ Safety and Infection Control	8-14%
Health Promotion And Maintenance	6-12%
Psychosocial Integrity	6-12%
Physiological Integrity	
▪ Basic Care and Comfort	6-12%
▪ Pharmacological and Parenteral Therapies	13-19%
▪ Reduction of Risk Potential	10-16%
▪ Physiological Adaptation	11-17%

2007 NCLEX-RN Test Plan Graphic



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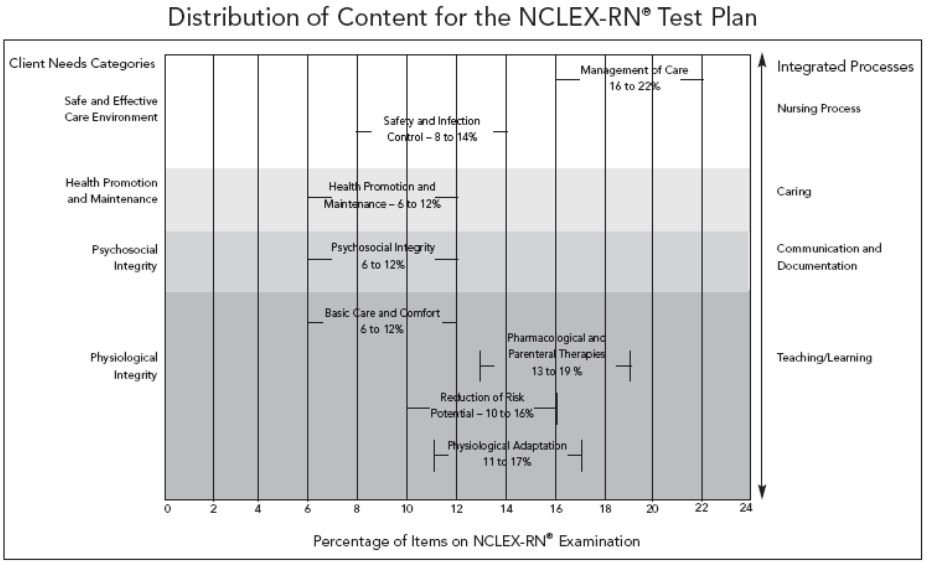
2010 NCLEX-RN Test Plan Graphic



Overview of Content

All content categories and subcategories reflect client needs across the life span in a variety of settings.

Safe and Effective Care Environment

The nurse promotes achievement of client outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect clients, family/significant others and other health care personnel.

- *Management of Care* – providing and directing nursing care that enhances the care delivery setting to protect clients, family/significant others and health care personnel.

  Related content includes but is **not limited** to:

  - Advance Directives
  - Advocacy
  - Case Management
  - Client Rights
  - Collaboration with Interdisciplinary Team
  - Concepts of Management
  - Confidentiality/ Information Security
  - Consultation
  - Continuity of Care
  - Delegation
  - Establishing Priorities
  - Ethical Practice
  - Informed Consent
  - Information Technology
  - Legal Rights and Responsibilities
  - Performance Improvement (Quality Improvement)
  - Referrals
  - Supervision

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- *Safety and Infection Control* – protecting clients, family/significant others and health care personnel from health and environmental hazards.

Related content includes but is **not limited** to:

- Accident/Injury Prevention
- Emergency Response Plan
- Ergonomic Principles
- Error Prevention
- Handling Hazardous and Infectious Materials
- Home Safety
- Reporting of Incident/Event/Irregular Occurrence/Variance
- Safe Use of Equipment
- Security Plan
- Standard Precautions/Transmission-Based Precautions/Surgical Asepsis
- Use of Restraints/Safety Devices

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Health Promotion and Maintenance

The nurse provides and directs nursing care of the client, and family/significant other that incorporates the knowledge of expected growth and development principles; prevention and/or early detection of health problems, and strategies to achieve optimal health.

Related content includes but is **not limited** to:

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Developmental Stages and Transitions
- Health and Wellness
- Health Promotion/Disease Prevention
- Health Screening
- High Risk Behaviors
- Lifestyle Choices
- Principles of Teaching/Learning
- Self-Care
- Techniques of Physical Assessment

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Psychosocial Integrity

The nurse provides and directs nursing care that promotes and supports the emotional, mental and social well-being of the client and family/significant others experiencing stressful events, as well as clients with acute or chronic mental illness.

Related content includes but is **not limited** to:

- Abuse/Neglect
- Behavioral Interventions
- Chemical and Other Dependencies
- Coping Mechanisms
- Crisis Intervention
- Cultural Diversity
- End of Life Care
- Family Dynamics
- Grief and Loss
- Mental Health Concepts
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Stress Management
- Support Systems
- Therapeutic Communication
- Therapeutic Environment

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Physiological Integrity

The nurse promotes physical health and wellness by providing care and comfort, reducing client risk potential and managing health alterations.

- *Basic Care and Comfort* - providing comfort and assistance in the performance of activities of daily living.

  Related content includes but is **not limited** to:

  - Assistive Devices
  - Elimination
  - Mobility/Immobility
  - Non-Pharmacological Comfort Interventions
  - Nutrition and Oral Hydration
  - Personal Hygiene
  - Rest and Sleep

- *Pharmacological and Parenteral Therapies* - providing care related to the administration of medications and parenteral therapies.

  Related content includes but is **not limited** to:

  - Adverse Effects/Contraindications /Side Effects/Interactions
  - Blood and Blood Products
  - Central Venous Access Devices
  - Dosage Calculation
  - Expected Actions/Outcomes
  - Medication Administration
  - Parenteral/Intravenous Therapies
  - Pharmacological Pain Management
  - Total Parenteral Nutrition

- *Reduction of Risk Potential* - reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatments or procedures.

  Related content includes but is not limited to:

  - Changes/Abnormalities in Vital Signs
  - Diagnostic Tests
  - Laboratory Values
  - Potential for Alterations in Body Systems
  - Potential for Complications of Diagnostic Tests/Treatments/ Procedures
  - Potential for Complications from Surgical Procedures and Health Alterations
  - System Specific Assessments
  - Therapeutic Procedures

- *Physiological Adaptation* - managing and providing care for clients with acute, chronic or life threatening physical health conditions.

  Related content includes but is not limited to:

  - Alterations in Body Systems
  - Fluid and Electrolyte Imbalances
  - Hemodynamics
  - Illness Management
  - Medical Emergencies
  - Pathophysiology
  - Unexpected Response to Therapies

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Administration of the NCLEX-RN® Examination

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With CAT, each candidate's examination is unique because it is assembled interactively as the examination proceeds. Computer technology selects items to administer that match the candidate's ability. The items, which are stored in a large item pool, have been classified by test plan category and level of difficulty. After the candidate answers an item, the computer calculates an ability estimate based on all of the previous answers the candidate selected. The next item is then chosen that measures the candidate's ability most precisely in the appropriate test plan category. This process is repeated for each item, creating an examination tailored to the candidate's knowledge and skills while fulfilling all *NCLEX-RN® Test Plan* requirements. The examination continues with items selected and administered in this way until a pass or fail decision is made.

All registered nurse candidates must answer a minimum of 75 items. The maximum number of items that the candidate may answer is 265 during the allotted six-hour time period. Examination instructions and all rest breaks are included in the measurement of the time allowed for a candidate to complete the examination.

Candidates should be aware and understand that the disclosure of any examination materials including the nature or content of examination items, before, during or after the examination is a violation of law. Violations of confidentiality and/or candidates' rules can result in criminal prosecution or civil liability and/or disciplinary actions by the licensing agency including the denial of licensure.

More information about the NCLEX® examination, including CAT methodology, items, the candidate bulletin and web tutorials, is listed on the NCSBN Web site: http://www.ncsbn.org.

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Anderson, L. W., Krathwohl, D. R. (eds). (2001). *A taxonomy for learning, teaching, and assessing. A revision of Bloom's taxonomy of educational objectives*. New York: Addison Wesley Longman, Inc.

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American Nurses Association. (2004). *Nursing: scope and standards of practice* - Silver Spring, MD: Author.¶
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American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements*. Washington DC: Author.

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Attachment B

Proposed 2010 NCLEX-RN® Test Plan-Clean Copy

Proposed 2010 NCLEX-RN® Test Plan

National Council Licensure Examination for Registered Nurses

(NCLEX-RN® EXAMINATION)

Introduction

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Beliefs

Beliefs about people and nursing underlie the *NCLEX-RN® Test Plan*. People are finite beings with varying capacities to function in society. They are unique individuals who have defined systems of daily living reflecting their values, motives and lifestyles. Additionally, people have the right to make decisions regarding their health care needs and to participate in meeting those needs.

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Test Plan Structure

The framework of Client Needs was selected for the examination because it provides a universal structure for defining nursing actions and competencies, and focuses on clients in all settings.

Client Needs

The content of the *NCLEX-RN® Test Plan* is organized into four major Client Needs categories. Two of the four categories are divided into subcategories:

Safe and Effective Care Environment
- Management of Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

Physiological Integrity
- Basic Care and Comfort
- Pharmacological and Parenteral Therapies
- Reduction of Risk Potential
- Physiological Adaptation

Integrated Processes

The following processes are fundamental to the practice of nursing and are integrated throughout the Client Needs categories and subcategories:

- *Nursing Process* – a scientific, clinical reasoning approach to client care that includes assessment, analysis, planning, implementation and evaluation.
- *Caring* – interaction of the nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the nurse provides encouragement, hope, support and compassion to help achieve desired outcomes.
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- *Teaching/Learning* – facilitation of the acquisition of knowledge, skills and attitudes promoting a change in behavior.

Distribution of Content

The percentage of test questions assigned to each Client Needs category and subcategory of the *NCLEX-RN® Test Plan* is based on the results of the *Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* NCSBN, 2009), and expert judgment provided by members of the NCSBN Examination Committee.

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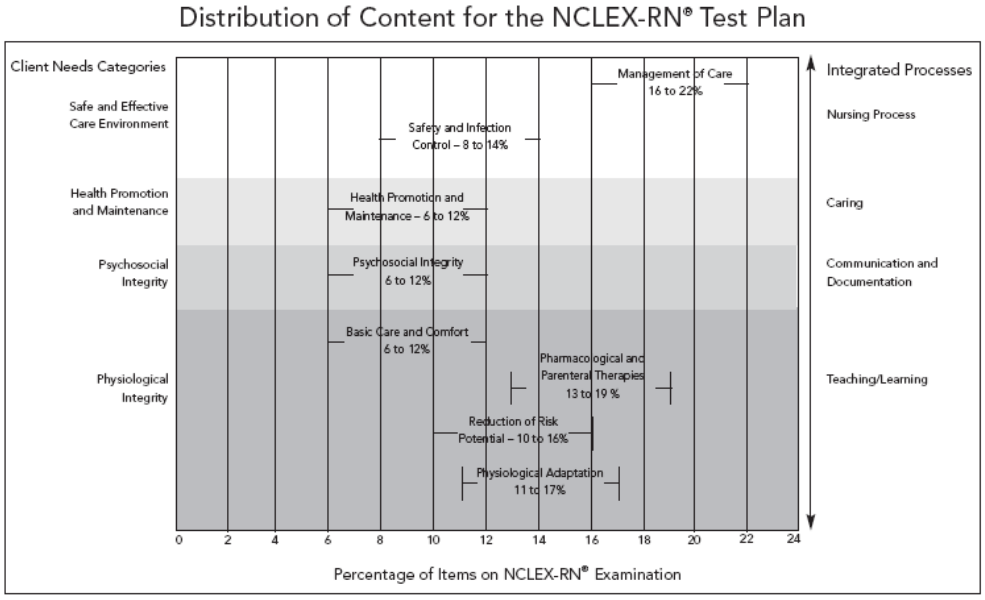

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- *Management of Care* – providing and directing nursing care that enhances the care delivery setting to protect clients, family/significant others and health care personnel.

  Related content includes but is **not limited** to:

  - Advance Directives
  - Advocacy
  - Case Management
  - Client Rights
  - Collaboration with Interdisciplinary Team
  - Concepts of Management
  - Confidentiality/ Information Security
  - Consultation
  - Continuity of Care
  - Delegation
  - Establishing Priorities
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  - Informed Consent
  - Information Technology
  - Legal Rights and Responsibilities
  - Performance Improvement (Quality Improvement)
  - Referrals
  - Supervision

- *Safety and Infection Control* – protecting clients, family/significant others and health care personnel from health and environmental hazards.

  Related content includes but is **not limited** to:

  - Accident/ Injury Prevention
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Health Promotion and Maintenance

The nurse provides and directs nursing care of the client and family/significant others that incorporates the knowledge of expected growth and development principles; prevention and/or early detection of health problems, and strategies to achieve optimal health.

Related content includes but is **not limited** to:

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Developmental Stages and Transitions
- Health and Wellness
- Health Promotion/Disease Prevention
- Health Screening
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- Techniques of Physical Assessment

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The nurse provides and directs nursing care that promotes and supports the emotional, mental and social well-being of the client and family/significant others experiencing stressful events, as well as clients with acute or chronic mental illness.

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- Behavioral Interventions
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- Crisis Intervention
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- Stress Management
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  - Elimination
  - Mobility/Immobility
  - Non-Pharmacological Comfort Interventions
  - Nutrition and Oral Hydration
  - Personal Hygiene
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  - Total Parenteral Nutrition

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  - Diagnostic Tests
  - Laboratory Values
  - Potential for Alterations in Body Systems
  - Potential for Complications of Diagnostic Tests/Treatments/ Procedures
  - Potential for Complications from Surgical Procedures and Health Alterations
  - System Specific Assessments
  - Therapeutic Procedures

- *Physiological Adaptation* - managing and providing care for clients with acute, chronic or life threatening physical health conditions.

  Related content includes but is not limited to:

  - Alterations in Body Systems
  - Fluid and Electrolyte Imbalances
  - Hemodynamics
  - Illness Management
  - Medical Emergencies
  - Pathophysiology
  - Unexpected Response to Therapies

Administration of the NCLEX-RN® Examination

The NCLEX-RN® examination is administered to the candidate by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. Items go through an extensive review process before they can be used as items on the examination.

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Attachment C

Proposed Timeline for Implementation of the 2010 NCLEX-RN® Test Plan

October 2008	NCLEX® Examination Committee reviews RN practice analysis results and makes recommendations for the test plan.
November 2008	Proposed test plan is sent to Member Boards for feedback.
March 2009	NCLEX® Examination Committee may present the proposed test plan at the NCSBN Midyear Meeting.
April 2009	NCLEX® Examination Committee reviews feedback on the test plan and submits recommendations to the Delegate Assembly.
August 2009	Delegate Assembly action is provided.
September 2009	RN test plan is published and placed on the NCSBN Web site.
October 2009	The panel of judges meets to recommend the passing standard.
December 2009	NCSBN Board of Directors evaluates the passing standard.
April 2010	Implement the test plan and passing standard.

Attachment D

Annual Report of Pearson VUE for the NCLEX®

This report represents information gained during Pearson VUE's sixth full year of providing test delivery services for the NCLEX® examination program to the National Council of State Boards of Nursing, Inc. (NCSBN®). This report summarizes the activities of the past year.

Pearson VUE Organizational Changes

In April 2008, Dr. Betty Bergstrom assumed the role of vice president of testing services, which includes working with the NCLEX program. Dr. Bergstrom has over 16 years experience with large scale, computer-based testing and has research expertise in the areas of item response theory (IRT), equating, standard setting, computerized testing and adaptive testing. She has authored numerous articles and publications relating to computer-based testing. Dr. Bergstrom earned her MS and PhD in measurement, evaluation and statistical analysis from the University of Chicago.

In June 2008, Bob Bailey assumed the role of interim director of test development for the NCLEX program. Mr. Bailey has been working exclusively in the testing industry for the past 10 years and has worked in the development and delivery of innovative item types, such as scenario-based items. Bob has worked predominantly with high-stakes, high-volume national programs.

In August 2008, Jerry Gorham joined Pearson VUE as psychometric manager for the NCLEX program and is responsible for managing the NCLEX psychometrics and research program. Dr. Gorham's work focuses on applied psychometrics in the area of high-stakes licensure examinations and his areas of expertise include licensure tests, computerized adaptive testing (CAT) examinations, item pool development, constructed-response items, IRT and non-parametric statistical methods.

In November 2008, Kathleen Spaltro joined Pearson VUE as a senior content editor for the NCLEX program. Kathleen brings five years of experience as a medical writer and editor for a physicians' professional association and a teaching hospital, in addition to eight years as managing editor of two quarterly publications for a librarians' professional association and 13 years of teaching professional writing at graduate schools of clinical psychology. After she earned a doctorate in English from Northwestern University, she also engaged in more than 25 years of freelance writing, editing, indexing, and proofreading for publishers, businesses, and nonprofit entities.

Special Reports

During the April 1, 2008, pool deployment, Pearson VUE standard operating procedures were not followed with regard to deploying the masking file (a file that turns off specific items). After careful review, Pearson VUE and NCSBN determined that all original candidate results should be retained. In May, Pearson VUE submitted a detailed report on the findings and recommendations to NCSBN.

Pearson VUE developed a series of new procedures and quality control checks to mitigate such incidents. In addition to the new procedures, a cross-functional team meeting is held approximately one week prior to the deployment of a new pool. Together with NCSBN, each quality control procedure and significant operational step is audibly confirmed and recorded, thus assuring that all quality control steps have been met.

Test Development

In 2008, psychometric and statistical analyses of the NCLEX data were conducted and documented as required. Pearson VUE developed multiple-choice items and items in alternate formats, including multiple-response, drag-and-drop, ordered response and chart/exhibit items. The focus was on producing high-quality traditional and alternate-format items at targeted difficulty levels in sufficient quantities to meet contract requirements. Pearson VUE conducted other test development activities, including coding and referencing of items. Pearson VUE facilitated Item Writing, Item Review, Master Pool Review, Sensitivity and Differential Item Functioning (DIF)

panels with subject matter experts (SMEs) and attended NCLEX® Examination Committee (NEC) and NCLEX® Item Review Subcommittee (NIRSC) meetings per the contractual agreement. Each quarter, Pearson VUE produced reports for the NEC on these activities.

NCLEX® Examinations Operations

In addition to Pearson VUE delivering the NCLEX examinations in the U.S., NCSBN has approved Pearson VUE to deliver the NCLEX examinations at 18 international Pearson Professional Centers (PPCs) in 11 countries. NCLEX examinations are currently being administered in Australia, Canada, Germany, Hong Kong, India, Japan, Mexico, the Philippines, Puerto Rico, Taiwan and the United Kingdom. These additions raise the number of PPCs delivering NCLEX examinations to a current total of 227 locations globally.

Pearson VUE visits to NCSBN

- Jan. 22-24, 2008, NCLEX® Examination Committee Meeting
- Jan. 25, 2008, Pearson VUE Business Review Meeting
- March 3-5, 2008, Midyear Meeting
- April 15-17, 2008, NCLEX® Examination Committee Meeting
- April 18, 2008, Pearson VUE Business Review Meeting
- May 7, 2008, Board of Directors Meeting
- June 12, 2008, NCLEX® Development Group Meeting
- July 7, 2008, Contract Evaluation Meeting
- July 22-23, 2008, NCLEX® Examination Committee Meeting
- Aug. 4-8, 2008, Delegate Assembly
- Oct. 21-23, 2008, NCLEX® Examination Committee Meeting
- Nov. 14, 2008, Pearson VUE Business Review Meeting

Monthly Meetings/Conference Calls:

- Weekly conference calls with NCSBN, test development and operations, psychometrics and administration
- Monthly administration conference call with Pearson VUE and NCSBN
- Conference calls with Pearson VUE and NCSBN content staff held periodically as needed
- Other visits and conference calls conducted as needed
- Cross-functional meetings are held a week before each scheduled pool deployment

Summary of NCLEX® Examination Results for the 2007 Calendar Year[1]

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 2007, the overall candidate volumes were higher for both the NCLEX-RN® (about +4.8 percent) and NCLEX-PN® (about +3.9 percent) examinations. The registered nurse (RN) passing rate for the overall group was 0.4 percentage points higher for 2008 than for 2007 and the passing rate for the reference group was 1.3 percentage points higher for this period compared to 2007. The PN overall passing rate was lower by 2.3 percentage points from 2007 and the practical nurse (PN) reference group passing rate was 1.7 percentage points lower than in 2007.

[1]Figures presented in this section may be slightly discrepant to those published in the 2008 NCLEX® Fact Sheet and NCLEX® Examination Pass Rates, as some candidates' results were on hold at the time of publication for the fact sheet and pass rates documents. Figures shown here reflect the most current information in the NCLEX examination database, with all result holds reconciled.

The slight decrease in the PN overall and reference group passing rates may be a result of the increase in the PN passing standard that went into effect on April 1, 2008. Generally, however, RN and PN passing rates are consistent with expected variations in annual passing rates. Passing rates are also typically influenced by demographic characteristics of the candidate populations and by changes in testing patterns from year to year.

The following points are candidate highlights of the 2008 testing year for the NCLEX-RN examination.

- Overall, 209,769 NCLEX-RN examination candidates tested during 2008, as compared to 200,215 during the 2007 testing year. This represents an increase of approximately 4.8 percent.
- The candidate population reflected 129,121 first-time, U.S.-educated candidates who tested during 2008, as compared to 119,574 for the 2007 testing year, representing an 8.0 percent increase.
- The overall passing rate was 69.8 percent in 2008 compared to 69.4 percent in 2007. The passing rate for the reference group was 86.7 percent in 2008 and 85.4 percent in 2007.
- Approximately 50.6 percent of the total group and 54.1 percent of the reference group ended their tests after a minimum of 75 items were administered. This is slightly higher than the 2007 testing year, in which 48.6 percent of the total group and 50.9 percent of the reference group took minimum-length exams.
- The percentage of maximum-length test takers was 14.3 percent for the total group and 12.8 percent for the reference group. This is slightly lower than last year's figures (15.4 percent for the total group and 14.5 percent for the reference group).
- The average time needed to take the NCLEX-RN examination during the 2008 testing period was 2.55 hours for the overall group and 2.28 hours for the reference group (approximately the same as last year's average times of 2.54 hours and 2.26 hours, respectively).
- A total of 59.4 percent of the candidates chose to take a break during their examinations (compared to 59.0 percent last year).
- Overall, 2.2 percent of the total group and 1.1 percent of the reference group ran out of time before completing the test. These percentages of candidates timing out were comparable to the corresponding percentages for candidates during the 2007 testing year (2.1 percent and 1.0 percent, respectively).
- In general, the NCLEX-RN examination summary statistics for the 2008 testing period indicated patterns that were similar to those observed for the 2007 testing period. These results provide continued evidence that the administration of the NCLEX-RN examination is psychometrically sound.

The following points are candidate highlights of the 2008 testing year for the NCLEX-PN examination:

- Overall 77,835 PN candidates tested in 2008, as compared to 74,933 PN candidates tested during 2007. This represents an increase of approximately 3.9 percent.
- The candidate population reflected 61,773 first-time, U.S.-educated candidates who tested in 2008, as compared to 60,235 for the 2007 testing year (an increase of approximately 2.6 percent).
- The overall passing rate was 76.2 percent in 2008 compared to 78.5 percent in 2007, and the reference group passing rate was 85.6 percent in 2008 compared to 87.3 percent in 2007.
- There were 54.4 percent of the total group and 58.8 percent of the reference group who ended their tests after a minimum of 85 items were administered. These figures are slightly lower than those from the 2007 testing year in which 55.1 percent of the total group and

59.9 percent of the reference group took minimum-length exams.

- The percentage of maximum-length test takers was 17.3 percent for the total group and 14.9 percent for the reference group. These figures are slightly higher than last year's percentages.
- The average time needed to take the NCLEX-PN examination during the 2008 testing period was 2.22 hours for the overall group, and 2.05 hours for the reference group (very similar to last year's times of 2.21 and 2.04 hours, respectively).
- Overall, 1.8 percent of the total group and 0.9 percent of the reference group ran out of time before completing the test (equivalent to last year's figures of 1.8 percent and 0.9 percent, respectively).
- In general, the NCLEX-PN examination summary statistics for the 2008 testing period indicated patterns that were similar to those observed for the 2007 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 2008 Testing Year

	Jan 08 - Mar 08		Apr 08 - Jun 08		Jul 08 - Sep 08		Oct 08 - Dec 08		Cumulative 2008	
	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	46,863	29,465	52,513	32,404	78,337	56,576	32,056	10,676	209,769	129,121
Percent Passing	70.5	87.1	70.7	89.3	74.7	86.3	55.5	80.0	69.8	86.7
Ave. # Items Taken	122.5	119.3	118.7	111.6	120.4	116.6	129.4	125.1	121.8	116.7
% Taking Min # Items	49.5	51.8	53.1	57.9	51.6	54.0	45.6	48.9	50.6	54.1
% Taking Max # Items	14.4	13.7	13.1	10.9	13.9	12.8	17.3	16.4	14.3	12.8
Ave. Test Time	2.58	2.35	2.50	2.15	2.48	2.29	2.75	2.42	2.55	2.28
% Taking Break	60.4	52.8	57.4	45.5	57.9	51.4	64.8	54.4	59.4	50.5
% Timing Out	2.2	1.1	2.3	0.9	1.9	1.1	3.1	1.4	2.2	1.1

Table 2: Longitudinal Technical Summary for the NCLEX-RN Examination: Group Statistics for 2007 Testing Year

	Jan 07 - Mar 07		Apr 07 - Jun 07		Jul 07 - Sep 07		Oct 07 - Dec 07		Cumulative 2007	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	44,516	26,923	49,305	31,379	72,952	51,424	33,442	9,848	200,215	119,574
% Passing	73.0	89.1	70.8	87.6	72.5	83.5	55.5	78.6	69.4	85.4
Ave. # Items Taken	119.4	113.8	122.2	118.4	127.6	125.3	129.7	127.4	124.8	121.1
% Taking Min # Items	53.2	56.5	50.2	52.7	46.6	48.0	44.5	45.6	48.6	50.9
% Taking Max # Items	13.6	11.7	14.5	13.6	16.6	16.1	16.8	16.5	15.4	14.5
Ave. Test Time	2.50	2.20	2.41	2.12	2.51	2.33	2.86	2.55	2.54	2.26
% Taking Break	59.5	49.7	53.7	43.3	57.2	50.7	69.9	59.3	59.0	49.2
% Timing Out	2.1	0.9	1.9	0.7	1.8	1.0	3.3	1.8	2.1	1.0

Table 3: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2008 Testing Year										
Operational Item Statistics										
	Jan 08 - Mar 08		Apr 08 - Jun 08		Jul 08 - Sep 08		Oct 08 - Dec 08		Cumulative 2008	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.20	0.08	0.20	0.08	0.19	0.07	NA	NA
Ave. Item Time (secs)	72.7	24.1	74.0	32.3	72.9	32.1	75.2	18.3	NA	NA
Pretest Item Statistics										
# of Items	890		851		1,322		245		3,308	
Ave. Sample Size	496		571		513		653		534	
Mean Point-Biserial	0.10		0.09		0.08		0.09		0.09	
Mean P+	0.57		0.52		0.56		0.57		0.55	
Mean B-Value	-0.13		0.23		-0.09		-0.19		-0.03	
SD B-Value	1.63		1.76		1.63		1.61		1.67	
Total Number Flagged	295		345		604		96		1,340	
% Items Flagged	33.1		40.5		45.7		39.2		40.5	

Table 4: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2007 Testing Year										
Operational Item Statistics										
	Jan 07 - Mar 07		Apr 07 - Jun 07		Jul 07 - Sep 07		Oct 07 - Dec 07		Cumulative 2007	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.20	0.08	0.20	0.07	0.19	0.07	NA	NA
Ave. Item Time (secs)	73.7	28.9	70.8	23.7	70.1	23.0	75.9	25.7	NA	NA
Pretest Item Statistics										
# of Items	489		519		1,289		217		2,514	
Ave. Sample Size	821		900		596		678		710	
Mean Point-Biserial	0.07		0.07		0.07		0.10		0.07	
Mean P+	0.56		0.56		0.55		0.53		0.55	
Mean B-Value	-0.17		-0.06		-0.04		0.02		-0.05	
SD B-Value	1.43		1.46		1.62		1.58		1.55	
Total Number Flagged	215		237		583		73		1,108	
% Items Flagged	44.0		45.7		45.2		33.6		44.1	

Table 5: Longitudinal Technical Summary for the NCLEX-PN Group Statistics for 2008 Testing Year										
	Jan 08 - Mar 08		Apr 08 - Jun 08		Jul 08 - Sep 08		Oct 08 - Dec 08		Cumulative 2008	
	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	18,047	14,429	15,452	11,378	26,497	22,506	17,839	13,460	77,835	61,773
% Passing	76.8	85.4	72.0	84.2	80.8	88.3	72.2	82.6	76.2	85.6
Ave. # Items Taken	115.1	110.7	119.4	114.6	114.5	111.1	119.2	115.2	116.7	112.6
% Taking Min # Items	56.1	60.8	51.6	56.7	56.7	60.1	51.8	56.0	54.4	58.8
% Taking Max # Items	16.0	13.6	19.1	16.3	16.1	14.1	18.8	16.5	17.3	14.9
Ave. Test Time	2.22	2.04	2.30	2.09	2.12	1.98	2.31	2.13	2.22	2.05
% Taking Break	52.9	46.1	56.6	48.2	49.6	44.1	57.5	50.3	53.6	46.7
% Timing Out	2.1	1.2	1.9	0.8	1.4	0.7	1.9	0.9	1.8	0.9

Table 6: Longitudinal Technical Summary for the NCLEX-PN Group Statistics for 2007 Testing Year										
	Jan 07 - Mar 07		Apr 07 - Jun 07		Jul 07 - Sep 07		Oct 07 - Dec 07		Cumulative 2007	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	16,500	13,123	15,566	11,741	26,184	22,619	16,683	12,752	74,933	60,235
% Passing	77.9	87.0	74.9	86.1	83.3	89.7	74.4	84.3	78.5	87.3
Ave. # Items Taken	117.3	112.5	118.6	112.9	113.0	109.5	116.9	112.0	116.0	111.3
% Taking Min # Items	53.6	58.2	52.7	58.4	58.2	61.9	54.1	59.4	55.1	59.9
% Taking Max # Items	17.7	14.8	18.4	15.0	15.1	13.1	16.9	14.3	16.8	14.1
Ave. Test Time	2.15	1.97	2.30	2.09	2.11	1.97	2.40	2.21	2.21	2.04
% Taking Break	51.3	44.2	57.2	49.3	48.9	43.7	61.1	54.4	53.5	47.2
% Timing Out	1.5	0.8	2.1	1.1	1.4	0.7	2.4	1.3	1.8	0.9

Table 7: Longitudinal Technical Summary for the NCLEX-PN Examination: Item Statistics for 2008 Testing Year										
Operational Item Statistics										
	Jan 08 - Mar 08		Apr 08 - Jun 08		Jul 08 - Sep 08		Oct 08 - Dec 08		Cumulative 2008	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.07	0.20	0.08	0.20	0.07	0.20	0.07	NA	NA
Ave. Item Time (secs)	66.1	17.0	68.3	23.2	64.8	22.2	66.6	16.9	NA	NA
Pretest Item Statistics										
# of Items	582		496		1,072		378		2,528	
Ave. Sample Size	620		573		493		760		578	
Mean Point-Biserial	0.13		0.13		0.09		0.11		0.11	
Mean P+	0.53		0.53		0.47		0.52		0.50	
Mean B-Value	-0.03		-0.07		0.39		0.04		0.15	
SD B-Value	1.66		1.63		1.83		1.69		1.75	
Total Number Flagged	157		147		455		134		893	
% Items Flagged	27.0		29.6		42.4		35.4		35.3	

Table 8: Longitudinal Technical Summary for the NCLEX-PN Examination: Item Statistics for 2007 Testing Year										
Operational Item Statistics										
	Jan 07 - Mar 07		Apr 07 - Jun 07		Jul 07 - Sep 07		Oct 07 - Dec 07		Cumulative 2007	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.20	0.08	0.21	0.08	0.20	0.08	NA	NA
Ave. Item Time (secs)	64.0	17.5	67.1	19.9	63.4	18.8	66.2	17.0	NA	NA
Pretest Item Statistics										
# of Items	488		408		1,040		461		2,397	
Ave. Sample Size	631		719		542		685		618	
Mean Point-Biserial	0.10		0.12		0.10		0.13		0.11	
Mean P+	0.53		0.57		0.47		0.49		0.50	
Mean B-Value	-0.08		-0.28		0.36		0.19		0.13	
SD B-Value	1.33		1.31		1.66		1.94		1.62	
Total Number Flagged	167		102		404		149		822	
% Items Flagged	34.2		25.0		38.8		32.3		34.3	

International Testing Update

Pearson VUE has a total of 209 PPCs in the U.S. and 18 PPCs internationally in Australia, Canada, Germany, Hong Kong, India, Japan, Mexico, the Philippines, Puerto Rico, Taiwan and the United Kingdom, for a total of 227 test centers globally.

Represented in the tables on the following pages are international volume by Member Board, country of education, test center and pass/fail rate, respectively.

Table 1: NCLEX International Test Center Volume by Member Board* Jan. 1 – Dec. 31, 2008

Member Board	Total	Sydney, Australia	Burnaby, Canada	Montreal, Canada	Toronto, Canada	Frankfurt, Germany	Hong Kong, Hong Kong	Bangalore, India	Chennai, India	Hyderabad, India	Mumbai, India	New Delhi, India	Chiyoda-ku (Tokyo), Japan	Yokohama City, Japan	Mexico City, Mexico	Manila, Philippines	San Juan, Puerto Rico	Taipei, Taiwan	London, United Kingdom
Alabama	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
Alaska	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Arizona	177	2	5	0	0	2	1	15	15	7	4	37	0	0	1	78	0	0	10
Arkansas	38	0	0	0	2	0	0	0	0	0	0	1	0	0	0	34	0	0	1
California - RN	12351	42	68	18	118	38	591	46	47	13	45	158	28	5	2	10230	1	274	627
California - VN	14	0	0	0	0	0	1	0	0	0	0	1	2	2	0	7	0	0	1
Colorado	21	0	0	0	2	2	0	0	1	0	3	0	0	0	0	12	0	0	1
Connecticut	48	0	0	0	0	3	1	1	0	0	1	0	0	0	0	39	3	0	0
District of Columbia	19	0	1	0	3	1	0	0	0	0	0	0	0	0	0	14	0	0	0
Florida	221	2	0	3	5	5	3	28	13	4	7	12	0	1	0	110	1	1	26
Georgia - RN	22	0	1	0	3	0	0	0	2	0	0	0	0	0	0	6	1	0	9
Hawaii	24	1	1	0	0	2	1	0	1	0	0	0	1	0	0	13	0	1	3
Idaho	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0
Illinois	615	0	2	1	4	1	14	5	8	1	0	1	0	0	0	565	0	0	13
Indiana	5	0	0	0	0	0	0	0	2	0	0	0	0	0	0	3	0	0	0
Iowa	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Kentucky	4	0	0	0	0	0	0	2	0	1	0	0	0	0	0	1	0	0	0
Maryland	87	1	0	0	3	1	0	3	1	0	1	0	0	0	0	66	0	0	11
Massachusetts	56	0	0	1	2	3	0	16	2	1	4	4	0	0	0	15	0	0	8
Michigan	184	2	1	1	10	2	2	13	11	2	11	9	0	0	0	117	0	0	3
Minnesota	278	0	74	31	135	0	0	1	2	0	1	0	0	0	0	31	0	0	3
Mississippi	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Missouri	10	0	0	0	1	2	0	0	0	0	0	0	0	0	0	7	0	0	0
Nebraska	8	0	1	1	4	0	0	0	0	0	0	0	0	0	0	2	0	0	0
Nevada	89	0	2	0	2	0	1	2	1	0	0	1	0	0	0	79	0	0	1

Table 1: NCLEX International Test Center Volume by Member Board* Jan. 1 – Dec. 31, 2008

Member Board	Total	Sydney, Australia	Burnaby, Canada	Montreal, Canada	Toronto, Canada	Frankfurt, Germany	Hong Kong, Hong Kong	Bangalore, India	Chennai, India	Hyderabad, India	Mumbai, India	New Delhi, India	Chiyoda-ku (Tokyo), Japan	Yokohama City, Japan	Mexico City, Mexico	Manila, Philippines	San Juan, Puerto Rico	Taipei, Taiwan	London, United Kingdom
New Hampshire	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
New Jersey	140	2	1	0	1	0	5	2	2	0	1	1	0	0	0	117	1	0	7
New Mexico	2774	23	8	0	4	6	211	70	85	24	70	26	0	0	4	2008	3	3	229
New York	2798	25	11	7	43	11	345	52	23	8	13	21	857	7	0	724	3	546	102
North Carolina	70	0	1	0	4	2	0	10	7	0	4	2	0	0	0	28	1	0	11
North Dakota	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Northern Mariana Islands	495	1	0	0	0	0	13	0	0	0	0	16	0	0	0	461	0	0	4
Ohio	17	2	1	0	0	2	1	1	1	0	3	1	0	0	0	2	0	0	3
Oregon	18	1	2	0	1	1	1	0	1	0	0	0	2	0	0	8	0	0	1
Pennsylvania	68	0	2	0	3	1	0	7	5	2	2	2	0	1	0	28	2	0	13
Rhode Island	3	0	0	0	0	0	0	0	1	0	0	0	0	0	0	2	0	0	0
South Carolina	12	0	0	0	0	0	0	0	0	0	0	0	2	0	0	10	0	0	0
South Dakota	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Tennessee	38	0	0	0	1	0	0	0	0	0	0	0	0	0	0	34	0	1	2
Texas	303	3	1	0	5	1	3	9	7	4	2	4	0	0	0	226	2	0	36
Vermont	4693	18	3	4	15	7	72	597	434	65	187	387	0	1	4	2417	0	0	482
Virginia	40	0	0	0	2	1	0	11	7	0	3	3	1	0	0	9	0	0	3
Washington	25	0	17	0	0	0	1	0	0	0	0	1	0	1	0	3	0	0	2
West Virginia - PN	26	1	0	0	0	0	1	0	0	0	0	0	0	0	0	24	0	0	0
West Virginia - RN	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Wisconsin	67	0	0	0	1	0	0	1	0	0	0	1	0	0	0	47	17	0	0
Wyoming	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Total	25871	126	204	67	374	94	1268	892	679	132	362	689	893	18	12	17582	35	826	1618

*Only Member Boards with international test center candidate data are represented.

Table 2: NCLEX International Test Center Volume by Country of Education Jan. 1 – Dec. 31, 2008

Member Board	Total	Sydney, Australia	Burnaby, Canada	Montreal, Canada	Toronto, Canada	Frankfurt, Germany	Hong Kong, Hong Kong	Bangalore, India	Chennai, India	Hyderabad, India	Mumbai, India	New Delhi, India	Chiyoda-ku (Tokyo), Japan	Yokohama City, Japan	Mexico City, Mexico	Manila, Philippines	San Juan, Puerto Rico	Taipei, Taiwan	London, United Kingdom
Albania	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Algeria	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Argentina	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Australia	18	14	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	1
Barbados	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Belarus	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Belgium	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Botswana	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Brazil	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Cambodia	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Cameroon	4	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	3
Canada	306	0	88	43	174	1	0	0	0	0	0	0	0	0	0	0	0	0	0
China	261	6	2	1	3	0	221	0	1	0	2	0	0	0	0	2	0	1	22
Cuba	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0
Czech Republic	3	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Dominica	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Eritrea	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ethiopia	3	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Finland	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
France	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Gambia	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Germany	15	0	0	0	1	11	0	0	0	0	0	0	0	0	0	0	0	0	3
Ghana	17	1	0	0	0	1	0	0	0	0	1	1	0	0	0	0	0	0	13
Greece	3	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
Guyana	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Hong Kong	4	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	1	0
Hungary	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Iceland	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

Table 2: NCLEX International Test Center Volume by Country of Education Jan. 1 – Dec. 31, 2008

Member Board	Total	Sydney, Australia	Burnaby, Canada	Montreal, Canada	Toronto, Canada	Frankfurt, Germany	Hong Kong, Hong Kong	Bangalore, India	Chennai, India	Hyderabad, India	Mumbai, India	New Delhi, India	Chiyoda-ku (Tokyo), Japan	Yokohama City, Japan	Mexico City, Mexico	Manila, Philippines	San Juan, Puerto Rico	Taipei, Taiwan	London, United Kingdom
India	2908	15	5	0	26	2	1	862	667	122	277	628	0	0	0	2	0	0	301
Indonesia	4	0	0	0	0	0	1	0	0	0	0	0	0	0	0	3	0	0	0
Iran	15	0	0	0	4	0	0	0	0	1	2	5	0	0	0	0	0	0	3
Ireland	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Israel	51	0	0	0	3	24	0	0	0	0	0	0	0	0	0	0	0	0	24
Italy	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Jamaica	17	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	16
Japan	41	0	0	0	0	1	0	0	0	0	0	0	36	3	0	0	0	1	0
Jordan	2	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0
Kenya	55	0	0	0	0	0	0	3	1	0	42	2	0	0	0	0	0	0	7
Korea, North	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Korea, South	1763	15	10	0	8	1	309	0	0	0	0	1	846	6	0	50	0	515	2
Latvia	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Lebanon	10	0	0	0	1	1	0	0	0	0	0	6	0	0	0	1	0	0	1
Macedonia	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Malaysia	6	1	0	0	0	0	3	1	0	0	0	0	0	0	0	1	0	0	0
Mexico	5	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0
Moldova	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Myanmar	3	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	0	0	0
Nepal	24	0	0	0	0	2	1	1	0	2	0	12	0	0	0	0	0	0	6
Netherlands	3	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1
New Zealand	18	15	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Nigeria	49	1	0	1	5	5	0	3	0	0	2	2	0	0	4	0	0	0	26
Norway	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pakistan	22	0	1	0	0	0	18	0	1	0	0	1	0	0	0	0	0	0	1
Peru	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Philippines	19398	49	66	20	126	16	590	12	4	5	31	22	6	5	0	17496	0	13	937
Pitcairn	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Poland	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2

Table 2: NCLEX International Test Center Volume by Country of Education Jan. 1 – Dec. 31, 2008

Member Board	Total	Sydney, Australia	Burnaby, Canada	Montreal, Canada	Toronto, Canada	Frankfurt, Germany	Hong Kong, Hong Kong	Bangalore, India	Chennai, India	Hyderabad, India	Mumbai, India	New Delhi, India	Chiyoda-ku (Tokyo), Japan	Yokohama City, Japan	Mexico City, Mexico	Manila, Philippines	San Juan, Puerto Rico	Taipei, Taiwan	London, United Kingdom
Portugal	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Puerto Rico	32	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32	0	0
Romania	8	0	0	0	0	2	0	0	0	0	0	1	0	0	0	0	0	0	5
Russian Federation	9	0	1	0	0	4	0	0	3	0	0	0	0	0	0	0	0	0	1
Saudi Arabia	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Sierra Leone	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Singapore	14	0	1	0	0	0	11	0	0	0	0	0	0	0	0	0	0	2	0
Slovakia	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
South Africa	19	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	18
Spain	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Sri Lanka	8	0	0	0	0	0	0	7	1	0	0	0	0	0	0	0	0	0	0
St. Vincent and Grenadines	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sudan	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Taiwan	297	1	2	0	0	0	2	0	0	0	0	0	0	0	0	0	0	291	1
Thailand	106	1	1	0	2	0	101	0	0	0	0	0	0	0	0	0	0	0	1
Trinidad and Tobago	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Uganda	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Ukraine	16	0	2	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	11
United Arab Emirates	3	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0
United Kingdom	154	4	2	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	147
United States	111	2	20	1	16	11	3	1	0	2	1	3	5	4	1	24	0	0	17
Zambia	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Zimbabwe	4	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Total	25871	126	204	67	374	94	1268	892	679	132	362	689	893	18	12	17582	35	826	1618

Table 3: NCLEX International Volume by Testing Center Jan. 1 – Dec. 31, 2008

Site ID	City	Country	Total	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
50482	Sydney	Australia	126	8	14	15	11	7	13	9	13	8	6	7	15
50486	Burnaby	Canada	204	15	23	13	12	11	25	25	20	17	18	9	16
50485	Montreal	Canada	67	5	5	2	6	6	10	4	4	6	5	7	7
50484	Toronto	Canada	374	39	19	30	38	33	26	40	33	42	26	24	24
50491	Frankfurt	Germany	94	9	7	6	10	7	8	10	1	12	6	9	9
50493	Hong Kong	Hong Kong	1268	98	74	83	134	127	110	131	112	75	122	96	106
50497	Bangalore	India	892	131	101	99	94	87	56	83	38	47	68	34	54
50498	Chennai	India	679	89	69	54	77	55	62	67	50	51	33	29	43
50496	Hyderabad	India	132	26	10	7	19	14	7	14	11	10	3	6	5
50494	Mumbai	India	362	33	36	23	38	41	27	38	33	27	28	6	32
50495	New Delhi	India	689	81	64	44	44	68	54	64	61	43	63	26	77
50500	Chiyoda-ku	Japan	893	72	100	90	73	91	74	61	65	75	65	63	64
50501	Yokohama City	Japan	18	3	2	2	0	1	1	2	0	3	0	2	2
50503	Mexico City	Mexico	12	1	0	0	0	4	2	2	0	2	0	0	1
54555	Manila	Philippines	17582	1351	1134	1396	1506	1444	1448	1551	1397	1639	1705	1429	1582
47108	San Juan	Puerto Rico	35	4	1	4	2	1	3	2	2	4	3	5	4
50506	Taipei	Taiwan	826	94	55	116	88	83	65	64	38	67	52	48	56
50140	London	United Kingdom	1618	188	154	91	175	169	133	143	128	128	109	95	105
	Total		25871	2247	1868	2075	2327	2249	2124	2310	2006	2256	2312	1895	2202

Table 4: NCLEX International Volume – by Pass/Fail Rate Jan. 1 – Dec. 31, 2008

Site ID	City	Country	Total Taken	Total Passed	Jan (%)	Feb (%)	Mar (%)	Apr (%)	May (%)	Jun (%)	Jul (%)	Aug (%)	Sep (%)	Oct (%)	Nov (%)	Dec (%)
50482	Sydney	Australia	126	57	25.00	21.43	60.00	36.36	71.43	38.46	33.33	38.46	62.50	33.33	57.14	66.67
50486	Burnaby	Canada	204	98	53.33	30.43	69.23	41.67	54.55	52.00	64.00	60.00	29.41	38.89	33.33	43.75
50485	Montreal	Canada	67	17	0.00	0.00	0.00	50.00	0.00	40.00	25.00	0.00	33.33	60.00	42.86	14.29
50484	Toronto	Canada	374	142	30.77	47.37	36.67	39.47	24.24	38.46	42.50	33.33	35.71	46.15	41.67	50.00
50491	Frankfurt	Germany	94	54	44.44	100.00	50.00	80.00	71.43	50.00	50.00	100.00	75.00	33.33	22.22	44.44
50493	Hong Kong	Hong Kong	1268	575	36.73	40.54	36.14	45.52	48.82	50.00	46.56	44.64	49.33	49.18	45.83	46.23
50497	Bangalore	India	892	532	73.28	63.37	72.73	56.38	54.02	50.00	51.81	63.16	55.32	51.47	50.00	50.00
50498	Chennai	India	679	380	67.42	55.07	57.41	53.25	47.27	38.71	53.73	62.00	58.82	60.61	62.07	58.14
50496	Hyderabad	India	132	67	46.15	30.00	71.43	63.16	50.00	57.14	42.86	72.73	30.00	0.00	50.00	80.00
50494	Mumbai	India	362	204	60.61	58.33	52.17	57.89	53.66	44.44	57.89	54.55	48.15	57.14	66.67	68.75
50495	New Delhi	India	689	320	59.26	62.50	52.27	56.82	44.12	44.44	43.75	37.70	37.21	39.68	34.62	37.66
50500	Chiyoda-ku	Japan	893	496	59.72	59.00	58.89	42.47	50.55	55.41	50.82	43.08	58.67	64.62	58.73	64.06
50501	Yokohama City	Japan	18	6	33.33	50.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00
50503	Mexico City	Mexico	12	5	0.00	0.00	0.00	0.00	25.00	0.00	100.00	0.00	50.00	0.00	0.00	100.00
54555	Manila	Philippines	17582	8619	48.11	50.53	51.50	46.35	50.48	49.03	48.29	48.25	50.09	49.56	49.20	47.28
47108	San Juan	Puerto Rico	35	10	25.00	0.00	25.00	0.00	0.00	33.33	50.00	50.00	0.00	33.33	80.00	0.00
50506	Taipei	Taiwan	826	417	54.26	56.36	56.90	48.86	46.99	44.62	50.00	36.84	56.72	50.00	58.33	35.71
50140	London	United Kingdom	1618	553	35.64	35.06	41.76	34.29	31.95	37.59	35.66	25.78	33.59	41.28	29.47	28.57
	Total		25871	12552	49.45	51.07	57.32	43.63	47.81	45.32	47.17	44.82	47.13	43.12	49.74	46.13

Report of the APRN Committee

Background

For the last four years, the APRN (advanced practice registered nurse) Committee has worked with the APRN Consensus Group to develop a consensus model for APRN regulation. The APRN Consensus Group consists of 26 organizations representing APRN stakeholders. The Consensus Model for APRN Regulation will be the model of the future.

In the consensus model, there are four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS) and certified nurse practitioner (CNP). These four roles are given the title of APRN. APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health. APRN education programs, including degree-granting and post-graduate education programs, are accredited. APRN education consists of a broad-based education, including three separate graduate-level courses in advanced physiology/pathophysiology, health assessment and pharmacology, as well as appropriate clinical experiences. All developing APRN education programs or tracks go through a preapproval, preaccreditation or accreditation process prior to admitting students. APRN education programs must be housed within graduate programs that are nationally accredited and their graduates must be eligible for national certification used for state licensure. The model was endorsed by the NCSBN Board of Directors in September 2008. The model APRN legislative language, which parallels the Consensus Model for APRN Regulation, was also developed by the APRN Committee and adopted during the 2008 Delegate Assembly.

After the development of the Consensus Model for APRN Regulation, the APRN Committee and the APRN Consensus Group continued meeting to develop a structure which would be used to implement and maintain the consensus model. This year they discussed how to develop the Licensure, Accreditation, Certification and Education (LACE) structure described in the APRN Consensus Model of Regulation document. A structure has been developed and plans for developing a communication system are currently underway.

This year, the APRN Committee met with a strategic consultant and identified a plan and strategies for the implementation of the legislative language, such as a fact sheet for legislators; a PowerPoint presentation, which could be used by APRN stakeholders; and an article template for the committee to write articles on the legislative language as an educational tool.

The APRN Committee also held an APRN Roundtable on May 12, 2009, in Chicago. Boards of nursing (BONs) were invited to the APRN Roundtable, an annual meeting during which the APRN Advisory Panel discusses APRN regulatory issues with a wide variety of APRN stakeholders.

Highlights of FY09 Activities

- Held the APRN Roundtable in Chicago on May 12, 2009.
- Developed a template to be used by committee members to write articles on how each APRN role will be affected by the APRN model legislative language.
- Developed a PowerPoint presentation on the APRN Consensus Model for Regulation, which was placed on the NCSBN public Web site.
- Drafted a fact sheet for federal and state legislators.
- Participated in NCSBN APRN Network Calls to enhance communication among BONs regarding APRN regulatory issues.
- Developed strategies and an implementation plan to assist BONs with implementing the APRN model legislative language.
- Collectively gave 32 presentations regarding the APRN Consensus Model in 28 states.

Members

Cathy Giessel, PhD, FNP
Alaska, Area I, Board Liaison

Tracy Klein, RN, WHCNP, FNP
Oregon, Area I

Kathleen Lavery, MS, CNM, RN
Michigan, Area II

Brenda Bergman-Evans, PhD, APRN-CNS, APRN-NP
Nebraska, Area II

Jennifer Smallwood, MS, RN, CNM
Ohio, Area II

Darlene Byrd, MNSc, APN
Arkansas, Area III

Faith Fields, MSN, RN
Arkansas, Area III

Linda Sullivan, DSN, FNP-BC, PNP-BC
Mississippi, Area III

Jolene Zych, MS, RN, WHNP-BC
Texas, Area III

Emmaline Woodson, MS, RN,
Maryland, Area IV

K. Stephen Anderson, MEd, CRNA
Pennsylvania, Area IV

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

Linda Rice, MSN, APRN, FNP
Vermont, Area IV

James Luther Raper, JD, DSN, CRNP
Alabama

Charlene Hanson, EdD, RN, CS, FNP, FAAN
External Member

Staff

Nancy Chornick, PhD, RN, CAE
Director, Outreach Services

Esther White
Coordinator, Outreach Services

Meeting Dates

- Sept. 16, 2008 (Conference call)
- Nov. 17-18, 2008
- Jan. 18-19, 2009
- Feb. 15-16, 2009
- April 7, 2009 (Conference call)
- May 1, 2009 (Conference call)

- May 11-12, 2009

Relationship to Strategic Plan

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

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

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

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

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

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

Future Activities

- Continue the APRN Roundtable.
- Maintain and enhance communication among APRN stakeholders, Member Boards and NCSBN.
- Assist BONs with the implementation of the new APRN legislative language.

Attachments

A. Legislative Fact Sheet

Attachment A

Legislative Fact Sheet

What the New APRN Model Act/Rules and Regulations Will Do for You

The new Advanced Practice Registered Nurse (APRN) Model Act/Rules and Regulations is based on the new Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education, which was developed over a three-year period through a consensus process and endorsed by 42 organizations. According to the Health Resources and Services Administration (HRSA), there are over 6,000 primary care health professional shortage areas involving 64 million people in the U.S. A goal of the APRN consensus model is to increase access to effective patient care by eliminating APRN practice barriers. Implementation of the new APRN model will enhance opportunities for workforce mobility and utilization.

- APRNs increase access to patient-centered health care for your constituents.
- Studies show nationally certified APRNs provide high-quality care, improve outcomes and increase patient satisfaction.
- APRNs are proven to be high–quality, effective health care providers, many of whom are primary care providers.
- APRNs graduate from nationally accredited educational programs.
- In 12 states and Washington D.C., APRNs have independent practices and outcomes are very good.
- Implementing these regulations will increase access to health care through increased number of providers.
- Licensed, independent practice leads to better tracking of outcomes, increases the transparency of billing and clarifies accountability.
- Physician enrollment in medical residency primary care training programs is decreasing, thereby compounding the current shortage of primary care providers.

What we need from legislators:

- Advocate to improve health care workforce and access issues.
- Meet with APRN leaders to discuss APRN model act/rules and regulations.
- Support licensed independent practice for APRNs to the full extent of their education and competency.
- Sponsor and support legislative change to enact the APRN model.

Report of the Awards Committee

Background

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

This year, the Awards Committee reviewed the 2008 Awards Program and the NCSBN 30th Anniversary Gala to provide the BOD with a recommendation regarding future award programs. The committee's recommendation was to hold future awards programs as an evening event. The committee recommended description, eligibility and criteria for the award categories be revised to denote inclusion of the associate membership. The committee did not recommend any new award categories as a result of changes to the current program.

Highlights of FY09 Activities

- Conducted a review of the awards program and recommended revisions to the award descriptions, criteria and eligibility to include Associate Members.
- Conducted a blind review of the award nominations.
- Selected the award recipients.
- Reported the award recipients selected by the Awards Committee to the BOD.
- Recommended that Charlene Kelly be acknowledged posthumously for a special award.
- Identified Member Boards celebrating their centennial celebration in 2009.
- Identified executive officers who were eligible for the Executive Officer Recognition Award for five, 10 and 15 years of service.
- Notified award nominees that they had been selected by the Awards Committee as an award recipient.
- Identified ways to make the recipients feel special at the awards program, such as giving them a rose and escorting them to the stage.
- Assigned committee members will read the biographies of each award recipient at the ceremony.
- Sent letters of regret to nominators whose nominee was not selected.

2009 AWARD RECIPIENTS:

R. Louise McManus Award

Faith Fields, MSN, RN, executive director, Arkansas State Board of Nursing

Meritorious Service Award

Sheila Exstrom, PhD, RN, nursing education consultant, Nebraska Board of Nursing

Regulatory Achievement Award

Ohio Board of Nursing

Exceptional Contribution Award

Nancy Murphy, MS, RN, BC, CPM, education consultant, South Carolina State Board of Nursing

Members

Judy Bontrager, MN, RN
Arizona, Area I

Nancy Sanders, PhD, RN
Alaska, Area I

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

Linda Rounds, PhD, RN, FNP, FAANP
Texas, Area III

Leo Felix-Jurado, MA, RN, NE-BC, APN
New Jersey, Area IV

Staff

Alicia Byrd
Director, Member Relations

Meeting Dates

- Oct. 29, 2008 (Conference Call)
- Dec. 16, 2008 (Conference Call)
- March 24, 2009

Relationship to Strategic Plan

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

Strategic Objective 1
Recognize Member Board excellence.

The BOD has voted to recognize Charlene Kelly and her many contributions to the organization through a $10,000 donation to the Charlene Kelly Scholarship Fund. An announcement and presentation of this donation will occur at the 2009 Awards Ceremony.

Executive Officer Recognition Awards

5 YEARS

- George J. Hebert, MA, RN, executive director, New Jersey Board of Nursing

10 YEARS

- N. Genell Lee, JD, MSN, RN, executive officer, Alabama Board of Nursing
- Mary Blubaugh, MSN, RN, executive administrator, Kansas State Board of Nursing
- Shirley Brekken, MS, RN, executive director, Minnesota Board of Nursing
- Kim Glazier, MEd, RN, executive director, Oklahoma Board of Nursing

15 YEARS

- Teresa Bello-Jones, JD, MSN, RN, executive officer, California Bureau of Vocational Nursing and Psychiatric Technicians

Member Boards Celebrating 100 Years of Nursing Regulation

- Delaware Board of Nursing
- Michigan/DCH/Bureau of Health Professions
- Missouri State Board of Nursing
- Nebraska Board of Nursing
- Oklahoma Board of Nursing
- Pennsylvania State Board of Nursing
- Texas Board of Nursing
- Washington State Nursing Care Quality Assurance Commission
- Wyoming State Board of Nursing

Future Activities

- Select the 2010 awards recipients; and
- Review Awards Presentation Program (including award symbols, recognition of Institute of Regulatory Excellence [IRE] Fellows and criteria for special awards) and make recommendations to the BOD.

Attachments

A. Past NCSBN Award Recipients

B. Awards Brochure/Awards Criteria

Attachment A

Past NCSBN Award Recipients

Past NCSBN Award Recipients

R. LOUISE MCMANUS AWARD

2008 – Shirley Brekken
2007 – Polly Johnson
2006 – Laura Poe
2005 – Barbara Morvant
2004 – Joey Ridenour
2003 – Sharon M. Weisenbeck
2002 – Katherine Thomas
2001 – Charlie Dickson
1999 – Donna Dorsey
1998 – Jennifer Bosma
Elaine Ellibee
Marcia M. Rachel
1997 – Jean Caron
1996 – Joan Bouchard
1995 – Corinne F. Dorsey
1992 – Renatta S. Loquist
1989 – Marianna Bacigalupo
1986 – Joyce Schowalter
1983 – Mildred Schmidt

MERITORIOUS SERVICE AWARD

2008 – Sandra Evans
2007 – Mark Majek
2005 – Marcia Hobbs
2004 – Ruth Ann Terry
2001 – Shirley Brekken
2000 – Margaret Howard
1999 – Katherine Thomas
1998 – Helen P. Keefe
Gertrude Malone
1997 – Sister Teresa Harris
Helen Kelley
1996 – Tom O'Brien
1995 – Gail M. McGuill
1994 – Billie Haynes
1993 – Charlie Dickson
1991 – Sharon M. Weisenbeck
1990 – Sister Lucie Leonard
1988 – Merlyn Mary Maillian
1987 – Eileen Dvorak

REGULATORY ACHIEVEMENT AWARD

2008 – Kentucky Board of Nursing
2007 – Massachusetts Board of Registration in Nursing
2006 – Louisiana State Board of Nursing
2005 – Idaho Board of Nursing
2003 – North Carolina Board of Nursing
2002 – West Virginia State Board of Examiners for Licensed Practical Nurses
2001 – Alabama Board of Nursing

MEMBER BOARD AWARD

2000 – Arkansas Board of Nursing
1998 – Utah State Board of Nursing
1997 – Nebraska Board of Nursing
1994 – Alaska Board of Nursing
1993 – Virginia Board of Nursing
1991 – Wisconsin Board of Nursing
1990 – Texas Board of Nurse Examiners
1988 – Minnesota Board of Nursing
1987 – Kentucky Board of Nursing

EXCEPTIONAL LEADERSHIP AWARD

2007 – Judith Hiner
2006 – Karen Gilpin
2005 – Robin Vogt
2004 – Christine Alichnie
2003 – Cookie Bible
2002 – Richard Sheehan
2001 – June Bell

NCSBN 30TH ANNIVERSARY SPECIAL AWARD

2008 – Joey Ridenour
Sharon Weisenbeck Malin
Mildred S. Schmidt

EXCEPTIONAL CONTRIBUTION AWARD

2008 – Lisa Emrich
Barbara Newman
Calvina Thomas
2007 – Peggy Fishburn
2005 – William Fred Knight
2004 – Janette Pucci
2003 – Sandra MacKenzie
2002 – Cora Clay
2001 – Julie Gould
Lori Scheidt
Ruth Lindgren

SILVER ACHIEVEMENT AWARD

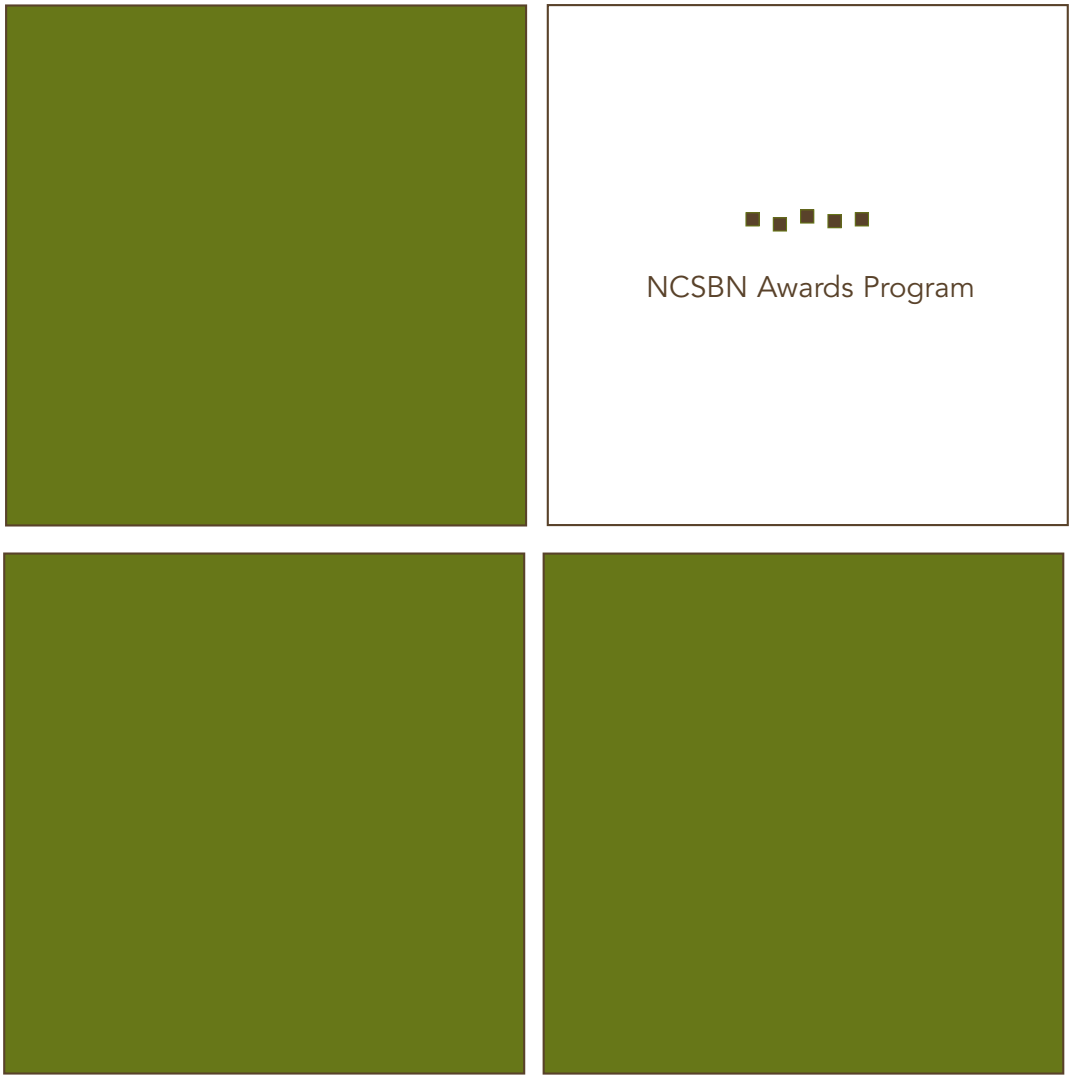
2000 – Nancy Wilson
1998 – Joyce Schowalter

*NCSBN SPECIAL AWARD

2008 – Thomas Abram
2004 – Robert Waters
2002 – Patricia Benner

Attachment B

Awards Brochure/Awards Criteria



The NCSBN awards will be announced at the 2009 Annual Meeting to recognize the outstanding achievements of NCSBN Member Boards. The awards are designed to celebrate significant contributions to nursing regulation.

Our goal is not only to recognize the successes of our peers, but also to learn what key factors contributed to this success. We encourage all members and their staff to nominate themselves and their peers.

Nomination Procedure and Entry Format

Please carefully read the eligibility requirements and criteria listed for each award. Only entries that meet all the requirements and criteria will be considered. Electronic submission of all nomination materials is required.

- Entries must be submitted in one complete e-mail; partial entries will not be considered. All entries must be e-mailed no later than Feb. 6, 2009, to Alicia Byrd, Director, Member Relations, at abyrd@ncsbn.org.
- Individuals may nominate themselves or others. For the Regulatory Achievement Award, Member Boards may nominate themselves or another board.
- Two letters of support are required. Entries must include one letter of support from the executive officer or designee. For the Regulatory Achievement Award, entries must include one letter of support from another Member Board or a representative of a regulatory agency.
- Entries must be typed and presented in a professional manner on the respective award template.
- Entries must be accompanied by the official entry form.
- Electronic submission of all materials is required. If you use any program other than Microsoft Word, please call to be sure it is readable at NCSBN.

If you have questions about the Awards Program, contact Alicia Byrd at 312.525.3666.

AWARDS REVIEW AND SELECTION

- To ensure a fair and equitable review and selection process, each individual nomination is subjected to a blind review by each Awards Committee member. The committee then makes the final decision about all award recipients.
- Awards Committee members are not permitted to nominate award recipients, participate in the nomination process or write letters of support during their tenure on the Awards Committee.
- Awards Committee members recuse themselves from both the blind review and the final decisions for the award recipient(s) in categories where their particular board of nursing, board members or board staff are nominated, or in cases where they feel that they cannot be objective about the nominee.
- Entries are evaluated using uniform guidelines for each award category.
- Awards will not necessarily be given in each category.
- Award recipients will be notified prior to the NCSBN Annual Meeting and will be honored at the Annual Meeting.
- The Awards Committee can recommend that a nominee be given an award that is different than the award he/she was originally nominated for. If this decision were made, a committee member would contact the nominator to determine if he/she is agreeable to having the nominee be given a different award.
- The Awards Committee can make recommendations for special awards to the NCSBN Board of Directors.

R. LOUISE MCMANUS AWARD

R. Louise McManus (1896-1993) is widely recognized as a major figure in furthering the professionalism of nusing. She worked tirelessly to produce a standardized national approach to nursing licensure. As a patient advocate, she developed the Patient Bill of Rights adopted by the Joint Commission in Accreditation of Hospitals.

ELIGIBILITY
Board member or staff member of a Member Board or Associate Member.

DESCRIPTION OF AWARD
The R. Louise McManus Award is the most prestigious award. Individuals nominated for this award shall have made sustained and significant contributions through the highest commitment and dedication to the purposes of NCSBN.

CRITERIA FOR SELECTION
- Active leadership in NCSBN along with direct and substantial contributions to the improvement of nursing regulation
- Impacts public policy and development to enhance the health and well-being of individuals and the community
- Contributions to the mission of NCSBN over a significant period of time

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One

MERITORIOUS SERVICE AWARD

ELIGIBILITY
Board member or staff member of a board of nursing

DESCRIPTION OF AWARD
The Meritorious Service Award is granted to a board member or staff of a Member Board or Associate Member for significant contributions to the purposes of NCSBN.

CRITERIA FOR SELECTION
- Significant promotion of the purposes of NCSBN
- Positive impact on the contributions of NCSBN
- Demonstrated support of NCSBN's mission

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One

EXCEPTIONAL CONTRIBUTION AWARD

ELIGIBILITY
Board member or staff of a Member Board or Associate Member (not an executive officer or a board president).

DESCRIPTION OF AWARD
The Exceptional Contribution Award is granted for significant contribution by a board member or staff of a Member Board or an Associate Member (not an executive officer or a board president).

CRITERIA FOR SELECTION
- Significant contributions to NCSBN activities
- Demonstrated support of NCSBN's mission

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
Unlimited

REGULATORY ACHIEVEMENT AWARD

ELIGIBILITY
A member.

DESCRIPTION OF AWARD
The Regulatory Achievement Award recognizes a Member Board or Associate Member body that has made an identifiable, significant contribution to the purposes of NCSBN in promoting public policy related to the safe and effective practice of nursing in the interest of public welfare.

CRITERIA FOR SELECTION
- Active participation in NCSBN activities by board members and/or board staff
- Effective leadership in the development, implementation and maintenance of licensing and regulatory policies
- Active collaborative relationships among the Member Board, NCSBN, the public and other Member Boards
- Demonstrated advancement of the NCSBN mission

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One

EXCEPTIONAL LEADERSHIP AWARD

ELIGIBILITY
Service as a state board of nursing president within the past two years

DESCRIPTION OF AWARD
The Exceptional Leadership Award is granted to an individual who has served as a Member Board or Associate Member president who has made significant contributions to NCSBN.

CRITERIA FOR SELECTION
- Demonstrated leadership as the Member Board or Associate Member president
- Served as a Member Board or Associate Member president within the past two years
- Overall contributions to the regulation of nursing

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One

EXECUTIVE OFFICER RECOGNITION AWARD

ELIGIBILITY
Award given in five-year increments to individuals serving in the Executive Officer role.

DESCRIPTION OF AWARD
The Executive Officer Recognition Award was established to recognize individuals who have made contributions to nursing regulation as an Executive Officer.

CRITERIA FOR SELECTION
- Significant contribution to nursing regulation and NCSBN
- Long-standing participation in activities of NCSBN
- Contributions to public protection through board and NCSBN service

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
As applicable

Report of the Chemical Dependency Committee

Background

Currently, 40 states have an alternative to discipline program. The objectives of these programs are to: (1) ensure the health and safety of the public through a program that closely monitors licensees whose ability to safely and competently practice may be impaired due to dependency on drugs or alcohol; (2) achieve earlier intervention with intent to accomplish decreased time between the licensee's acknowledgement of chemical dependency and entry into the recovery process, while providing a means of returning the licensee to safe and effective practice in a more efficient and rapid manner, minimizing financial impact, than was achieved through the disciplinary process; and (3) provide a process for licensees to recover from impairment in a therapeutic and non-punitive process.

For FY09, the Board of Directors appointed the Chemical Dependency Committee to review discipline and alternative programs and provide recommended regulatory practices for chemically dependent licensees.

Highlights of FY09 Activities

- In order to develop elements of a model impaired nurse program, a survey instrument was developed to help the committee determine what alternative to discipline programs are currently doing and how they are doing it. The survey helps determine both the strengths and vulnerabilities of programs and identifies additional research questions that need to be addressed. The survey was distributed to all alternative to discipline programs. Out of 40 programs surveyed, 90 percent responded.
- While conducting the survey to determine what is happening among alternative to discipline programs, the committee also began conducting literature reviews to determine what should be happening. A handbook is being written which will provide recommendations on best practices for detection, prevention and intervention of chemical dependency cases based on the most current research and evidence. While nurse managers will be able to use the handbook as a resource to utilize when handling chemical dependency cases, the focus of the handbook will be on presenting evidenced-based models and best practices so that boards of nursing and alternative to discipline programs can improve and better evaluate their own programs.

Future Activities

- Complete the Handbook for Best Practices for Boards of Nursing and Alternative Programs.
- Survey disciplinary programs for nurses whose competency may be impaired because of the use of drugs and/or alcohol. This will provide a comparison with the alternative to discipline programs and identify the differences and similarities in how the two approaches address the chemically dependent nurse.

Attachments

None

Members

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

Carol Stanford, BA
California-RN, Area I

Anjeanette Lindle, JD, BS
Montana, Area I

Nancy Darbro, PhD, RN, CNS
New Mexico, Area I, Chair

Karl A. Hoehn, JD, BA
Washington, Area I

Tom Dilling, JD
Ohio, Area II

Joan Bainer, MN, RN, CNA, BC
South Carolina, Area III

Kathy Thomas, MN, RN
Texas, Area III, Board Liaison

Michael Van Doren, MSN, RN
External Member

Kate Driscoll Malliarakis, MSN, RN, CNP
External Member

Staff

Kevin Kenward, PhD
Director, Research

Lindsey Gross
Administrative Assistant, Research

Meeting Dates

- Sept. 11-12, 2008
- Jan. 5-6, 2009
- April 6-7, 2009
- May 8, 2009 (Conference call)
- May 30 – July 1, 2009

Relationship to Strategic Plan

Strategic Initiative 2
Promote evidence based regulation that provides for public protection (regulatory excellence).

Strategic Objective 1
Review discipline and alternative programs and provide recommended regulatory practices for chemically dependent licensees for the purposed of public protection.

Report of the Continued Competence Committee

Background

Continued competence has dominated the NCSBN agenda since the early 1980s. For over a decade, committee work resulted in a series of documents supporting the need for a uniform method of continued competence across the U.S. These included the development of a conceptual framework for continued competence, definitions, standards, several position papers and models (1985, 1991, 1993, 1995 and 1996).

In 1995, the Nursing Practice and Education Committee proposed adoption of the Continued Competence Accountability Profile (CCAP) to the Delegate Assembly. This was a continued competence program based on the self-reflection/portfolio model. The Delegate Assembly acknowledged it as being interesting and innovative; however, there was concern regarding the feasibility of implementation and monitoring of the program. Subsequently, it was not adopted. NCSBN resumed work on this subject and these renewed efforts resulted in a research project examining the efficacy of a continuing education mandate and several more papers supporting the concept of continued competence.

In 2006, a Continued Competence Task Force conducted a postentry practice analysis to determine whether any core competencies could be identified for the practice of nursing. This was accomplished through the licensed practice/vocational nurse (LPN/VN) and registered nurse (RN) postentry practice analyses. Results of these studies revealed that there are core knowledge and skills that are required of all practicing nurses, regardless of their specialty, years of experience or geographic location. These core competencies became the content outline for a potential competency assessment instrument. Utilizing the RN and LPN/VN test specification reports and the professional judgment of the continued competency advisory panel, an external consultant was engaged to submit a proposal for the construction of RN and LPN/VN competency assessment tools, and a national pilot test of the proposed assessment tools. The final report from the consultant was presented to the 2008 Board of Directors (BOD) who requested feedback from the participants of the 2008 Midyear Meeting. A formal presentation was followed by discussions at the area meetings. A request, made by the membership, was for the development of a continued competence regulatory model. This would provide a clearer context for understanding the use of a potential assessment tool.

The BOD requested the 2009 Continued Competence Committee address the following charge:

Develop guiding principles and a regulatory model with multiple options for demonstration of continued competence.

See Attachment A for the results emerging from this charge. The committee has diligently addressed the charge and has produced a set of guiding principles and the first regulatory model of its kind for nursing. In their discussion, the committee addressed the advantages and disadvantages of this model and this information has been added as a supplement (see Attachment B).

Highlights of FY09 Activities

- Developed the *Guiding Principles of Continued Competence*.
- Developed a regulatory model with multiple options for demonstration of continued competence.

Future Activities

- Test the regulatory model using NCLEX® items in a six to 10 state pilot program.
- Establish a committee to advise on the implementation of the pilot program. Committee representation should be based on participation in the pilot program and representative of the 2009 Continued Competence Committee.

Members

Kathy Malloch, PhD, MBA, RN
Arizona, Area I, Board Liaison

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

Teresa Bello-Jones, JD, MS, RN
California-VN, Area I

Debra Scott, MSN, RN, APN
Nevada, Area I, Chair

Sean Gorman, JD, BS
Indiana, Area II

Pamela Autrey, PhD, MBA, MSN, RN
Alabama, Area III

Kathy K. Hicks, RN, LNC
Arkansas, Area III

Terry Karfonta, PhD
Florida, Area III

Robbin Wilson, MSN, RN
Texas, Area III

Staff

Maryann Alexander, PhD, RN
Chief Officer, Nursing Regulation

Meeting Dates

- Nov. 3-4, 2008
- Jan. 26-27, 2009
- April 27-28, 2009

Relationship to Strategic Plan

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

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

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

- Focus on answering the following questions:
  - Does a universal computerized diagnostic assessment identify/validate continued competency for nurses?
  - What other indicators are there of continued competence for nursing?
- Proposed 2010 Continued Competence Committee charges:
  - Assist in the implementation of a continued competence assessment pilot project.
  - If appropriate, provide input into the development of a business plan.

Attachments

A. NCSBN Guiding Principles and Regulatory Model for Continued Competence

B. Advantages and Challenges of the Regulatory Model

Attachment A

NCSBN Guiding Principles and Regulatory Model for Continued Competence

Introduction

Boards of nursing (BONs) have a responsibility to assure the competency of their licensees. This pertains not only to new graduates and internationally educated nurses applying for licensure by examination, but also postentry level nurses holding a license. Currently, there is a lack of uniformity among states as to what, if anything, should be required of postentry licensees. Many BONs find themselves struggling to answer questions concerning how to assure the public that nurses maintain competency throughout their careers and how to determine whether an individual that has left nursing practice for an extended period of time is competent to return to nursing practice.

Although states have attempted various approaches to ensure competency for nurses, there are no evidence based methods, with the exception of the NCLEX® exam, that measure or support this endeavor. The issue of what method is most efficient and effective continues to confound nursing regulators who are looking to NCSBN for leadership in this matter.

The need for ongoing competency requirements is not isolated to nursing. Continued competency of health care providers has been addressed by the Institute of Medicine (IOM) (2000, 2001, 2003, 2003, 2004) and a host of other commissions and organizations, including the Citizens Advocacy Center (1996, 2004); the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (2006); and the Pew Health Professions Commission (1995). All have advocated for a process that will objectively measure competence among postentry health care professionals. NCSBN has long recognized the necessity to assess ongoing competence and has been at the forefront addressing this issue. Since 1985, when the first continued competence paper was written (Kelly, 1985), NCSBN has addressed, supported and promoted the development of a continued competence assessment for nurses.

In 2007, NCSBN renewed its ongoing commitment to continued competence in its three year strategic plan. Two strategic initiatives lay the foundation for the current work:

- NCSBN advances evidenced-based nursing regulation and regulatory solutions for public protection; and
- NCSBN is the premier organization to define and measure entry and continued competence.

Charged with the development of a set of guiding principles and a Regulatory Model for Continued Competence, the 2008-2009 Continued Competence Committee has worked diligently to analyze data and the complex issues related to this topic, while also considering feedback from Member Boards. One of the most pressing questions discussed by the committee was whether or not the assessment of competence was the responsibility of regulators and whether or not a national initiative to measure postentry level competency was necessary. The committee determined that maintaining competency to practice is a shared responsibility; it is first and foremost with the nurse. Every individual nurse is accountable for maintaining current knowledge and skills. The employer also bears responsibility and any national initiative for competence must be supplemented with additional assessment and resources from employers. Regulators, however, administer the nursing license and in doing so, are assuring the public that the practitioner is competent. Given this, regulators should provide leadership and a uniform method for assessing postentry competency.

The major thrust of a national continued competence initiative is safe patient care. This is not to suggest that nurses in the U.S. are not safe practitioners; it means that maintaining competence is integral to safe nursing practice. While a method for determining/measuring competence has been explored and discussed for decades, several contemporary factors support the need for the

development of an evidenced-based, psychometrically sound, legally defensible, professionally accepted tool for measuring competence in the 21st century. These include:

- The continuous outpouring of new knowledge. Experts state that knowledge now becomes obsolete after two and a half years.
- The public expectation that health care professionals demonstrate competency throughout their career. In a recent survey, 90 percent of private citizens polled stated they thought health care professionals were already undergoing postentry competency assessment (AARP, 2007).
- The Just Culture and Patient Safety Movements. While it is acknowledged that error is often a result of system and environmental issues, there is also a call for the remediation of practitioners that have gaps in their knowledge.

In response to their 2008-2009 charge determined by the NCSBN Board of Directors to develop a set of guiding principles and a regulatory model for continued competence, the NCSBN Continued Competence Committee has set forth a vision for continued competence in the U.S. It is hoped that this vision, based on the Guiding Principles for Nursing Regulation, will lay the groundwork for pilot projects whose data will provide answers to questions about competence assessment and bring nursing one step closer to a national model for continued competence.

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THE GUIDING PRINCIPLES FOR CONTINUED COMPETENCE IN NURSING

1. Nursing regulation is responsible for upholding licensure requirements. Competence is assessed at initial licensure and during the career life of licensees. (Adapted from NCSBN's Guiding Principles of Nursing Regulations.)

2. The individual nurse, in collaboration with the state BON, nursing educators, employers and the nursing profession, have the responsibility to demonstrate continued competence through:

- Acquisition of new knowledge; and
- Appropriate application of knowledge and skills.

3. A culture of continued competence is based on a premise that the competence of any nurse should be periodically assessed and validated.

4. Requirements for continued competence should support nurses' accountability for lifelong learning and foster improved nursing practice and patient safety.

5. A continued competence regulatory model for nursing:

- Includes a secure, standardized, psychometrically sound and uniformly administered diagnostic assessment;
- Is proactive, flexible and nonpunitive;
- Offers a choice of options to address gaps in knowledge, skills and abilities identified by a diagnostic assessment;
- Is evidence based;
- Meets APPLE criteria (see Definition of Terms); and
- Is rigorously pilot tested before adoption.

6. The regulatory authority for establishing continued competence requirements should remain with the state BON.

2009 CONTINUED COMPETENCE REGULATORY MODEL FOR NURSING

Step 1: Initial diagnostic assessment of licensees

- Is based on core competencies for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs);
- Has a passing standard;
- Is computer-adaptive; and
- Is to be administered in a secure environment.
- The state BON shall determine:
  - Time frame; and
  - Population.

Step 2: Dissemination of diagnostic assessment results

- The licensee receives individual results of the diagnostic profile directly from the vendor.
- Results indicate whether the licensee meets or falls below the passing standard.
- The diagnostic profile describes the licensee's strengths and areas needed for improvement.
- The vendor sends state aggregate results to each BON.
- Individual licensee results may be requested by the state BON.

Step 3: Follow-up actions by state BON

Each individual state BON determines follow-up actions. Possible actions may include any one or combination of the options listed below:

1. The BON elects to obtain the individual licensee results that meet the passing standard and awards one of the following:
    - Certificate of competency;
    - Certificate of recognition; or
    - Indication on license that individual has met continued competence requirements.
2. The BON elects to obtain the individual licensee results below the passing standard.
    - The BON requests further evaluation of a licensee's knowledge and skills.
    - The BON requests the development of a competency remediation plan by the licensee.
        - The plan should be comprehensive and describe in detail the activities the licensee will complete to address knowledge gaps identified in the diagnostic profile.
        - The plan should include target dates for completion of each activity outlined in the plan.
    - The BON randomly audits licensees' competency remediation plans and evidence of plan implementation and/or completion.
    - The BON refers the licensee to an approved practice enhancement program (pending the results of the evaluation).
3. The results of the diagnostic assessment are left to the discretion of each licensee and/or employer.
    - Licensee does his/her own follow-up.
    - Licensee who has fallen below the passing standard may repeat the diagnostic assessment at his/her option.
4. BON takes no action.

Step 4: Diagnostic reassessment requirements determined by the BON

*The word licensee refers solely to RNs and LPN/VNs licensed by a BON. It does not include any other group or profession that may be regulated by a BON.

DEFINITION OF TERMS

APPLE criteria: an acronym for the criteria used to guide the development of a policy or regulation. **A**dministratively feasible, **P**rofessionally acceptable, **P**ublicly credible, **L**egally defensible and **E**conomically feasible.

Assessment: A tool used for measuring the application of the knowledge, skills and abilities required for safe and effective nursing practice.

Competence: Having the knowledge, skills and ability to practice safely and effectively.

Continued competence: The ongoing synthesis of knowledge, skills and abilities required to practice safely and effectively in accordance with the scope of nursing practice.

Core competencies: Knowledge, skills and abilities identified through a practice analysis that are universal to RNs or LPN/VNs regardless of practice setting, specialty practice area and/or years of experience.

- **RN competencies**: Clinical judgment and provision of care, professional responsibilities, communication, inter/intra-disciplinary collaboration, supervision/management and safety.
- **LPN/VN competencies**: Provision of care, legal/ethical responsibilities, communication, inter/intra-disciplinary collaboration and safety.

Culture of competence: The shared beliefs, values, attitudes and actions that promote lifelong learning and result in an environment of safe and effective patient care.

Diagnostic assessment: A tool to measure current nursing knowledge, skills and abilities for the purpose of identifying an individual's strengths and/or potential gaps in core competencies.

Diagnostic profile: A confidential report that describes the outcomes of the diagnostic assessment.

Passing standard: The minimum level of knowledge, skill and ability required for safe and effective nursing practice.

Postentry level: Practicing nurses licensed for six months or more.

Practice analysis: A study intended to describe postentry practice of RNs or LPN/VNs with the intention of determining if there are core nursing activity statements, regardless of practice setting, specialty practice area and/or years of experience.

Remediation: The process whereby identified deficiencies in core competencies are corrected.

Secured environment: A designated monitored testing site that meets specific standards related to test security.

Attachment B

Advantages and Challenges of the Regulatory Model

Advantages	Challenges
1. Provides a validated measure of continued competence.	1. Potential dissention/competition from other stakeholders.
2. Promotes collaboration between practice and service.	2. Need is not universally recognized by all nursing regulators, including members of the profession.
3. Fosters new types of collaboration.	3. High cost, although there may be revenue generation down the line.
4. Potential for establishing a long-term measure for continued competence.	4. States adopting different options does not promote uniformity.
5. A basis for other studies.	5. Many logistics regarding implementation and potential follow-up. This may present the greatest challenges for compact states.
6. Supports our mission.	6. Test format may be intimidating.
7. NCSBN has the resources and expertise to accomplish this.	
8. Role of profession is to demonstrate competence to the public. This model may provide us with the ability to do that.	
9. Will assist employers in demonstrating competency of staff.	
10. Will assist employers in identifying gaps in knowledge.	
11. Will help nurses identify their limitations.	
12. Standard knowledge and standard language leads to evidence based regulation.	
13. Global possibilities.	
14. Will help us play a role in the patient safety movement.	
15. A method of guiding remediation in a concrete way.	
16. A response to consumers who expect that regulators evaluate competency.	
17. If not us, then someone else will.	
18. Empowering for the profession.	

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

Background

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

BONs have been surveyed four times since 2000; the last survey occurring in 2008. They are surveyed regarding five board functions: (1) discipline; (2) practice; (3) education program approval; (4) licensure; and (5) governance. Three groups of stakeholders that were directly affected by BON actions are also surveyed. These three groups included: (1) employers; (2) nursing programs; and (3) nurses. Random samples of these stakeholders were surveyed to gain their perspectives about interactions with their BON and about the effectiveness of nursing regulation in general.

Highlights of FY09 Activities

- Work has begun on developing survey instruments for the 2010 survey using a logic model. Basically, this model is a systematic and visual way to present and share one's understanding of the relationships among available resources, the activities planned and the changes or results one hopes to achieve. The model describes the sequence of activities thought to bring about change and how these activities are linked to the results the program is expected to achieve. This approach helps create shared understanding of and focus on goals, relating the questions asked to the activities performed to projected outcomes. More work will be required before indicators are finalized.
- By the end of December 2008, all BONs received four reports: (1) a report aggregating data from all participating BONs; (2) a report for state level data; (3) a report comparing umbrella and independent BONs; and (4) a report comparing BONs by number of licensees. Half a day was devoted to the CORE Midyear Meeting sessions to assist BONs in using and interpreting these reports. Specific examples were used and attendees were walked through a process that explained the meaning of these results, setting goals based on the data and how to evaluate the attainment of these goals. Other presentations included how two states incorporate the CORE findings into their strategic objectives and how they assist in their legislative reviews.

Future Activities

- Collect and analyze data from the 2010 surveys.
- Identify top performing BONs and the reasons for their excellent performance.
- Implement strategies to increase knowledge and use of CORE performance measures.
- Compare and contrast the profiles of independent and umbrella board structure and outcomes.

Attachments

None

Members

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Meeting Dates

- Oct. 20-21, 2008
- Dec. 8-9, 2008
- Jan. 8-9, 2009
- March 23-24, 2009

Relationship to Strategic Plan

Strategic Initiative 2
Promote evidence based regulation that provides for public protection (regulatory excellence).

Strategic Objective 1
Refinement of CORE research process.

Strategic Objective 2
Develop an implementation plan for use of CORE resources.

Report of the Disciplinary Resources Committee

Background

Comprised of seven members, plus the board liaison and three NCSBN staff members, the Disciplinary Resources Committee had extensive charges this year. In order to meet the 2009 charges, the committee had to review an extensive amount of literature, develop a survey instrument and work with the NCSBN Marketing & Communications department to ensure continuity with other resources that would be part of an outreach tool kit. The following is a report on the progress of their charges.

Develop an outreach tool kit to inform the public of the board of nursing (BON) discipline process.

In an effort not to duplicate materials previously developed or in the process of being revised, the committee worked in collaboration with NCSBN's Marketing & Communications Department, which was already working on a tool kit for the public and the nursing profession. Two brochures related to the BON discipline process have been developed by the committee and will be a part of an NCSBN Outreach Tool kit that will contain the following resources: Your Nursing License is the Key to Your Career; A Nurse's Guide to the Importance of Appropriate Professional Boundaries; A Consumer's Guide to the Expected Behavior of a Health Care Provider; How Boards of Nursing Protect the Public; Your State Nursing Board Works for You: A Health Care Consumer's Guide; and Your State Nursing Board is Here for You: A Nurse's Guide.

Identify available alternative, early intervention programs related to practice, including advantages and disadvantages.

A survey developed by the committee was used to gather qualitative information from seven BONs that have alternative programs for practice related violations (Ohio, North Carolina, South Carolina, West Virginia-PN, Colorado, Minnesota and Pennsylvania). BONs were interviewed about the programs and their advantages and disadvantages. The data from the survey is contained within an extensive report prepared by the committee (see Attachment A). This report is intended to answer this charge and may provide assistance to BONs considering developing an alternative program for practice related violations. Below is a summary of the findings for this charge.

Advantages	Disadvantages
▪ Establishes collaboration between BON and employer. Employer is the eyes and ears of the BON. ▪ Utilizes Just Culture principles for improving practice and retention of nurses. ▪ The goal is to initiate collaborative remediation of a perceived practice deficiency before the situation rises to a level of disciplinable action and/or poses a patient safety threat. ▪ Nondisciplinary resolution permits the BON to address the situation with better timing than litigation. Cases can be addressed more expediently and remediation occurs in a shorter length of time than traditional discipline.	▪ Facilities are hesitant to enter into a binding agreement with a regulatory BON. Many want to stay off the radar. ▪ Difficult for institutions to proactively identify individuals who are a potential threat to patient safety. ▪ If the early remediation program is truly predisciplinary (precomplaint), as opposed to being an alternative to discipline, there are no cost savings for the BON to realize in terms of diverting disciplinary cases to these alternative resolutions. ▪ Entails a shift in resources. The BON and employer must expend much more energy towards early intervention in the hopes of realizing these disciplinary cost savings down the road.

Members

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Meeting Dates

- Sept. 15-16, 2008
- Dec. 9-10, 2008
- Jan. 29-30, 2009
- March 12-13, 2009

Relationship to Strategic Plan

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

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

Advantages	Disadvantages
▪ Calls deficiencies to the attention of the employer. Increases awareness of potential growing clinical deficiencies with their staff. ▪ May assist an employer in retaining staff nurses. ▪ Removing the process from the contentious public/punitive environment and designing a remediation plan in a predisciplinary collaborative context may make for more timely regulation. In addition, the practitioner may be more willing to engage in a collaborative process to address the deficiencies in their practice with a tailored action plan. ▪ By limiting the pool of practitioners who may participate in such programs, the BON confirms its interest in exercising its regulatory priorities responsibly. The BON is not abandoning its fundamental obligation to intervene forcefully in any case where patient care is truly at risk, but instead, is wisely exercising its discretion so as to expend resources in the most efficient way possible and stave off future serious misconduct.	▪ Resolution of cases prior to and without initiating formal discipline may precipitate public perception that the BON is protecting the nurse. ▪ Complete confidentiality may be difficult to achieve. In the majority of states, the statutory expectation is that any and all business that is conducted by its government is publicly available. As a result, there is a legal limit to the confidentiality aspect of these programs in that any such alternative resolutions, while not proactively disseminated as with any traditional disciplinary action, must still be made publicly disclosable. ▪ It is a challenge to assess the risk level and determine whether a nurse is a safe and appropriate candidate for a more informal and nondisciplinary regulatory approach. If the BON is too liberal in its application of the criteria, then it risks failing to remove a nurse that is a public threat. If the BON is too restrictive, the benefits of the alternative approach cannot be realized in numbers great enough to make a difference, either in cost or effectiveness. ▪ No amount of tailored remediation can be viewed as effective if there is no subsequent plan for reliable monitoring, preferably in the real world conditions of the workplace. Thus, the employer plays a critical role in underpinning the credibility of any such program to truly ensure public protection. Unfortunately, there is no assurance the nurse's employer is available and willing to participate in such a program. Oftentimes, the nurse is no longer working for the same employer where the practice deficiencies were identified. ▪ Effective hands on remedial education resources need to be available at a reasonable cost.

Update the Sexual Misconduct Handbook

Extensive research and committee input went into the development of this product. After deliberation by the committee, a decision was made to not only update this document, but to also ensure that this is a useful and practical resource for BONs. Step–by-step guidance through various cases, information on how to select an evaluator and guidelines for establishing sanctions are among the contents of the resource. Once approved by the Board of Directors, it will be finalized by the NCSBN Marketing & Communications Department for online, as well as paper distribution.

Highlights of FY09 Activities

- Developed outreach materials to be used by BONs to inform the public of the BON discipline process.
- Extensive interviews with BONs, which helped identify advantages and disadvantages of alternative, early intervention programs related to practice.
- Updated the Sexual Misconduct Handbook with an emphasis on utility and practicality.

Future Activities

- Develop model rules on sexual misconduct, including boundaries.
- Develop content for a model course on professional ethics and conduct for use in remediation and discipline.
- Conduct a conference on the disciplinary process for nurses.
- Extend the work on alternative programs for practice violations by exploring how states can implement successful programs; develop a model or best practices.

Attachments

A. Advantages and Disadvantages of Alternative Early Intervention Programs for Substandard Practice

Attachment A

Advantages and Disadvantages of Alternative Early Intervention Programs for Substandard Practice

TO: Board of Directors, NCSBN

FR: Disciplinary Resources Committee

RE: Alternatives to Discipline for Substandard Practice

Overview and Profiles of Various Programs

In 1999 the Citizens Advocacy Center (CAC), aided by a federal grant, promoted the forging of a new partnership between health care regulatory boards and the facilities that employ their licensees. The CAC proposed an agreement between boards of nursing (BONs) and various hospitals and other health care organizations to work together to identify, remediate and monitor health care professionals. This new collaboration was sought to ensure early identification of doctors and nurses with clinical deficiencies that have yet to rise to the level of substandard care that would warrant discipline. The hope was that through early intervention, such deficiencies could be remedied by a nonpunitive action plan devised amongst the three key players: the BON, practitioner and employer/facility. The proposed new approach to substandard care cases was called PreP 4 Patient Safety (the "PreP" standing for Practitioner Remediation and Enhancement Partnership).

While the CAC had launched this initial concept, one state had already begun its own version of predisciplinary alternatives.

Ohio was in the vanguard with their Practice Intervention and Improvement Program (PIIP). Statutorily authorized in 1997, this was an effort to approach the challenge of nurses who exhibited practice concerns in the same fashion that was employed in the case of chemical dependency monitoring programs. In Ohio's PIIP program, the case is reviewed by a board member at the conclusion of investigating substandard practice complaints. They determine whether the nurse's identified practice deficiency can be corrected through participation in the program, as opposed to formal disciplinary action. If the nurse is determined to be an appropriate candidate, he/she is offered an agreement to formally enter this program in lieu of discipline.

The key distinction between the CAC's original proposal and Ohio's PIIP program is that Ohio is not using PIIP as a tool for early intervention into practice deficiencies that have yet to rise to a violation of the practice act. Instead the program is used as an alternative to discipline, or an in lieu of program, patterned after its substance abuse monitoring programs. That is, Ohio is taking some portion of their substandard practice cases that could have previously resulted in disciplinary action and instead attempting to resolve them in a nondisciplinary fashion.

A licensee who is referred into the Ohio PIIP program must sign an agreement and their participation is confidential. One aspect of the agreement is a stipulation that the licensee acknowledges that their underlying substandard practice amounts to an actionable violation of the law. This stipulation was designed to prevent a situation in which a nurse who fails out of the program puts the BON at a disadvantage in prosecuting a stale case. Another aspect built into the agreement is that failure to complete the program is viewed as an aggravating factor to the underlying conduct. The heart of the agreement is an action plan that entails an educational remediation component and a workplace monitoring component.

Soon to follow Ohio's lead in exploring alternatives to discipline is North Carolina. Its BON appears to be the first to adopt such an alternative program in its purest form using the CAC model. North Carolina also made what appears to have been the greatest commitment of resources in general to this new approach in practice deficiency cases.

North Carolina developed and piloted its own version of PreP in 2001 and launched it statewide in 2004. North Carolina's program is closer to the original idea promoted by the CAC in that it

not only offers this alternative to disciplinary complaints, but also in cases where the employer reports clinical deficiencies in their nursing staff that have yet to rise to the level of practice act violations. The North Carolina program involves a new collaboration between the BON and facilities that employ nurses in an effort to prevent patient harm through early intervention. The BON enters into an agreed framework or memorandum of understanding (MOU) with the various facilities to ensure these employers report nurses with growing clinical deficiencies as possible candidates for this alternative intervention program. Collaborative early identification and remediation is achieved before the deficiencies reach the level of significant patient risk. The nurse's employer identifies patterns/issues with the employee and they partner with the BON to develop a remedial action plan. This is similar to the employing facility's employee assistance program relating to addiction issues, except with substantive BON involvement.

The catalyst for this initiative, according to North Carolina's Board of Nursing staff, was found in the principles of Just Culture. This is the regulatory approach that considers not only the individual nurse's conduct in isolation, but also includes the big picture circumstances and culture of the facility's workplace. This adoption of Just Culture principles, along with a new partnership with employers, is the key to North Carolina's attempts at more enlightened regulation. North Carolina's program seeks to ensure not only that the BON understands the workplace context of the nurse's perceived practice deficiencies, but that the employer is engaged to cure the underlying systemic issues that, if left unresolved, would set up any future practitioner working in that setting for failure. The North Carolina Board of Nursing's uniquely independent status may be one contributing factor for why such a bold experiment could be pursued successfully.

Nearby South Carolina has been exploring its own PreP program, but not achieving the same positive results. As with its neighbor to the north, South Carolina's program requires a candidate nurse facing discipline to sign a contract to participate. The contract sets out the conditions which usually involve remedial education followed by a workplace monitoring (shadowing) component to ensure that the education was effective and remedied the deficiency. If the nurse fails to abide by the contract, then the matter converts to a disciplinary case and is fully investigated. If they meet the conditions then no disciplinary record is publicized by the BON.

South Carolina experienced a degree of frustration in its attempts to forge a new, more collaborative relationship with employer facilities. This BON's challenge was establishing the requisite trust and convincing nurse employers that it wanted to educate, as well as discipline. The South Carolina Board of Nursing found that it can take significant time and energy to build the political infrastructure for such a progressive endeavor. Without the wherewithal to do the heavy lifting up front, South Carolina stalled in its efforts to successfully launch such an alternative vision. South Carolina reports some success with launching their version of this partnership. However, relying on the facilities to report candidates has resulted in very low participation levels and little impact on that BON's overall disciplinary business.

West Virginia's State Board of Examiners for Licensed Practical Nurses reports a similar frustration with getting their experiment with PreP off the ground. General hesitancy by employers to work in tandem with the BON has been a big hurdle, especially in long term care facilities. Most employers in this setting have already terminated the nurse by the time they report the action to the BON, thus removing the chance for a workplace collaboration to ensure remediation. A key to the underlying incentive for such collaboration is the notion that the nursing shortage prompts facilities to want to keep staff, work through the problem and thus avoid unnecessary turnover. Apparently, this has not been the case in West Virginia. Instead, employers prefer to handle the problem by removing the nurse and at best, filing a complaint with the BON. Nonetheless, West Virginia reports that it has not given up on the experiment and hopes to be able to recommit soon to the effort.

The Colorado Board of Nursing experienced a similar challenge in attempting to launch an alternative disciplinary approach, citing a political landscape and regulatory environment that was not conducive. Colorado also cited inadequate resources in terms of having the necessary staff to allot to the endeavor. They report having more success in their efforts to instill notions of Just Culture into the probationary phase of its discipline.

Just Culture, as an overlay to the regulatory model, was again the underlying catalyst for change in Minnesota's experiment with disciplinary alternatives for practice related cases. Minnesota Board of Nursing staff was trained to focus on licensee's behavior versus the outcome. The specific tool codified into Minnesota's law is their Agreement for Corrective Action (ACA), which can be used by any health care regulatory board in that state.

Minnesota's ACA is used not only in response to a complaint received, but is a predisciplinary contract between the BON and licensee used in cases where the subsequent investigation indicates the source of the complaint was a knowledge deficit. As with most all of the states mentioned above, this alternative approach is limited by specific criteria. For example, Minnesota's program does not apply to a situation in which the nurse's behavior was intentional or reckless. However, a couple common scenarios in which Minnesota's program is applicable include a licensee who has not stayed up to date on a particular nurse activity he/she was involved in and a supervising nurse who did not have the appropriate protocol in place for particular activity/circumstance. If a participant completes the steps outlined in the ACA, the disciplinary action is dismissed and the resolution is not published. The ACA resolution is expressly not classified as discipline and thus need not be reported either statewide or to a national database. If, however, the nurse fails to complete remedial steps, then pursuant to the agreement the matter proceeds to discipline. In this case, the nurse has already accepted that the BON will not have to prove its case according to the ACA terms. Interestingly, Minnesota's ACA terms never contemplate worksite monitoring; the remedial terms instead have to be under the exclusive purview and control of the licensee. If the circumstances of the case warrant employer oversight, then under Minnesota's approach, the matter would have to be resolved by a traditional disciplinary approach involving an agreed order. However, the employer/complainant is always notified of the outcome so if the nurse keeps his/her position, then the facility is aware their employee entered into an ACA.

While many of the states mentioned sought and were given express authority by their legislature to abstain from discipline in select cases, Pennsylvania, alternatively, is moving forward with a similar endeavor, but without amending its laws. The Pennsylvania Board of Nursing is instead relying on its inherent powers to exercise prosecutorial discretion to decide which cases warrant traditional disciplinary proceedings and which category of complaints may be resolved in a more informal manner.

Pennsylvania still requires that a nurse wishing to take advantage of this alternative resolution sign an agreement whereby the underlying conduct is admitted to and stipulated as a violation of the practice act. The agreement is initially presented for BON approval, but if the nurse successfully completes the remedial steps outlined in their agreement, then the matter is closed in lieu of discipline without further BON review. The matter is kept confidential in that there is no publishing of the resolution. If the nurse is unsuccessful, then the matter proceeds to a sanction-only hearing.

Unlike Minnesota, Pennsylvania contemplates significant employer involvement in their alternative program. Pennsylvania views the employer as key in designing the agreed game plan for remediation which this BON anticipates will always have a workplace monitoring component. However, it is not anticipated that the employer would sign on formally as a party to the remediation agreement.

Pennsylvania's new alternative program is in its infancy, so at this point, it cannot speak to its success in handling a significant percentage of substandard practice complaints. The Pennsylvania Board of Nursing is looking to remain flexible as it embarks on this pilot program.

Universal Key Features and their Challenges and Benefits

Based on this overview of how these various states have launched PreP-like alternative programs, the following are the key features found in all such initiatives, as well as a discussion as to benefits and challenges related to each.

A Closer Working Relationship Between BONs and Employers

All of the these programs involve BONs working more in tandem with health care facilities versus merely the licensee in order to achieve its regulatory goals. In the original proposed PreP model, this involves a new partnership memorialized in written MOUs entered into by BONs and employers. Such MOUs state expectations that growing clinical deficiencies observed in staff performance will be identified and referred to the BON as a candidate for the PreP program. Most states, however, have settled for a lesser form of partnership where an employer merely plays a greater role in helping to craft and then monitor a nurse's compliance with the action plan for remediation.

Benefits: A BON cannot best fulfill its regulatory goals in isolation and on a complaint driven basis only. It needs the employer to act as its eyes and ears on the front lines of the health care industry. True public protection through early identification and intervention cannot happen without a committed partnership between BONs and health care facilities. Moreover, by including the employer in the regulatory process, the BON has a better chance at utilizing Just Culture principles to regulate the overall practice setting as opposed to punishing individual nurses for the system in which they work.

Challenges: Facilities are hesitant to enter into a binding agreement with a regulatory board. This is especially true in states where the regulatory climate is not conducive to such intimate working relationships. For example, hospitals may have historically viewed the work of their state's BON as heavy-handed and wish to remain at a distance. Efforts at establishing mandatory reporting are an example of the tension that exists on this political front. Trust must be forged before effective agreements can be built and relied upon. Unfortunately, BONs faced with doing more with less often lack the extra resources to commit to such an endeavor. There may also be concerns that such a soft predisciplinary reporting requirement may be susceptible to workplace abuse in terms of scapegoating, bias, etc.

Regulatory Approach that Entails: Predisciplinary/Early Intervention

All PreP like programs tout that their early intervention aspects are better at getting ahead of the curve when it comes to substandard care in comparison with traditional disciplinary models. However, before exploring these efficiencies, clarification is necessary when referring to the predisciplinary aspect of such programs.

There is an important difference between programs where the BON is attempting to remediate conduct that amounts to a violation of their practice act and where such attempts are made even before the perceived clinical deficiencies get that far. Most all such programs contemplate a remedial action plan being executed on a precharging basis. However, is that because there are not yet grounds for charges or because the action plan, once completed, will likely remove the need to discipline?

The former was the model for the CAC's original proposed PreP program. The goal was to initiate collaborative remediation of a perceived practice deficiency before the situation arose to a level of disciplinable action and/or posed a patient safety threat. While this is an important practical distinction, especially in terms of selling the idea to stakeholders, much of this depends on the BON's discretion and is a somewhat fluid standard. In other words, there is a thin red line between a pattern of deficiency that must be addressed with discipline and that which can be nipped in the bud through predisciplinary remediation. That being said, taking steps to remediate on a precharging basis, however that is meant, poses significant risks and benefits.

Benefits: If remediation is initiated on a predisciplinary basis in the purest sense, then the underlying premise of the CAC's original PreP proposal was that through this collaborative early intervention process, a growing patient safety problem is eliminated before it can become more serious and result in a disciplinable action.

Even if the BON's program does not attempt remediation until receipt of a substandard practice complaint, this arguably is a better approach to resolving low to moderate risk cases. Nondisciplinary resolution permits the BON to address the situation with better timing than

litigation. Fully investigating and litigating a case can take months to well over a year and once a probationary solution is hammered out between parties, the events that gave rise to the concern are so dated as to make the regulatory actions seem too belated to be effective or even relevant.

Alternative resolutions also permit an employer to address growing clinical deficiencies with their staff without throwing the nurse out with the bathwater, so to speak. The facility can work with the BON to remediate the potential safety concerns and not lose their investment in that employee. It seems fair to presume that in the current market where nurses are in short supply, employers are reluctant to lose staff whose deficiencies could be cured short of the traditional fire and report remedy.

Challenges: If the early remediation program is truly predisciplinary (precomplaint), as opposed to being an alternative to discipline, there are no savings for the BON to realize in terms of diverting disciplinary cases to these alternative resolutions, thus avoiding normal costs associated with full investigation and litigation. Early intervention in the case of growing clinical deficiencies that have yet to violate nursing law is clearly a more enlightened approach in terms of patient safety. On one level, it seems logical for a BON to be proactive and exercise its regulatory authority prior to the nurse's practice putting a patient at risk. However, one reason this pure model may not have caught on is because it entails an extraordinary shift in resources. The BON and employer must expend much more energy towards early intervention in the hopes they will realize disciplinary savings down the road. A transition to such a new early intervention approach must be attempted while the BON still faces its current disciplinary workload, which is usually in the context of limited resources where staff are being asked to do more with less.

Another challenge is that whenever a regulatory entity attempts to resolve their cases prior to and without initiating formal discipline, there is an automatic public perception issue. The immediate reaction by stakeholders, public, media and legislators is that the BON is protecting their own and sweeping the problems under the carpet by informal resolution.

Heightened Confidentiality

All such alternative programs provide some greater degree of confidentially as to the resolution than would be the case under traditional discipline where resolutions are published and reported. In a few cases, and through new legislation or rule making, a BON has carved out an express exception to normal public disclosure expectations for any successful participation in the alternative program, similar to the substance abuse monitoring program. However, in the majority of states, the statutory expectation is that any and all business that is conducted by its government is publicly available. As a result, there is a legal limit to the confidentiality aspect of these programs in that any such alternative resolutions, while not proactively disseminated as with any traditional disciplinary action, must still be made publicly disclosable. Still, the matter can be quietly closed as otherwise resolved and only specific requests for disclosure would result in release.

Benefits: The less public nature of these alternative programs is a significant enticement for nurses to participate in such alternative programs. No matter what a state's practice act cites as its underlying philosophy, health care discipline is often viewed by the respondent as punishment meted out in the public square. If a resolution can be achieved that meets all the requirements of public protection, but does not involve a broad dissemination of the results to include national databank reporting, the practitioner will likely be much more willing to engage in a more collaborative process to address the deficiencies in their practice with a tailored action plan. Indeed, the nurse may be willing to agree to a more onerous probationary scheme than would be the case with a very public disciplinary document.

Challenges: Even though in every case a record is kept as to how the disciplinary matter was resolved, the BON will have to confront the perception by stakeholders that they are sweeping discipline under the carpet or conducting their business behind a curtain of confidentiality. The public's right to know, to include being affirmatively notified of what was done regarding risky conduct, will be a significant political challenge to a BON.

Limited to Select Class of Practitioners with Deficiencies

One way to fight this perception challenge is to expressly limit any such alternative program to only those cases where the alleged conduct is not so risky as to warrant traditional discipline. If the conduct at issue is such that continued practice poses an unacceptable risk of patient harm, then pursuing suspension or restriction of the license and disclosing it as public information remains the appropriate option.

Regardless of how risky the conduct, participants must have the right attitude and acknowledge that they need help and be willing to work collaboratively. Nurses whose substandard care was intentional, involved reckless disregard or who simply want to clear their name are not eligible for this program. It is also common for the participant to be asked to stipulate to the underlying facts and that the facts amount to a violation of the practice act. The benefit here to the BON is that its case does not grow stale from an evidentiary standpoint as the parties seek a predisciplinary resolution.

Cases involving serious patient injury or death may have to be expressly excluded from such alternative programs in light of political realities. This is true, despite notions of Just Culture and the proposition that outcomes should not dictate the disciplinary treatment warranted.

Benefits: By limiting the pool of practitioners who may participate in such programs, the BON confirms its interest in exercising its regulatory priorities responsibly. The BON is not abandoning it fundamental obligation to intervene forcefully in any case where patient care is truly at risk, but instead, is wisely exercising its discretion so as to expend resources in the smartest way possible and stave off future serious misconduct.

Challenge: Assessment of each case with firm criteria is key, though no such assessment is free from miscalculation. It is a challenge in itself to assess the risk level in a case where a nurse's clinical deficiencies have come to light in the workplace and determine whether that nurse is a safe and appropriate candidate for a more informal and nondisciplinary regulatory approach. The BON must acknowledge the subjective scale they will employ in any such process of deferring certain cases away from traditional discipline models. If the BON is too liberal in its application of the criteria it risks failing to remove a real public threat. If the BON is too restrictive, the benefits of the alternative approach cannot be realized in numbers great enough to make a difference, either in cost or effectiveness.

Involves a Remediation Action Plan

The heart of any such alternative program is an agreed plan to address the clinical deficiencies that appear to be the cause for the alleged substandard care. The plan is developed in collaboration by the BON, the nurse in question and, in most instances, the employer. The plan should be focused, tailored and specific. The plan will usually include both an educational component, as well as some sort of subsequent monitoring aspect, ideally in the workplace, to confirm that the remedial education achieved its desired effect on the nurse's practice.

Benefits: A plan for remediation of a perceived deficiency in a nurse's practice is almost always the end result in disciplinary cases involving low to moderate risk practice deficiencies. In the traditional disciplinary model, the agreed set of probationary conditions, potentially watered down by the negotiating process, may not be the ideal method for improving practice. Moreover, there is the timeliness of the resolution. What results from months or years of investigation, litigation and no involvement of the current employer with monitoring from a distance by BON staff, may not be the best instrument to affect change in practice. Removing the design process for the remediation plan from the contentious public/punitive environment and placing it in a predisciplinary collaborative context makes for much more timely and effective regulation.

Challenges: No amount of tailored remediation can be viewed as effective if there is no subsequent plan for reliable monitoring, preferably in the real world conditions of the workplace. Thus, the employer plays a critical role in underpinning the credibility of any such program to truly ensure public protection. Unfortunately, there often is no assurance the nurse's employer is available and willing to participate in such a program. Oftentimes, the nurse is no longer working for the same

employer where the practice deficiencies were identified. And as mentioned previously, there must first and foremost be a climate of trust to ensure a closer working relationship between the BON and those that employ its licensees.

Other Considerations and Unresolved Issues

Express authorization in statute or rule: While express authorization is ideal, is a statutory amendment necessary or can such a program be launched on a limited pilot basis in keeping with notions of prosecutorial discretion? That is, if a BON can close low risk substandard care cases that amount to practice act violations as below threshold, why can the BON not seek to resolve such cases first on a predisciplinary basis?

In those states that have Letters of Concern, then these tools already address and resolve the low-level substandard practice issues that make up the bulk of cases that the above alternative approach would remedy. But will a Letter of Concern truly resolve a case of potential growing patient risk when they involve no remediation expectations?

Cost related issues: Most would agree that all costs associated with the remediation plan, especially the educational component, should be born by the nurse. But even if the nurse in question can afford this, are there effective hands on remedial education resources available at a reasonable cost in your state? The nursing shortage is most pronounced in the academic arena and there are not enough teachers to train the nursing students, much less those graduates who need remediation. Or is the employer expected to provide these opportunities at the workplace?

Conclusion and Possible Next Steps

While the Disciplinary Resources Committee notes the low number of states that have successfully launched alternatives to discipline in substandard care, we feel there remains reason for optimism on this front. Current budget challenges of historical severity grip all state governments and the nursing shortage is forecast to worsen in light of demographic trends. Within this crisis, there is unique opportunity. Budget woes and shortages serve to undercut the trends of resistance to fundamental changes in a regulatory model that can be made more efficient and effective. Doing more with less is no longer merely an ideal, but an imperative.

However, Member Boards need practical tools for exploring such alternative models, whether they are considering them for the first time or revisiting these alternative schemes. Moreover, they need the best practices model for launching their exploration with greater long term success.

In an effort to take this charge by the Board of Directors to the next logical phase, this committee recommends the following possible next steps in terms of strategies to support implementation of any such initiative:

- Develop and/or gather best practices model policies/procedures to include related criteria, templates (e.g., action plans, etc.), draft statutory or rule language.
- Design a recommended implementation strategy. For example, a small scale pilot could be developed for low-level cases that might have been closed below threshold or with a warning letter in order to work out the bugs before expanding to moderate risk cases where the cost savings can be greater.
- Continue to monitor and gather data from laboratory states, especially those states just beginning to embark on such an endeavor.
- Explore how principles of Just Culture can be integrated into launching nondisciplinary alternatives in practice related cases.

Report of the Finance Committee

Background

The Finance Committee advises the Board of Directors (BOD) on the overall direction and control of the finances of the organization monitoring income, expenditures and program activities against projections. They present quarterly financial statements, and review and recommend a budget to the BOD.

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. They recommend to the BOD the appointment of a firm to serve as independent auditors.

The Finance Committee makes recommendations to the BOD with respect to investment policy and assures that the organization maintains adequate insurance coverage.

Highlights of FY09 Activities

- Reviewed and discussed with management and the organization's independent accountant, Legacy Professionals LLP, the organization's audited financial statements as of and for the fiscal year ended Sept. 30, 2008. With and without management present, the Finance Committee discussed and reviewed the results of the independent accountant's examination of the internal controls and financial statements. Based on the review and discussions referred to above, the Finance Committee recommended to the BOD that the financial statements and the Report of the Auditors be accepted and provided to the membership (Attachment B).
- Reviewed and discussed the performance and the independence of Legacy Professionals LLP. Based on the review and the discussion, the Finance Committee recommended the engagement of Legacy to audit the financial statements for the fiscal years ending Sept. 30, 2009, 2010, and 2011.
- Reviewed and discussed the long range forecast and proposed NCSBN budget for FY09. Recommended to the BOD approval of the FY09 budget.
- Reviewed and discussed the financial statements and supporting schedules quarterly and made recommendations that the reports be accepted by the BOD.
- Reviewed and discussed the performance of NCSBN investments with NCSBN staff and the organization's investment consultant, Becker Burke, on a quarterly basis.
- Conducted a search and recommended a new firm, JP Morgan Asset Management, to manage NCSBN bond investments.
- Informed the BOD that the current investment policy and strategy appear to be appropriate for NCSBN.
- Reviewed and discussed with the insurance brokers from USI Midwest the property and professional liability coverage for NCSBN. Informed the BOD that the organization is appropriately insured.
- Recommended revisions to financial policies.

Future Activities

- Review the budget proposal for the fiscal year beginning Oct. 1, 2009.

Attachments

A. Financial Summary Report for the Period Oct. 1, 2008 to March 31, 2009

B. Report of the Independent Auditors FY08

Members

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

Diane M. Sanders, MN, RN, BC, CNA
Washington, Area I

Gayle Bellamy, BA
North Carolina, Area III

Mark Majek, MA, PHR
Texas, Area III

Myra A. Broadway, JD, MS, RN
Maine, Area IV

Stan Yankellow, BS
Maryland, Area IV

Rula Harb, MS, RN
Massachusetts, Area IV

Staff
Robert Clayborne, MBA, CPA
Director, Finance

Meeting Dates

- Dec. 2, 2008
- Feb. 2, 2009
- April 27, 2009
- July 14, 2009

Relationship to Strategic Plan

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

Strategic Objective 3
Assure integrity of fiscal management and responsiveness.

Attachment A

Financial Summary Report for the Period Oct. 1, 2008 to March 31, 2009

At March 31, 2009, the net cash position, cash and marketable securities less current liabilities, equaled $103 million. NCSBN has no significant long term liabilities except the lease for office space. Net assets decreased by $1.8 million during the first six months of the fiscal year.

Revenue

NCLEX® exam revenue for the first six months of FY09 decreased by $727,000 from the prior year for the same period. 118,801 paid registrations were processed for the six month period ended March 31, 2009. This was a 1.4 percent decrease from the FY08 count of 120,471. There were 10,149 registrations at international test sites during the first six months of the fiscal year compared to 12,731 for the same period last year.

There are currently 38 boards of nursing using Nur*sys*® for licensure verification. Fee revenue totaling $1.1 million for Nur*sys* verifications is up by 3.6 percent compared to the same period the prior year.

Learning Extension sales revenue increased by 10 percent for the first six months of FY09 compared to the same period for the prior year. Enrollments declined by two percent for the NCLEX-RN® Review course, which is expected to generate 75 percent of e-learning's sales revenue. Increased enrollments in other courses more than offset the decline in sales of the NCLEX-RN® Review course for the period.

As the economy remains mired in a deep recession, stock and real estate market valuations continued to decline during the second quarter. The Federal Reserve is holding shot-term interest rates at very low levels, keeping the returns on short-term cash down.

The NCSBN total long-term investment portfolio, stocks, bonds and real estate, was down $1.5 million and returned -4.2 percent for the quarter. The long-term portfolio is down $8.3 million and returned -12 percent for the six month period ended March 31, 2009. NCSBN continues to hold a significant cash position. Total stock, bond, real estate and short-term cash investments are down $7.8 million and returned a net -9.5 percent for the six month period.

Expenditures

The FY09 budget includes $2.8 million for software development and $2.2 million for hardware and software purchases. $1.3 million was expended during the first six months of FY09. It is expected that spending will catch up to the budget for these items over the second half of the fiscal year. The $1.25 million budgeted for the purchase of the National Nurse Aide Assessment Program (NNAAP™) and Medication Aide Certification Examination (MACE™) intellectual property rights were expended during the second quarter.

The number of proposals for research grants received from external organizations is lower than expected. Actual grants awarded for FY09 total $934,000; $2.5 million was budgeted for the year.

Actual expenses for staff salaries, travel, and meetings were favorable to budget amounts through the end of March, and are projected to be less than budgeted for the full year.

Other operating expense variances are assumed to be timing differences and are projected to be at or near the budgeted amounts.

Financial Position

Total NCLEX registrations for the first six months of the fiscal year were down 1.4 percent. Registrations at international test centers were down by 20 percent for the same period. As in the past, the third quarter is critical, as we typically earn 39 percent of our annual NCLEX revenue during that period.

The net cash position is projected to equal $103.4 million by the end of FY09.

Six Month Summary

- Total NCLEX registrations are down by 1.4 percent and international test center registrations are down 20 percent.
- $7.8 million dollar loss on investments, -12 percent return on long term investments and -9.5 percent net return on total investments (including short-term cash).
- $934,000 in external research grants were awarded in FY09 compared to a budget of $2.5 million.
- Only 25 percent of Information Technology (IT) capital budget expended to date. Spending is expected to equal budget by the end of the year.
- Total other operating expenses should be favorable to budget for the year.
- One percent growth projected for cash position; $103.4 million expected by fiscal year end.

NCSBN Statement of Revenue and Expense

Revenue	Year to Date Actual at 3/31/09	Annual Budget	Projected Actual	Variance Favorable/ (Unfavorable)	Variance %	Year to Date as a % of Annual Budget
NCLEX revenue	25,277,350	62,156,000	62,840,000	684,000	1%	41%
NCLEX program reports royalty	58,800	94,000	71,000	(23,000)	-24%	63%
NCLEX quick results	222,542	478,000	441,000	(37,000)	-8%	47%
NNAAP royalty income	82,757	57,500	82,757	25,257	44%	144%
Learning Extension	897,869	2,042,600	2,004,000	(38,600)	-2%	44%
Nursys license verification fees	1,098,846	2,156,000	2,220,000	64,000	3%	51%
Nursys data query fees	7,005		7,005	7,005		
Meeting revenue	5,900	146,500	109,000	(37,500)	-26%	4%
Membership fees	181,500	181,500	181,500	0	0%	100%
NCLA Fees	43,000	43,000	43,000	0	0%	100%
Government grants and other income	180,769	324,800	325,000	200		56%
Total Revenue	**28,056,338**	**67,679,900**	**68,324,262**	**644,362**	**1%**	**41%**

Expense	Year to Date Actual at 3/31/08	Annual Budget	Projected Actual	Variance Favorable/ (Unfavorable)	Variance %	Year to Date as a % of Annual Budget
Salaries	2,896,455	6,659,300	6,259,000	400,300	6%	43%
Fringe benefits	776,232	1,823,300	1,714,000	109,300	6%	43%
NCLEX processing costs	12,352,150	31,764,700	32,125,000	(360,300)	-1%	39%
Other professional service fees	1,700,355	5,324,800	5,325,000	(200)	0%	32%
Supplies and materials	34,943	110,300	110,000	300	0%	32%
Meetings and travel	1,290,604	3,456,200	3,158,000	298,200	9%	37%
Telephone and communications	157,942	472,900	473,000	(100)	0%	33%
Postage and shipping	50,563	176,600	177,000	(400)	0%	29%
Occupancy	442,829	913,600	914,000	(400)	0%	48%
Printing, copying and publications	119,766	699,900	700,000	(100)	0%	17%
Library/Memberships	63,781	105,700	106,000	(300)	0%	60%
Insurance	58,929	58,400	58,000	400	1%	101%
Equipment rental and maintenance	803,402	1,188,500	1,188,000	500	0%	68%
Depreciation and amortization	1,153,021	3,925,600	3,926,000	(400)	0%	29%
External research grants	74,878	2,500,000	934,000	1,566,000	63%	3%
JRC and other expenses	61,116	708,600	709,000	(400)	0%	9%
Total Expense	**22,036,966**	**59,888,400**	**57,876,000**	**2,012,400**	**3%**	**37%**
Surplus/(deficit)	6,019,372	7,791,500	10,448,262	2,656,762		
Investment Income	(7,798,268)	3,900,000	(7,798,000)	(11,698,000)	-300%	-200%
Capital	2,558,913	6,243,100	6,243,100	0		

This statement has not been audited. Projected amounts are estimates.

Attachment B

Report of the Independent Auditors FY08

LEGACY
PROFESSIONALS LLP
CERTIFIED PUBLIC ACCOUNTANTS

REPORT OF INDEPENDENT AUDITORS

To the Board of Directors of
National Council of State
Boards of Nursing, Inc.

We have audited the accompanying statements of financial position of National Council of State Boards of Nursing, Inc. (NCSBN) as of September 30, 2008 and 2007, and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the NCSBN's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform an audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of National Council of State Boards of Nursing, Inc. as of September 30, 2008 and 2007, 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

January 7, 2009

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

STATEMENTS OF FINANCIAL POSITION

SEPTEMBER 30, 2008 AND 2007

	2008	2007
ASSETS		
Cash	$ 48,621,831	$ 43,396,299
Accounts receivable	190,115	281,767
Due from test vendor	5,840,113	5,815,288
Accrued investment income	507,712	669,196
Prepaid expenses	1,317,641	1,224,221
Investments	66,896,909	59,523,245
Property and equipment - net	4,130,203	3,623,047
Cash held for others	291,443	223,704
Total assets	$ 127,795,967	$ 114,756,767
LIABILITIES AND NET ASSETS		
LIABILITIES		
Accounts payable	$ 1,294,055	$ 737,882
Accrued payroll, payroll taxes and compensated absences	548,109	402,719
Due to test vendor	9,941,741	10,256,375
Deferred revenue	338,410	242,304
Grants payable	1,321,647	1,642,366
Deferred rent credits	323,661	398,359
Cash held for others	291,443	223,704
Total liabilities	14,059,066	13,903,709
UNRESTRICTED NET ASSETS	113,736,901	100,853,058
Total liabilities and net assets	$ 127,795,967	$ 114,756,767

See accompanying notes to financial statements.

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

STATEMENTS OF ACTIVITIES

YEARS ENDED SEPTEMBER 30, 2008 AND 2007

	2008	2007
REVENUE		
Examination fees	$ 63,156,300	$ 61,113,670
Other program services income	5,698,590	5,335,731
Net realized and unrealized gain (loss) on investments	(7,471,337)	1,371,162
Net realized (loss) on disposal of property and equipment	-	(9,686)
Interest and dividend income	4,466,763	4,820,748
Membership fees	177,000	177,000
Total revenue	66,027,316	72,808,625
EXPENSES		
Program services		
Nurse competence	37,288,471	34,820,112
Nurse practice and regulatory outcome	6,456,365	6,632,842
Information	6,615,912	5,407,653
Total program services	50,360,748	46,860,607
Supporting services		
Management and general	2,782,725	2,342,066
Total expenses	53,143,473	49,202,673
NET INCREASE	12,883,843	23,605,952
UNRESTRICTED NET ASSETS		
Beginning of year	100,853,058	77,247,106
End of year	$ 113,736,901	$ 100,853,058

See accompanying notes to financial statements.

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

STATEMENTS OF CASH FLOWS

YEARS ENDED SEPTEMBER 30, 2008 AND 2007

	2008	2007
CASH FLOWS FROM OPERATING ACTIVITIES		
Net increase	$ 12,883,843	$ 23,605,952
Adjustments to reconcile net increase to net cash provided by (used in) operating activities		
Depreciation and amortization	2,158,840	1,795,733
Net realized and unrealized (gain) loss on investments	7,471,337	(1,371,162)
Net realized loss on disposal of property and equipment	-	9,686
(Increase) decrease in assets		
Accounts receivable	91,652	(10,657)
Due from test vendor	(24,825)	(920,272)
Accrued investment income	161,484	(150,225)
Prepaid expenses	(93,420)	(267,360)
Increase (decrease) in liabilities		
Accounts payable	556,173	278,351
Accrued payroll, payroll taxes and compensated absences	145,390	98,765
Due to test vendor	(314,634)	1,814,617
Deferred revenue	96,106	(105,163)
Grants payable	(320,719)	1,642,366
Deferred rent credits	(74,698)	(74,699)
Net cash provided by operating activities	22,736,529	26,345,932
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of property and equipment	(2,665,996)	(2,161,270)
Purchases of investments	(28,323,891)	(30,847,870)
Proceeds on sale of investments	13,478,890	22,263,405
Proceeds on sale of property and equipment	-	10,649
Net cash (used in) investing activities	(17,510,997)	(10,735,086)
NET INCREASE	5,225,532	15,610,846
CASH		
Beginning of year	43,396,299	27,785,453
End of year	$ 48,621,831	$ 43,396,299

See accompanying notes to financial statements.

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 2008 AND 2007

NOTE 1. DESCRIPTION OF THE ORGANIZATION

The National Council of State Boards of Nursing, Inc. (NCSBN) is a not-for-profit corporation organized under the statutes of the Commonwealth of Pennsylvania. The primary purpose of NCSBN is to serve as a charitable and educational organization through which state boards of nursing act on matters of common interest and concern to promote safe and effective nursing practice in the interest of protecting public health and welfare including the development of licensing examinations in nursing.

The program services of NCSBN are defined as follows:

Nurse Competence - Assist Member Boards in their role in the evaluation of initial and ongoing nurse competence.

Nurse Practice and Regulatory Outcome - Assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role. Analyze the changing health care environment to develop state and national strategies to impact public policy and regulation affecting public protection.

Information - Develop information technology solutions valued and utilized by Member Boards to enhance regulatory efficiency.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting - The accompanying financial statements have been prepared on the accrual basis of accounting.

Basis of Presentation - Financial statement presentation follows the recommendations of the Financial Accounting Standards Board in its Statement of Financial Accounting Standards (SFAS) No. 117, *Financial Statements of Not-for-Profit Organizations*. Under SFAS No. 117, NCSBN is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets and permanently restricted net assets. Net assets are generally reported as unrestricted unless assets are received from donors with explicit stipulations that limit the use of the asset. NCSBN does not have any temporarily or permanently restricted net assets.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Accounts Receivable - Represents amounts owed to NCSBN for services dealing with board membership fees, meeting fees and royalties. Accounts receivable at September 30, 2008 and 2007 were $190,115 and $281,767 respectively. An allowance for doubtful accounts was not considered necessary.

Investments - Investments are carried at fair value which generally represents quoted market price as of the last business day of the year. Money market funds and certificates of deposit are carried at cost and maintained within an individual investment portfolio.

The investment in the Clarion Lion Real Estate Properties is carried at estimated fair value as estimated by the investment manager.

Due from Test Vendor - Due from test vendor represents amounts owed by Pearson VUE for candidate applications received as well as rebates calculated on vendor performance and volume per contract. The amounts owed by Pearson VUE at September 30, 2008 and 2007 were $5,840,113 and $5,815,288 respectively.

Pearson VUE performs substantially all testing services for NCSBN.

Property and Equipment - Property and equipment are carried at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation is computed using the straight-line method over the following estimated useful lives:

Furniture and equipment	5 - 7 years
Course development costs	2 - 5 years
Computer hardware and software	2 - 5 years
Leasehold improvements	life of lease

Due to Test Vendor - Due to test vendor represents unpaid amounts to Pearson VUE for candidate testing, which includes approximately $6,673,000 at September 30, 2008 and $6,966,000 at September 30, 2007 for registered candidates who as of year end had not taken the exam. The amounts owed to Pearson VUE at September 30, 2008 and 2007 were $9,941,741 and $10,256,375 respectively.

Deferred Revenue - Deferred revenue consists of membership fees of $181,500 for 2008 and $177,000 for 2007 and online course revenue of $156,910 for 2008 and $65,304 for 2007.

Grants Payable - Represents Nurse Practice and Regulatory Outcome research grants that are generally available for periods of one to two years. NCSBN awarded eight grants ranging in amounts from $20,000 to $294,000 during the current year. For the year September 30, 2008, the amount remaining to be paid on grants awarded for 2008 and 2007 is $964,670 and $356,977, respectively.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Deferred Rent Credits - Deferred rent credits were established in conjunction with taking possession of new leased office space in 2003. The landlord abated a portion of the monthly rent and made cash disbursements to NCSBN in connection with the lease. These amounts are amortized to reduce rent expense over the term of the lease.

Statement of Cash Flows - For purposes of the statement of cash flows, NCSBN considers all marketable securities as investments. Cash includes only monies held on deposit at banking institutions, petty cash and certificates of deposit with an initial maturity date of less than three months when purchased. It does not include cash held for others.

Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

NOTE 3. TAX STATUS

NCSBN is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (Code) and is exempt from federal income taxes on income related to its exempt purpose pursuant to Section 501(a) of the Code and has been classified as an organization which is not a private foundation under Section 509(a).

NOTE 4. CASH CONCENTRATIONS

The cash balance as of September 30, 2008 and 2007 consisted of the following:

	2008	2007
JP Morgan Chase		
Checking account	$ 782,906	$ 4,807,491
Money market account	15,153,219	-
Certificates of deposit	32,086,910	38,328,527
Wells Fargo Bank:		
Checking account	562,158	231,140
Credit card merchant accounts	36,388	28,891
Petty cash	250	250
Total	$ 48,621,831	$ 43,396,299

NCSBN places its cash with financial institutions deemed to be creditworthy. Cash balances may at times exceed the insured deposit limits. Effective October 3, 2008, balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000.

NOTE 5. INVESTMENTS

The composition of investments at September 30, 2008 and 2007 is as follows:

	2008	2007
U.S. Government and Government Agency obligations	$ 13,426,931	$ 13,930,820
Corporate bonds	22,639,119	21,732,084
Mutual funds:		
DWS Equity 500 Index Fund	16,125,471	9,564,629
Spartan Extended Market Index Fund	4,901,473	2,404,945
Spartan International Inded Fund	4,533,646	2,709,987
Others	30,832	15,243
Clarion Lion Real Estate Properties	5,224,499	-
Money market fund	14,938	5,165,537
Certificates of deposit - JP Morgan Chase	-	4,000,000
Total	$ 66,896,909	$ 59,523,245

NCSBN assets can be invested in various securities, including United States government securities, corporate debt instruments, corporate stocks, and unit investment trust securities. Investment securities, in general, are exposed to various risks, such as interest rate risk, credit risk, and overall market volatility. NCSBN invests in securities with contractual cash flows, such as asset backed securities, collateralized mortgage obligations and commercial mortgage backed securities. The value, liquidity and related income of these securities are sensitive to changes in economic conditions, including real estate value, delinquencies or defaults, or both and may be adversely affected by shifts in the market's perception of the issuers and changes in interest rates. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the financial statements.

NOTE 6. PROPERTY AND EQUIPMENT

The composition of property and equipment at September 30, 2008 and 2007 is as follows:

	2008	2007
Property and equipment		
Furniture and equipment	$ 1,356,482	$ 1,324,457
Course development costs	271,729	271,729
Computer hardware and software	13,418,864	10,942,921
Leasehold improvements	440,183	369,614
	15,487,258	12,908,721
Less accumulated depreciation and amortization	(11,357,055)	(9,285,674)
Net property and equipment	$ 4,130,203	$ 3,623,047

Depreciation was $2,158,840 and $1,795,733 for the years ended September 30, 2008 and 2007, respectively.

NOTE 7. OPERATING LEASE

NCSBN has a lease agreement for office space which expires January 31, 2013. The following is a summary by year of future minimum lease payments required under the office lease as of September 30, 2008:

Year ending September 30,	
2009	$ 506,950
2010	522,343
2011	538,011
2012	554,276
2013	186,668
Total	$ 2,308,248

Rent expense for the years ended September 30, 2008 and 2007 was $841,932 and $837,356 respectively.

NOTE 8. RETIREMENT PLANS

NCSBN maintains a 403(b) defined contribution pension plan covering all employees who complete six months of employment. Contributions are made at 8% of participants' compensation. NCSBN's policy is to fund accrued pension contributions. In the year ended September 30, 2007, NCSBN instituted a 457(b) non-qualified deferred compensation plan. Eligibility is limited as it is considered a top hat plan. Retirement plans expense was $433,749 and $423,853 for the years ended September 30, 2008 and 2007, respectively.

NOTE 9. COMMITMENTS

NCSBN has entered into an agreement to purchase the intellectual property rights for the nurse aid certification examination (NNAAP) and the medication aid certification examination (MACE). In exchange for the purchase, NCSBN will pay $1,250,000 upon transfer of the NNAAP and MACE intellectual property. The exchange is expected to be completed within six months after year end.

NCSBN has entered into contracts for services and accommodations for future meetings. These contracts include penalty clauses which would require NCSBN to pay certain amounts if a meeting were to be canceled or guarantees for room blocks are not fulfilled. At September 30, 2008, the requirements to fulfill these commitments approximated $428,000.

NCSBN has also entered into various contracts for futures services. At September 30, 2008, the requirements to fulfill these commitments approximate $183,000 and are expected to be completed within one year.

During the year ended September 30, 2008, NCSBN entered into a subscription agreement to invest in an international equity fund. On October 1, 2008 NCSBN transferred cash in the amount of $2,000,000 to fund the investment.

Report of the Institute of Regulatory Excellence Committee

Background

As part of NCSBN's mission to promote regulatory excellence, a four-year fellowship program called the Institute of Regulatory Excellence (IRE) was developed for nursing regulators. The 2008-2009 year marked its sixth anniversary. Since its inception, every effort has been made to promote the growth and leadership of those participating in the program. In addition to the Annual IRE Conference, participants enhance their knowledge and skills in research design, evidenced-based regulation and/or project management. This is achieved through the development of a project related to a regulatory problem or need in their individual state.

The IRE was restructured in 2007. The committee evaluates the program, as well as the progress of the participants, on an ongoing basis. A total of 15 individuals currently participate in the program. These individuals belong to the following cohorts:

Year 4 (2006 cohort): four participants

Year 3 (2007 cohort): one participant

Year 2 (2008 cohort): five participants

Year 1 (2009 cohort): seven participants

The following is a report on the committee's 2009 charges:

- **Select 2009 IRE Fellowship participants and mentors, approve fellowship project proposals and final reports**
  - Seven individuals applied to the program for the 2009 cohort. The committee reviewed all applications for admission into the program and determined that all applicants met the qualifications for an IRE Fellowship. Assistance in choosing a mentor has been provided; the committee approved the mentors during their April meeting.
  - Final project reports for the 2006 cohort are due June 1, 2009. Committee members will review the reports and determine eligibility for fellowship induction. Proposals from the 2008 cohort have been reviewed and feedback has been provided.
- **Advise staff on issues related to the implementation of the IRE Fellowship Program**
  - Evaluation of the fellowship program occurs on an ongoing basis and the committee is constantly striving to make improvements. Exemplars from 2009 include:
    - The committee added performance measures to the IRE program. All fellowship candidates will be required to complete a self-evaluation related to these measurements. Feedback will also be given to each candidate from the mentor, as well as the committee. Feedback from this process will also be used to improve the program in subsequent years.
    - A more formalized learning plan was developed and implemented with participants given feedback about their objectives and related activities.
    - The committee has reevaluated the mentorship process. Some mentors have been unable to assist the participants with their projects because it was outside their area of expertise. NCSBN Nursing Regulation staff has taken on the role of project consultants and assists participants with the development and analysis of their projects. IRE Fellows will be asked to volunteer as mentors.

Members

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Ann M. Jones, PhD, RN
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Mary E. Bowen, JD, DSN, CRNP, CNAA
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Staff

Maryann Alexander, PhD, RN
Chief Officer, Nursing Regulation

Meeting Dates

- Sept. 25-26, 2008
- Dec. 11-12, 2008
- April 21, 2009

Relationship to Strategic Plan

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

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

- The IRE Committee requested from the Board of Directors (BOD) that an individual in their last year of the program be allowed to finish the program with approval from their executive officer and the committee. The BOD granted approval.
- Biannual cohort conference calls have been instituted to allow participants to share ideas, support one another and network.

- **Advise staff regarding the content of the Annual IRE Conference and the Annual Induction Ceremony**
  - The theme of the 2009 conference was discipline. This year's program had several modifications from former conferences:
    - An IRE orientation day was added to the program. This included presentations about the IRE program, conducting a literature review, developing a project and writing a proposal. An IRE tool kit was distributed to every participant containing valuable references and resources for project development and writing a proposal. Based on evidence and feedback from various sources, the committee determined that every participant attending the conference should attend these presentations. This ensures that everyone understands the program's expectations and is on the same page.
    - An emphasis was placed on challenging the participants to think, ask questions, and share ideas and perspectives. For the first time, one day of the meeting was centered on a case study. Each presentation addressed one aspect of a complex practice case. A final analysis at the end of the day involved all speakers and participants in a rich and thought-provoking discussion.
  - The conference was very well received by the participants. All participants gave high ratings to the speakers and felt the conference met the objectives. Many participants verbally commented that the case study and its presentations were not only a great learning experience for them, they also enjoyed the opportunity to participate and share their ideas and perspectives.
  - The induction ceremony was addressed by the BOD and they have requested that the Awards Committee address this issue.
  - Because of the need to arrange speakers in advance, the committee has already begun discussions on the 2010 conference.

Overall, the IRE continues to improve on an annual basis and provide a unique learning experience for those who participate. Membership in 2009 rose for the first time in four years. The only aspect of the IRE that NCSBN members voice concern over is the fact that the four-year program limits those who can participate. Some members are reluctant, due to time constraints, to make a four-year commitment. Board members who have less than a four-year term left are also unable to become involved.

There is no other program/conference that is so aptly geared towards meeting the learning needs of nursing regulators. The committee will continue to evaluate the program and progress of participants to make this a worthwhile and enriching experience for all who participate.

Highlights of FY09 Activities

- The addition of seven new IRE participants in the 2009 IRE cohort.
- The 2009 Annual IRE Conference on Discipline was one of the year's highlights, including the addition of an IRE Orientation and Research Day, and devoting one day to a complex case study.
- Addition of performance measures and a more structured learning plan to provide direction for IRE participants.
- Participation by NCSBN senior staff in the IRE program as research/project consultants.

Future Activities

- Select 2009 IRE Fellowship participants and mentors, and approve fellowship project proposals and final reports.
- Advise staff on issues related to the implementation of the IRE Fellowship Program.
- Advise staff regarding the content of the Annual IRE Conference and the Annual Induction Ceremony.
- Strategize methods for maintaining involvement of IRE Fellows in the IRE program.

Attachments

None

Report of the National Nurse Aide Assessment Program (NNAAP™) and the Medication Aide Certification Examination (MACE™)

Background

In August 2008, NCSBN acquired exclusive ownership of the intellectual property for the National Nurse Aide Assessment Program (NNAAP™) and the Medication Aide Certification Examination (MACE™) program. NNAAP is a two-part examination consisting of a written (oral) examination and a skills evaluation. NNAAP has been administered to more than 2.5 million candidates and is the leading nurse aide assessment instrument in the U.S. MACE is a new national examination that NCSBN is developing for state regulatory agencies. MACE will help to evaluate the competence of unlicensed individuals allowed to administer medications to clients in nonacute settings, such as assisted living facilities and elder care settings.

With the new acquisition of programs that certify unlicensed, direct care workers, NCSBN gains exclusive control over the establishment of the NNAAP and MACE test plans, and ownership of exam content. Pearson VUE, the contracted test service, will be responsible for all delivery, administration, publishing (electronic and paper), sales and market development activities associated with the exams, in addition to the following testing services: eligibility screening and registration; test site scheduling; test administration (test site and Registered Nurse Evaluator management); scoring; and reporting. The registry services provided by Pearson VUE include initial certification, recertification and reciprocity management, as well as public access registry verifications through the Internet.

The NNAAP examination is consistent with the training requirements for nurse aides delineated in the Omnibus Budget Reconciliation Act (OBRA) of 1987. This act states that anyone working as a nursing assistant/nurse aide must complete a competency evaluation program. The competency evaluation program must be state approved and consist of a minimum of 75 hours of training and include 16 hours of supervised clinical training.

The Model Nursing Practice Act and Model Nursing Administrative Rules, developed by NCSBN and its Member Boards, along with the Medication Assistant-Certified (MA-C) Model Curriculum, are two resources used to develop content for the MACE program. Subject matter experts (SMEs) are selected to participate in item writing and review workshops for MACE using criteria delineated in the above stated resources. The national MACE program is designed to assess entry level competence of unlicensed workers who have been approved by their state to administer medications in nonacute health care settings.

With the newly acquired NNAAP and MACE programs, NCSBN can continue to serve as the premier organization that advances regulatory excellence for public protection. Moving forward, NCSBN will play a pivotal role in the content development for the NNAAP and MACE programs. Pearson VUE will continue to administer the certifying exams to our client states. States participating in these examination programs, through NCSBN, will continue to provide support to licensed health care professionals who need more qualified staff at the bedside to assist in the delivery of safe, competent care.

Highlights of FY09 Activities

- Thirty-four new skills forms went into operational use July 1, 2008, across 24 states.
- In August 2008 NCSBN acquired exclusive ownership of the intellectual property for NNAAP and MACE.
- In October 2008 NCSBN established the NNAAP™ & MACE™ Examinations Department.
- In January 2009 a coordinator and statistician were hired for the department.

Staff
Michelle Riley, DNP, RN
Director, NNAAP™ & MACE™ Examinations Department

Marijana Dragan, MS
Statistician, NNAAP™ & MACE™ Examinations Department

Melissa Franke
Coordinator, NNAAP™ & MACE™ Examinations Department

Meeting Dates

- June - August 2008 (item review and development meetings)
- Feb. 17, 2009 (NNAAP™ Webinar)
- April 14-17, 2009 (NNAAP™ Item Writing and Review Workshop)
- May 12-14, 2009 (MACE™ Item Writing and Review Workshop [National Bank])
- May 19-21, 2009 (MACE™ Item Writing and Review Workshop [North Carolina Bank])
- July 21-22, 2009 (Nurse Aide Job Analysis Meeting)
- July 23, 2009 MACE™ Standard Setting Panel

Relationship to Strategic Plan

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

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

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

Strategic Objective 2
NNAAP and MACE development, security, psychometrics, administration and quality assurance processes are consistent with Member Boards examination needs.

- In January 2009 six new NNAAP written forms went into operational use.
- The 2010 NNAAP™ Examination Test Plan and content outline will be published on the NCSBN Web site.

Program Highlights and Test Development Activities

REVIEW OF NNAAP SKILLS EXAMINATION

A Skills Review and Revision meeting was conducted by Pearson VUE for the NNAAP™ Skills Evaluation in April 2007. Due to concerns regarding the increased incidence of community-based methicillin-resistant staphylococcus aureus (MRSA), one important goal of the meeting was to review infection control standards to determine if any additional practice standards needed to be incorporated into the skills evaluation. A highlight during this review was the discussion of the use of gloves and when they are necessary. After the review and revision session with an infection control consultant, the group of SMEs reviewed the remaining skills and considered several new skills for incorporation into the skills evaluation. The final activity of the SMEs was to discuss and identify expectations of behaviors of newly certified, minimally competent, entry level nurse aides.

The SME group reviewed, revised and approved 23 existing skills and decided to delete the skill, *Measures and Records Oral Temperature Using a Non-Mercury Glass Thermometer.* The committee also developed one new skill, *Donning and Removing PPE (Gown and Gloves)*, and this skill was approved for inclusion in the NNAAP skills evaulation.

SKILLS STANDARD SETTING MEETING

Pearson VUE and the NNAAP™ Skills Exam Standard Setting Committee met for two days in November 2007 to conduct a standard setting meeting to set passing standards for all approved skills on the NNAAP™ Skills Evaluation. The lead test developer for Nurse Aide Services and two PhD psychometricians from Pearson VUE facilitated the meetings. The review committee consisted of registered nurses (RNs) from across the country involved in the education, evaluation and supervision of entry level nurse aides.

The meeting began with an overview of the skills examination, a review of the OBRA requirements for the exam and a discussion of the purpose of standard setting. Then characteristics of the minimally competent, entry level, certified nurse aide were identified through an extensive discussion among the committee. Included in the discussion were contrasting characteristics that may be observed in the incompetent, as well as the highly competent nurse aide. These characteristics were displayed and referenced throughout the standard setting process so that the panel could readily identify the expectations for minimal, entry level certified nurse aide competence.

Once the committee had defined the concept of minimum competency, they were asked to review the steps on Skill 1 and make an initial rating of how many points they felt were necessary to demonstrate minimum competency. The committee was asked to make their ratings independently and were encouraged to discuss the process they used to arrive at a rating. Most SMEs on the committee reported that they reviewed the steps on the skill and identified individual steps that could be missed without jeopardizing a client. Once the SMEs were comfortable with the process, they were asked to read through and independently rate the remaining 22 skills.

The results of the standard setting meeting were used to score the skills on the test forms published on July 1, 2008.

ITEM REVIEW AND DEVELOPMENT

From June through August 2008, six four-hour virtual item review meetings were scheduled utilizing Web conferencing technology. Participating SMEs used computer technology and a telephone conference line to view and engage in test development activities. The purposes of these meetings were to review and approve pretest items, review active items for currency,

validate the items, and review statistically underperforming items for the NNAAP written exam.

The virtual item review meeting was composed of seven SMEs from various regions of the country (Minnesota, Mississippi, Pennsylvania, Rhode Island and Washington). The SME group represented a broad spectrum of expertise in nurse aide education and practice, including teaching in and/or directing nurse aide programs, coordinating programs at the state level and evaluating the NNAAP.

The SMEs began their work with an item review orientation that included the principles of item review, explanations of important statistical characteristics to apply in the review of items, use of the *NNAAP™ Written/Oral Exam Content Outline* in item review and item development, and an overview of the construction and review of items.

During the item review meetings, the SMEs reviewed a total of 296 items; 93 items were approved, 19 items were deleted, 97 items were set to pretest status, and 87 items were identified as problem items and marked for further review. The SMEs also rewrote seven under performing items, which were set to pretest status.

In April 2009 NCSBN held its first NNAAP™ Item Writing and Review Workshop under the new agreement with Pearson VUE. Eleven SMEs attended the workshop and represented all four NCSBN geographic areas. The SMEs were diverse in relation to nursing specialties, experience, clinical practice settings and qualifications. Three of the 11 SMEs attended a prior item writing and review meeting held by Pearson VUE.

NCSBN implemented a similar format as the contracted test service to host the workshop. The format included an overview of NCSBN; principles of item review and item writing; item construction and exercises related to item writing; and peer review of newly written and problem items to validate currency, accuracy, entry level content, and statistical characteristics. A representative from Pearson VUE and a testing consultant were present during the workshop.

During the April 2009 NNAAP™ Item Writing and Review Workshop, 206 items were reviewed; one pretest item, 39 problem items and 166 of the newly written items from the workshop. Of the newly written items, 146 were set to pretest status.

2010 NNAAP™ EXAMINATIONS TEST PLAN AND CONTENT OUTLINE

On Feb. 17, 2009, the NNAAP™ & MACE™ Examinations Department held a Webinar meeting with SMEs from the four NCSBN geographic areas to review the NNAAP test plan and content outline. The SMEs reviewed the *2010 NNAAP™ Written (Oral) Examination Content Outline* and *Report of Findings from the 2005 Job Analysis of Nurse Aides: Employed in Nursing Homes, Home Health Agencies and Hospitals* and adopted the *2010 NNAAP™ Written (Oral) Examination Content Outline*. There were no major changes recommended by the SMEs to the content categories for the 2010 NNAAP content outline.

Future Activities

- Share with the public information about the NNAAP and MACE examination programs.
- Develop new test items and maintain item pools for NNAAP and MACE.
- Perform appropriate item response and statistical analyses of items for NNAAP and MACE.
- Build paper and pencil and computer-based test forms for the written cognitive component of the NNAAP examination.
- Update skills-demonstration test forms and scoring standards for NNAAP.
- Build computer-based forms for MACE.
- Conduct nurse aide and medication aide job analyses.
- Carry out standard setting exercises for the written and skills portions of the NNAAP.

- Create a national bank of items using the MA-C Model Curriculum.
- Conduct standard setting exercises for MACE.
- Enhance the quality of NNAAP and MACE programs.
- Increase the number of states that use NNAAP and MACE programs.

National Nurse Aide Assessment Program (NNAAP™) Summary of NNAAP™ Examination Results for Testing Year 2008 Pass Rates by State

	Written/Oral		Skills	
Year	% Pass	Number	% Pass	Number
Alabama	93	1,557	81	1,716
Alaska	96	592	90	628
California	93	8,107	91	8,248
Colorado	94	5,212	75	6,066
District of Columbia	74	622	63	689
Georgia	89	6,582	81	6,917
Louisiana	84	710	79	748
Maryland	91	3,528	83	3,676
Minnesota	96	7,795	88	8,322
Mississippi	88	2,927	71	3,262
New Hampshire	100	12	92	13
New Jersey	81	5,264	95	5034
North Carolina	95	18,791	73	21,705
North Dakota	97	1,107	92	1,145
Oregon	98	1,032	77	1,231
Pennsylvania	94	9,923	82	10,849
Rhode Island	84	1,605	67	1,890
South Carolina	93	5,104	82	5,433
Texas	89	19,567	N/A	N/A
Virgin Islands	80	133	52	153
Virginia	88	5,476	65	6,486
Washington	93	6,326	77	7,149
Wisconsin	97	9,794	85	10,720
Wyoming	98	972	86	1063
TOTAL	92	122,738	80	113,143

Attachment

A. *2010 NNAAP Written (Oral) Examination Content Outline*

Attachment A

2010 NNAAP™ Written (Oral) Examination Content Outline

**The 2010 National Nurse Aide Assessment Program (NNAAP™)
Written (Oral) Examination Content Outline**

The revised content outline is based on the findings from the *2005 Job Analysis of Nurse Aides* published by the National Council of State Boards of Nursing (NCSBN) in May 2006. The examination content outline will be effective January 2010.

The NNAAP written examination is comprised of 70 multiple-choice questions; 10 of these questions are pretest (non-scored) questions on which statistical information will be collected. The NNAAP oral examination is comprised of 60 multiple-choice questions and 10 reading comprehension (word recognition) questions.

	2010 Content Outline		Prior Content Outline	
Content Domain	**Weighting of Content Domain**	**Number of Questions in Domain**	**Weighting of Content Domain**	**Number of Questions in Domain**
I. Physical Care Skills				
A. Activities of Daily Living 1. Hygiene 2. Dressing and Grooming 3. Nutrition and Hydration 4. Elimination 5. Rest/Sleep/Comfort	13%	8	14%	9
B. Basic Nursing Skills 1. Infection Control 2. Safety/Emergency 3. Therapeutic/Technical Procedures 4. Data Collection and Reporting	40%	24	35%	21
C. Restorative Skills 1. Prevention 2. Self Care/Independence	8%	5	8%	5
II. Psychosocial Care Skills				
A. Emotional and Mental Health Needs	13%	8	10%	6
B. Spiritual and Cultural Needs	2%	1	4%	2
III. Role of the Nurse Aide				
A. Communication	8%	5	7%	4
B. Client Rights	5%	3	7%	4
C. Legal and Ethical Behavior	3%	1	5%	3
D. Member of the Health Care Team	8%	5	10%	6
	100%	60	100%	60

Report of the TERCAP® Committee

Background

The number of Member Boards interested in using the data collection instrument Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®) continues to increase. Currently, 14 Member Boards are participating in TERCAP by submitting data and five Member Boards are initiating the implementation phase of TERCAP. Between August 2008 and March 2009, the number of TERCAP cases submitted has tripled. A few Member Boards are exploring using TERCAP, seeking board of nursing (BON) approval or investigator buy in.

Some Member Boards are not yet able to participate in TERCAP due to lack of resources, time and support within umbrella boards, in which the BON has no oversight over investigators. It is understood by the committee that TERCAP requires a paradigm shift by Member Boards when investigating cases and determining issues beyond those directly attributable to the nurse. There is also a difference in the purpose of TERCAP and what investigators have considered necessary for proving up a case that may go to administrative hearing.

1. Provide Member Board resources for the use of TERCAP.

TERCAP Webinars have been conducted with 10 different Member Boards in attendance. A new data reporting Webinar was created for Member Boards to access their own data.

Member Boards continued to be supported by TERCAP committee members and NCSBN staff. Newly interested and participating Member Boards are updated through bimonthly TERCAP user calls and documented highlights from those calls that were initiated this year. We have begun to have users share actual cases as an exercise to assist in the determination of the primary and secondary practice breakdown categories.

At the Midyear Meeting, information was provided about TERCAP by committee members. An updated TERCAP® Overview subsequently sent to all executive officers has been updated (Attachment A), along with the TERCAP® Research Criteria (Attachment B). Information about TERCAP was also shared at the 2009 Attorney/Investigator Symposium.

Data summaries are provided to participating Member Boards to acknowledge their contributions and as a resource for quality improvement. The frequency that individual Member Boards answered questions as unknown is provided to encourage submission of quality data. As part of the continuous quality improvement process, changes were made to the page breaks in the online data collection instrument that resulted in a significant decrease in the amount of time users spend submitting data online.

2. Advise staff on the content of the 2009 TERCAP® Roundtable.

The TERCAP committee members were initially very involved in advising staff on the content of the TERCAP® Roundtable. In the December 2008 report to the Board of Directors, the research department staff advised, based on a power analysis, that 1,300 cases would be required to carry out the desired statistical analysis. The committee would like to share TERCAP study findings as soon as it is responsible and practical to do so. The committee recommended the TERCAP® Roundtable not be presented during this fiscal year. The basis for this recommendation is the insufficient number of complete data categories to report findings at this time.

3. Determine the implications of the aggregated data analysis.

In November 2008 the research department staff analyzed 137 cases submitted to TERCAP since March 2008. The low number of cases, in addition to a large amount of unknown or missing data, meant that no valid or significant results could be drawn from the data.

Subsequently, the committee discussed the possibility of prioritizing the TERCAP questions and selecting less data for analysis than required by the original 11 research questions. A data set consisting of 32 questions (out of a potential 60 questions) was identified. In February 2009 the research department analyzed these selected data on 243 cases submitted between March 2008

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Associate, Nursing Regulation

Kevin Kenward, PhD
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Qiana Hampton, MBA, MHRM
Administrative Assistant, Regulatory Innovations

Meeting Dates

- Oct. 1-8, 2008
- Nov. 25, 2008 (Conference Call)
- Dec. 16, 2008 (Conference Call)
- Jan. 26-27, 2009
- March 10, 2009 (Conference Call)
- May 12, 2009 (Conference Call)
- July 7-8, 2009

Relationship to Strategic Plan

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

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

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

Strategic Objective 1
Promote commitment to ongoing regulatory excellence.

Strategic Objective 3
Conduct and support research that provides evidence regarding regulatory initiatives that support public protection.

and January 2009. Analysis of the selected questions revealed a significant number of unknown responses and high margins of error for most of the questions, thereby thwarting the ability to make any valid conclusions. The committee decided not to share the data available from the smaller data set and, as always intended, to continue to have all the TERCAP questions completed for future aggregate data analysis.

There were 360 cases submitted from March 2008 through April 2009. The 14 participating Members Boards have submitted anywhere from two to 141 cases. The majority (45 percent) of the cases submitted to date are from one Member Board. The research department will conduct additional analysis from time to time throughout the remainder of FY09 as more cases become available.

Highlights of FY09 Activities

- Provided assistance to the 14 Member Boards submitting cases online and the five Member Boards beginning to implement TERCAP.
- Reviewed and provided feedback on the data analysis from the cases submitted in TERCAP 2007 and TERCAP 2008, determining to only use the data provided in TERCAP 2008.
- Implemented quality improvement processes to improve the quality of Member Board data and the national aggregate data.

Future Activities

- Develop and implement a plan to increase data collection.
- Evaluate the TERCAP protocol to improve the quality of the data collection process.

Attachments

A. TERCAP Overview

B. TERCAP Research Criteria

Attachment A

TERCAP® Overview

TERCAP®

Taxonomy of Error, Root Cause Analysis and Practice-responsibility

Overview

Taxonomy of Error, Root Cause Analysis, and Practice-responsibility (TERCAP®) is a data collection instrument designed to collect information for the purpose of identifying the root cause(s) of nursing practice breakdown. Practice breakdown is defined broadly as the disruption or absence of any of the aspects of good practice. The seminal research project, which gained knowledge from nurse practice breakdown experiences reported to boards of nursing, helped create the instrument to support prevention of practice breakdown. Since 2001, the practice breakdown project, through the work of various NCSBN committees, has included such consultants as Dr. Patricia Benner, Dr. Marie Farrell and Dr. Kathy Scott.

Since boards of nursing possess a rich source of data which can be used to determine causes of nursing error, they are well positioned to add to the body of knowledge surrounding practice breakdown. The TERCAP instrument has been designed for and made available to all NCSBN member boards of nursing, after completion of a standard NCSBN educational offering. The instrument allows for standardized, comprehensive and consistent data collection by investigators and facilities reporting cases to boards of nursing. The online instrument includes explanations and examples of the question and answer selections through an automatic online link to the TERCAP Protocol. The NCSBN research department will perform aggregate data analysis on the secure and confidential information submitted online to NCSBN.

Cases meeting the following criteria will be included in the NCSBN aggregate data analysis:

1. The case involves a randomly selected practice breakdown case or all practice breakdown cases reported to a participating board of nursing.
2. The case involves a nurse who was involved in the practice breakdown.
3. The case involves one or more identifiable patients (if more than one patient was involved, data are to be gathered and submitted on the patient with the most harm or risk of harm).
4. The case results in some type of board outcome (disciplinary action, alternative program, non-disciplinary action, referral to other agency) other than case dismissal.
5. The case allows for all or almost all of the data collection instrument fields to be completed.
6. Ideally, TERCAP is used on cases when a nurse is initially reported to a board of nursing to ensure that the information requested in the data fields can be obtained.
7. Cases involving diversion /substance abuse/chemical impairment should be included only when they are associated with practice breakdown.

TERCAP® consists of the following sections:	
Patient Profile	Health Care Team
Patient Outcome	Nurse Profile
Setting	System Issues
Intentional Misconduct or Criminal Behavior	Board of Nursing Outcome
Eight practice breakdown categories:	
Safe Medication Administration	Intervention
Documentation	Prevention
Attentiveness/Surveillance	Clinical Reasoning
Interpretation of Authorized Provider's Orders	Professional Responsibility/Patient Advocacy

Since the goal of TERCAP is to isolate the precipitating cause(s), one primary category, which is the most relevant and direct cause of the practice breakdown and, if applicable, a secondary category of practice breakdown are required to be selected by member boards completing TERCAP. Prioritization of categories is to identify the root cause of the practice breakdown. It is generally up to the member board staff that investigated a case to determine the most applicable practice breakdown category for each case submitted.

The TERCAP data instrument also includes questions relating to whether willful negligence and/or intentional misconduct occurred. These areas of inquiry were initiated prior to the Institute of Medicine's (IOM) Recommendation 7-2: "The National Council of State Boards of Nursing, in consultation with patient safety experts and health care leaders, should undertake an initiative to design uniform processes across states for better distinguishing human errors from willful negligence and intentional misconduct, along with the guidelines for their application by state boards of nursing and state regulatory bodies having authority over nursing." (*Keeping Patients Safe: Transforming the Work Environment of Nurses*. IOM, 2004, pg. 5.)

The overall goal of TERCAP is to promote patient safety by better understanding nursing practice breakdown and by improving the effectiveness of nursing regulation. The ultimate goal is to develop and maintain a database of practice breakdown cases, contributed to NCSBN from all member boards, to perform aggregate data analysis to share with the regulatory bodies to plan, implement, evaluate and sustain new strategies. Effective change requires partnership with educators, practicing nurses, facility leadership and other policy leaders. This rich data source will help support change and can be used to develop proactive regulatory strategies for the promotion of patient safety.

TESTIMONIALS

"When I started in my new position at the Idaho Board of Nursing, I wasn't sure how to approach a complaint against a nurse… I wanted to be sure I covered all the aspects of an investigation so that the board could make informed decisions. I thought to myself, isn't there a document or some sort of checklist of questions that could guide a uniform approach? Fortunately, my executive officer had tapped into a resource before I came to the board: TERCAP. Reviewing some of the older documents produced by NCSBN, I learned a bit about the history and development of this data collection instrument. I discovered there were processes in place to not only comprehensively gather the information, but there was an opportunity to submit the data online. Thus, I can view the data that I submit for my board and have a more uniform method for investigations while NCSBN can conduct data analysis in the aggregate on all the data submitted."

Jan Edmonds, MSN, RN, Director for Professional Compliance, Idaho Board of Nursing

"Having worked with TERCAP since its inception, I have seen this project evolve from a research project to what is now - a significant and essential component of the North Dakota Board of Nursing investigative process. The interview process, including investigative techniques and interview questions, has been streamlined to better capture nurse, team and system issues. The national research data obtained from TERCAP will lead the future of nursing regulation as it relates to error and practice breakdown."

Karla Bitz, PhD, RN, FRE, Associate Director, North Dakota Board of Nursing

"We find that integrating TERCAP as part of the investigation, for nurse and non-nurse investigators alike, provides increased awareness of circumstantial factors that might have been beyond the nurse's control. TERCAP contributes consistency in the identification and review of these factors in cases. We now have every investigator beginning each case by starting the TERCAP process, and we have even developed our own inter-rater reliability process so that everyone understands the questions and answer choices from which to select. Although I was skeptical at first and thought there were too many questions, we have found that it does not take as much time as we thought it would. Plus, the quality of our investigations has improved across the board through using TERCAP."

J.L. Skylar Caddell, RN-BC, Lead Investigator, Texas Board of Nursing

"As a new executive officer for an NCSBN member board, I had the goal of meeting with nurse executives around the state to establish a collaborative working relationship. TERCAP was one of the projects shared with those executives. It gave us an opportunity to work together in defining how best the board and health care facilities could collaborate to report and address practice breakdown. The idea was well received and has forged a new partnership between the board and the facilities that provide nursing care across Kentucky."

Charlotte Beason, EdD, RN, NEA, Executive Director, Kentucky Board of Nursing

Attachment B

TERCAP® Research Criteria

NCSBN
National Council of State Boards of Nursing

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TERCAP® Research Criteria

Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®) data to be submitted for NCSBN's national data collection research project

Cases meeting the following criteria will be included in the NCSBN aggregate data analysis:

1. The case involves a randomly selected practice breakdown* case or all practice breakdown cases reported to a participating board of nursing.
2. The case involves a nurse who was involved in the practice breakdown.
3. The case involves one or more identifiable patients (if more than one patient was involved, data is to be gathered and submitted on the patient with the most harm or risk of harm).
4. The case results in some type of board outcome (disciplinary action, alternative program, non-disciplinary action, referral to other agency) other than case dismissal.
5. The case allows for all or almost all of the data collection instrument fields to be completed.
6. Ideally, TERCAP is used on cases when a nurse is initially reported to a board of nursing to ensure that the information requested in the data fields can be obtained.
7. Cases involving diversion /substance abuse/chemical impairment should be included only when they are associated with practice breakdown.

TERCAP is not meant for cases in which the nurse enters an alternative program where there is no investigation or determination that there was practice breakdown.

*Practice breakdown is defined broadly as the disruption or absence of any of the aspects of good practice. Often those are cases involving errors or near misses.

TERCAP®
Taxonomy of Error, Root Cause Analysis and Practice-responsibility

Report of Transition to Practice Committee

Background

The following were the charges of the Transition to Practice Committee and a general description of their activities to meet the charges.

1. Recommend an evidenced-based regulatory model for transition to practice.

Committee members built more detail into the transition to practice model, focusing on input from Member Boards, stakeholders and the literature.

2. Collaborate with Member Boards and stakeholders regarding a future regulatory model.

Committee members formally sought input from Member Boards and 14 stakeholders through a fact sheet (Attachment B), which provides a compelling argument that transition to practice should be implemented through regulation, and the model description (Attachment C), for the purpose of communicating our vision of the model.

3. Identify strategies for implementation of the model.

Committee members developed a tool kit for Member Boards, which is available on the NCSBN Web site. The tool kit will continually be built, with the particular components being listed under Highlights and Accomplishments.

4. Develop model rules.

Committee members developed model rule language (Attachment A), but they recommend that the model rules not be voted on until pilot data have been analyzed. The pilot studies will provide us with valuable information on the cost to boards of nursing, the resources needed and how to best regulate transition to practice.

Highlights of FY09 Activities

The Transition to Practice Committee collaborated with NCSBN's membership and 14 stakeholders to gain insight into further developing the evidence based transition to practice model that last year's committee members developed. Building on the input from the NCSBN membership and stakeholders, as well as further review of the literature, the members of the committee built more detail into the transition model and updated the evidence grid. Strategies to implement the model were identified, and members of the committee developed an online tool kit to for the implementation phase of this initiative. The timeline for the transition to practice initiative was envisioned and is captured on the dashboard (Attachment E). Specific highlights from this year's committee include:

- Sought Member Board feedback on the model at the Midyear Meeting and via e-mail.
- Hosted a collaborative conference call with the following organizations to gain their input:
  - Advisory Board Company
  - American Association of Colleges of Nursing
  - American Nurses Association
  - American Organization of Nurse Executives
  - Association of Community Health Nursing Educators
  - Joint Commission
  - National Association of Directors of Nursing Administration – Long Term Care
  - National Association for Practical Nurse Education and Service

Members

Janine Baxter, MSN, RN
Idaho, Area I

Debra Werner, MSN, RN
New Mexico, Area I

Marcy Echternacht, MS, RN, APRN-CNS, BC
Nebraska, Area II, Chair

Lanette Anderson, JD, MSN, RN
West Virginia-PN, Area II

Greg Howard, LPN
Alabama, Area III, Board Liaison

Carol Komara, MSN, RN
Kentucky, Area III

Pamela Zickafoose, EdD, RN, CNA-BC, CNE
Delaware, Area IV

Carol Silveira, MS, RN
Massachusetts, Area IV

Mary Botter, PhD, RN
Vermont, Area IV

Cynthia VanWingerden, MS, RN
Virgin Islands, Area IV

Carol Reinick, PhD, RN, FAAN, NEA-BC
American Organization of Nurse Executives

Guest Member

Jean Barry, MSN, RN
Director of Regulatory Policy, Canadian Nurses Association

Staff

Nancy Spector, PhD, RN
Director, Regulatory Innovations

Qiana Hampton, MBA, MHRM
Administrative Assistant, Regulatory Innovations

Meeting Dates

- Nov. 18-19, 2008
- Jan. 7-8, 2009
- March 9-11, 2009
- March 25, 2009 (Conference Call)

Relationship to Strategic Plan

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

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

  - National League for Nursing
  - National Nursing Staff Development Association
  - National Student Nurse Association
  - Professional Nurse Educators Group
  - University HealthSystem Consortium
  - Versant
- Developed a tool kit for implementing the model with the following components:
  - Model rule language (Attachment A)
  - Transition to practice fact sheet (Attachment B)
  - Transition to practice model description (Attachment C)
  - Transition to practice FAQs (Attachment D)
  - Transition to practice dashboard (Attachment E)
  - Transition to practice goals/premises/definitions (Attachment F)
  - Transition to practice verification form (Attachment G)
  - Transition to practice article (Attachment H)
  - Transition to practice evidence grid (Attachment I)
- Extensive discussion was held about the development of the modules for new nurses. It is essential that these modules not be "reteaching" of content, but instead, should incorporate experiential learning. The committee members envision designing interactive modules, which allow opportunities for deliberate practice, such as the use of virtual reality, avatars and computer simulation.
- Committee members also discussed the need to develop interactive modules for preceptor development, as well as using cutting edge Internet technologies for connecting new nurses to preceptors in rural areas or in areas where preceptors aren't readily available.
- Committee members heard from NCSBN and stakeholders about the importance of piloting the transition to practice program and plans were made for developing pilot studies.
- Members of the committee recommended that NCSBN convene an advisory panel to assist NCSBN's Research Department with developing outcome measures. The advisory panel should be consulted throughout the piloting period. It is critical that the pilot research be rigorously planned and conducted so that nursing can use the data to persuade legislators, policy makers, private and public funding sources, and consumers that transition to practice is necessary for public protection.
- Committee members revised the description of the model to reflect input from Member Boards and stakeholders, as well as new information:
  - Clarified that orientation and transition to practice can be done at the same time.
  - Clarified that the preceptorship is normally six months in length, but it can be individualized.
  - Specialty was changed to specialty content for clarity; utilize research was changed to evidence based practice.
  - Reviewed and made some minor revisions on our definitions and developed a definition for deliberate practice.

- Committee members discussed at length the various functions that are needed to make this vision of a comprehensive transition to practice program, implemented through regulation, a reality. They recommended that NCSBN hire a consultant to develop a business plan that will address all the areas highlighted on the dashboard (Attachment E), including preceptor development, research, funding, pilots, module development and marketing. The dashboard was designed to present the key elements of the Transition to Practice Initiative on a timeline from 2009-2011.
- Committee members met with NCSBN's Marketing & Communications department about branding our Transition to Practice Initiative; a plan is currently in development.
- NCSBN's Marketing & Communications Department has assisted committee members with designing marketing materials for the tool kit, and the NCSBN Interactive Services Department has developed an interactive and user-friendly online tool kit display.

Future Activities

Committee members recommend that the Transition to Practice Committee continue for another year to complete the following:

- Develop essential elements for the pilot study.
- Develop essential elements for the new nurse modules.
- Develop essential elements for preceptor training.

Attachments

A. Model Act and Rules for Transition to Practice

B. Transition to Practice: Promoting Public Safety

C. Description of Transition to Practice Model

D. NCSBN's Transition to Practice Model: Frequently Asked Questions

E. Transition to Practice Committee Dashboard

F. Goals of NCSBN's Transition to Practice Model

G. Transition to Practice Verification Form

H. Transition to Practice Article

I. Transition Evidence Grid

Attachment A

Model Act and Rules for Transition to Practice

Grey highlighting indicates changes to current model rules.

Article VI. – Licensure (Practice Act)

Section 9. Renewal of RN/LPN/VN Licenses.

Registered nurses and licensed practical/vocational nurse licenses issued under this Act shall be renewed every <> years according to a schedule established by the board.

Effective <> all newly licensed nurses during their first year of practice in the U.S. will be required to complete a transition to practice program that meets the criteria as established by the board.

A, B, and C, follow.

6.9 Renewal of Licenses (Rules)

The renewal of a license must be accomplished by <date determined by the board>. Failure to renew the license on or before the date of expiration shall result in the forfeiture of the right to practice nursing in this jurisdiction.

All newly licensed registered nurses (RN) and licensed practical/vocational nurses (LPN/VN) will be required to complete a transition to practice program during their first year of practice in the U.S. The program will be specific to the scope of practice of RNs and LPN/VNs. Transition to practice programs include the following:

A) A minimum 6-month preceptorship with ongoing support through the first year of practice.

B) Precepted experiences with deliberate practice which incorporate:

1. Specialty content in the area of practice
2. Communication
3. Safety
4. Clinical reasoning
5. Prioritizing/organizing
6. Evidence based practice
7. Role socialization
8. Delegating/supervision

C) Opportunities for reflection.

D)Ongoing formal and informal feedback.

Preceptors will complete a standardized course, including, but not limited to:

A) Scope of practice

B) Supervision of newly licensed nurses

C) Providing opportunities for reflection

D) Providing feedback

E) Adult learning principles

F) Content referred to in 6.9 (B)

6.9.1 Notification to Renew

At least <>days before the expiration date of a license, the board shall notify the licensee that it is time to renew and inform the licensee of the timeliness and options for completing the application.

6.9.2 Application for Renewal of License as a Registered Nurse or Licensed Practical/ Vocational Nurse

An applicant for license renewal shall submit to the board the required fee for license renewal, as specified in Chapter 14, and a completed application for license renewal that provides the following information: (continues with A., B., C., then add the following:)

D. Evidence of completion of a transition to practice program, if applicable, specified in 6.9.4 below.

6.9.4. License Renewal Transition to Practice Requirement for RNs and LPN/VNs.

A. Purpose: To promote public safety by supporting newly licensed nurses during their critical entry period and progression into practice.

B. When newly licensed registered nurses or licensed practical/vocational nurses have finished the first year of practice, they will:

1) Complete a Transition to Practice Verification (TPV) form approved by the board.

2) Present a completed TPV form to the board, after the first year in practice, in order to renew the license.

Change 6.9.4. to 6.9.5.

The board shall renew the license of each renewal applicant who complies with the requirements listed in 6.9.2, 6.9.3 and 6.9.4, if applicable.

Continue with rest of the model rules.

Attachment B

Transition to Practice: Promoting Public Safety

NCSBN
National Council of State Boards of Nursing

Attachment B

Transition to Practice: Promoting Public Safety

THE PROBLEM

- **Complex Health Care Needs:** Newly licensed nurses are expected to care for sicker patients with multiple conditions in increasingly complex health care settings.
- **Practice Readiness:** Educators and employers agree that there is an education to practice gap in nursing, particularly related to experiences with risk management.
- **Expertise Gap:** Ten percent of a typical hospital's nursing staff is comprised of new graduate nurses.[1]
- **Variable Transition Experiences:** Excellent transition programs exist. However, both orientation and transition experiences for newly licensed LPNs and RNs are tremendously variable and may be nonexistent in some practice settings.[2]
- **Risk for Practice Errors:** Several studies show that new nurses experience increased stress three to six months after hire;[3] data has shown that increased stress levels are risk factors for patient safety and practice errors.[4]
- **Turnover/Retention:** 35 to 60 percent of new nurses leave a position in their first year of practice,[5] resulting in an estimated replacement cost of $46,000 to $64,000 or higher, per nurse.[6]

THE IMPACT

- **Medical Errors:** Medical errors are the eighth leading cause of death; $17 billion is spent annually on preventable errors.[7] Annually, there are 2,300 hospitalization deaths due to errors/million admits, whereas comparatively, there are 0.43 deaths/million airline passengers.[8]
- **Newly Licensed Nurse Errors:** More than 40 percent of newly licensed nurses report making medication errors.[9]
- **Life-Threatening Complications:** Studies indicate 50 percent of new graduates would fail to recognize life-threatening complications due to lack of experience.[10]
- **Patient Safety:** Decreased staffing, use of inexperienced staff and increased turnover rates have a negative influence on patient safety and health care outcomes.[11]
- **Error Reduction and Better Outcomes:** An NCSBN study shows newly licensed RNs report significantly fewer errors when they have had a transition program with specialty content.[12] Another study finds that a mentoring program with new RNs is related to improved patient outcomes.[13]
- **Cost Savings:** Studies show that transition programs reduce first-year turnover from 35 to 60 percent to six to 13 percent;[14] institutions that provide transition programs report positive return on investment (ROI) from 67.3 to 884.7 percent.[15]
- **Response:** A panel of nursing leaders at NCSBN's Transition Forum on Feb. 22, 2007, representing practice, education and regulation, supported the need for a national, standardized transition to practice model implemented through regulation.

THE PROPOSED SOLUTION

Adopt the transition to practice regulatory model (see back) that is designed to promote public safety by supporting newly licensed nurses. The model has been designed to be:

- Flexible (Institutions could meet the module criteria individually or in partnerships, or the modules will be available on the Web)
- Robust (across all settings and inclusive of all levels of licensed nurses)
- Evidence-based

Verification of successful completion of a transition program will be required at the first license renewal.

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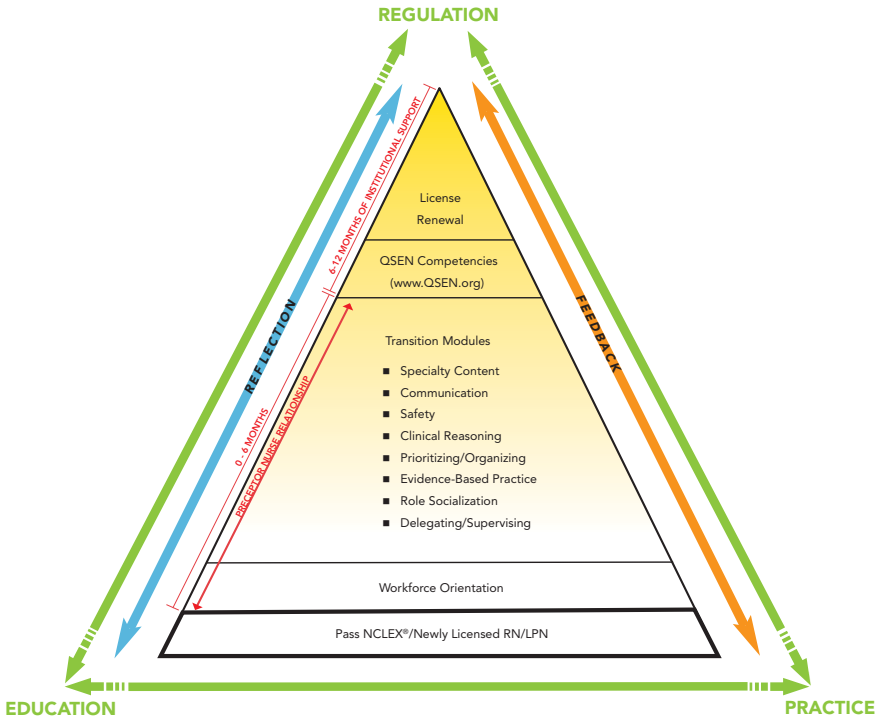
References on back



Transition to Practice Regulatory Model

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15. Beecroft et al. (2001); Halfer (2007); Pine & Tart (2007).

Refer to the 2009 Evidence Grid at https://www.ncsbn.org/363.htm for complete citation of sources.

Attachment C

Description of Transition to Practice Model

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April 24, 2009

Attachment C

Description of NCSBN's Transition to Practice Model

NCSBN's Transition to Practice model is intended to be collaboratively implemented with education and practice, but through regulation. Collaboration will be essential for this model to be successful. Educators are the experts in curriculum design and evaluation and will be able to assist with the design of the transition modules. Practice provides a crucial link that will provide new graduates with planned practice experiences with qualified nurses to mentor them. Nursing regulators provide new graduates with information on their scope of practice, the Nurse Practice Act, and maintaining their license throughout their careers. If adopted, regulation will be able to enforce the transition program through licensure.

This is an inclusive model, which would take place in all health care settings that hire newly graduated nurses and for all educational levels of nurses, including practical nurse, associate degree, diploma, baccalaureate and other entry-level graduates. The new graduate must first take and pass the NCLEX®, obtain employment and then enter the transition program.

The preceptors in this model will be trained and most will work one-on-one with newly graduated nurses, though in some settings team preceptorships may be used. This model is strongly dependent on a well-developed preceptor-nurse relationship. Novice nurses will learn the importance of being a seasoned, dedicated preceptor and the responsibility to transition new nurses into practice. In the future, becoming preceptors and mentors for new nurses will be an expected part of professional nursing.

In this model orientation is defined as teaching the policies and procedures of the workplace, as well as role expectations. Therefore, orientation is separate from the concept of transition to practice. Transition to practice is defined as a formal program designed to support new graduates during their progression into practice.

The eight transition modules for this model include delegating/supervising, role socialization, evidence-based practice, prioritizing/organizing, clinical reasoning, safety, communication, and specialty content. These were identified from the literature and from successful transition programs. These modules could be presented at the institution where the new nurse works, in a collaborative program with other institutions, or via the Internet. The Transition to Practice Committee is working with NCSBN's E-Learning Department on the feasibility of developing a Web site with the online learning modules and with linking new nurses to preceptors.

Feedback and reflection are essential parts of this model and must be integrated throughout the entire transition program. This should be built into the preceptor-nurse relationship, but also should be maintained after the six-month transition period is complete.

The time period for this Transition Regulatory Model will be six months, though it is expected that the new graduate will have ongoing support for another six months. At the end of the year, the new RN is expected to have met the Quality and Safety Education for Nurses (QSEN) competencies. The QSEN competencies, developed by experts from across the health care disciplines, are based on the Institute of Medicine's (IOM) recommended competencies for health care professionals and include patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. The Transition to Practice Committee members already have developed some definitions of competencies for practical nursing, based on the QSEN definitions for RNs. The Transition to Practice Committee also has been working with NCSBN's Research Department to develop outcome competency measures. If NCSBN develops a continued competency model, it is anticipated that there will be some changes in this model so that these two models will be congruent.

In order for the new graduates to maintain licensure after one year in practice, it will be incumbent upon them to provide the Board of Nursing with a Transition to Practice Verification (TPV) form, which will be signed by the new graduates, their preceptors and their supervisors, verifying the new nurse has met all the requirements of the jurisdiction's transition program. In many states new drivers have similar requirements for maintaining their license after their first year of driving. In 2008 the Commission of Collegiate Nursing Education (CCNE) has developed standards for accrediting transition programs that use the UHC/AACN model, and it is hoped that accreditation of transition to practice programs will continue, thus assisting with standardization.

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

For more information, please contact Nancy Spector, PhD, RN at 312.525.3657 or nspector@ncsbn.org.

Attachment D

NCSBN's Transition to Practice Model: Frequently Asked Questions

NCSBN's Transition to Practice Model: Frequently Asked Questions

1. Q. Why should Boards of Nursing consider regulating transition to practice?

A. Please see our Fact Sheet, which outlines the compelling argument that transition to practice programs should be implemented through regulation: https://www.ncsbn.org/363.htm. As background to this work, NCSBN studies in the early 2000s found that new graduates and employers cited transition to practice as a problem. For example, one NCSBN study reported that new nurses were expected to practice independently in a mean of eight days after the first day of hire. Other NCSBN studies found that fewer than 50% of the employers reported that new graduates were prepared to practice safely and competently. In further studies NCSBN found that well-planned, post-hire transition programs had better outcomes than pre-graduation clinical immersion programs and were related to fewer practice errors and fewer risks for practice breakdown. In an extensive literature review NCSBN also found that post-hire transition programs were linked to fostering better practice outcomes and safer practice.

2. Q. How was the model designed?

A. NCSBN's Transition to Practice Committee spent a year analyzing the available evidence from transition to practice programs, published and unpublished. Data were retrieved from international, national, and individual studies and projects and were outlined in our Evidence Grid, available here: https://www.ncsbn.org/363.htm. The model was derived from the evidence and in concert with the Boards' mission of public protection.

3. Q. Are you seeing this as a failure of education and/or practice in nursing?

A. Absolutely not! Health care delivery in the U.S. is becoming increasingly complex, necessitating the use of sophisticated technologies and the need for systems thinking in order for nurses to practice safely. Further, more than ever before nurses are caring for sicker, older, and more diverse patients with myriad chronic conditions. In order to keep up with this these changes, NCSBN is proposing that nursing needs to regulate that critical period between education and competent practice where the novice nurse needs practice experience and support from competent nurses in order to develop professionally.

4. Q. Are the modules "re-teaching" didactic content that you are assuming the newly licensed nurses did not effectively learn?

A. No! The modules will not be designed as didactic courses. The modules will build on the nurse's educational experiences, providing opportunities for deliberate practice. For example, there will be interactive practice exercises designed for newly licensed nurses in areas that are critical for public protection, such as experiences with: priority setting; delegating and supervising; making decisions in a fast paced environment; communicating with other health care professionals; and implementing risk management principles.

5. Q. What about cost?

A. All published studies have shown positive return on investment for the workplace when well-planned transition programs are implemented. However, we recognize that the start-up of these programs might require some out-of-the-box thinking. We encourage partnerships between practice agencies, as well as between practice and education, in developing a transition program that would meet the jurisdiction's criteria. NCSBN

is investigating the possibility of small start-up grants as well as federal funding for the employers. One of the purposes of NCSBN's pilot studies will be to investigate the cost/benefit ratio for employers as well as the cost to Boards of Nursing.

6. Q. How can this be implemented in rural areas?

A. NCSBN is planning to develop online modules and online connections with preceptors that could be used if the facility does not have the resources to develop a transition to practice program. The online connection for preceptors would also be valuable in those settings where there might be a paucity of preceptors, such as correctional institutions or schools.

7. Q. What if an agency already has an excellent residency program?

A. As long as it meets the criteria of our model, it would be acceptable. Many of the current models out there meet our criteria. An underpinning of our model is that it was designed to be *flexible* (we won't mandate the program to be used) and *robust* (inclusive of all settings and all education levels of nurses).

8. Q. What about preceptor training?

A. Our model has preceptor training built in. We will have set criteria for preceptor training, and we will develop modules for those agencies that do not have resources to train their preceptors. However, we absolutely think it's essential for preceptors to be adequately trained.

9. Q. During the time of the 6-month preceptorship is the newly licensed nurse considered part of the work schedule?

A. At the beginning of the relationship the preceptor will work very closely with the newly licensed nurse, providing much support and feedback. However, as the relationship develops (and this will be on an individual basis), that newly licensed nurse will be supported to work more independently since the goal of this relationship is to foster safe and competent practice by allowing for experiential learning.

10. Q. Must it be a one-to-one preceptor relationship?

A. While some research has found the one-to-one relationship between preceptor and newly licensed nurse to be more effective than multiple preceptors, this might not always be feasible. Furthermore, new studies have found that team preceptorships can be effective. Therefore, a one-to-one preceptorship won't be required; the workplace should decide what works better for their situation.

11. Q. Will NCSBN mandate transition to practice programs across all Boards of Nursing?

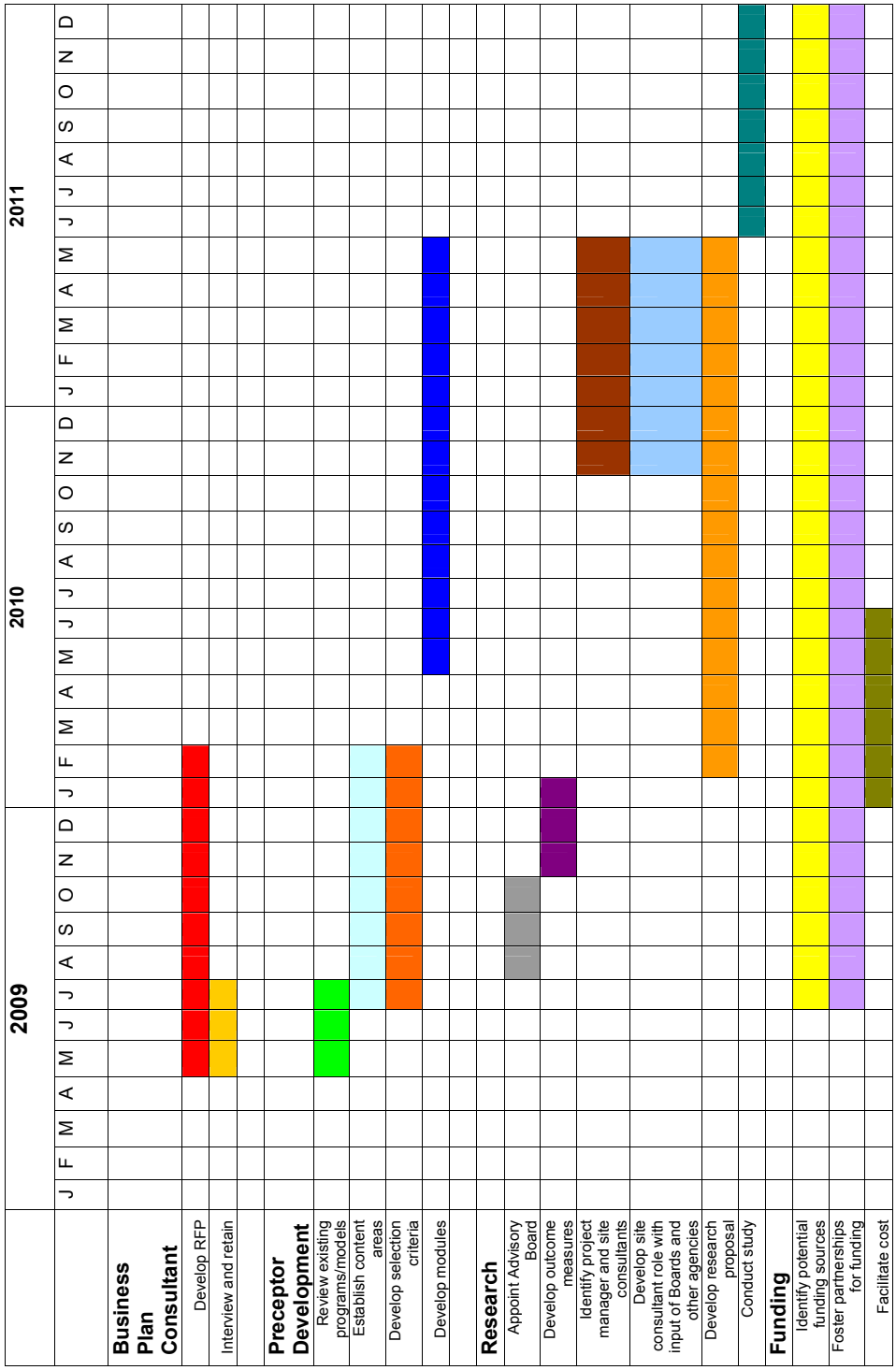
A. No! Because of state's rights, NCSBN does not have the authority to mandate regulation in the Boards of Nursing. If our members support this initiative, we will make the recommendation and will assist those Boards that want to implement transition to practice to do so.

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

For more information, please contact Nancy Spector, PhD, RN at 312.525.3657 or nspector@ncsbn.org.

Attachment E

Transition to Practice Committee Dashboard




2009
2010
2011
J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D
analysis and projection for pilot projects
Pilots
Identify Pilot elements
Develop selection criteria for pilots
Select pilot locations
Pilots launched
Modules
Identify module elements
Develop module goals/objectives and content
Create interactive/state of the art modules
Marketing
Branding
Develop talking points
Estimate cost of marketing
Identify resources available to Boards and Pilot sites
Hold collaborative calls

Attachment F

Goals of NCSBN's Transition to Practice Model

NCSBN
National Council of State Boards of Nursing

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Chicago, IL 60601-4277

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www.ncsbn.org

April 24, 2009

Attachment F

Goals of NCSBN's Transition to Practice Model

Goal for Transition to Practice: To promote public safety by supporting newly licensed nurses during their critical entry period and progression into practice.

Premises:

- The mission of the Boards of Nursing is the protection of public health, safety, and welfare.
- Nursing regulators recognize the value of evidence-based models in their responsibility of public protection.
- Transitioning new nurses to practice is best accomplished when practice, education, and regulation collaborate.
- Transition to practice programs should occur across all settings and all education levels.
- Regulation criteria for transition programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection.
- Transition program outcomes are consistent with the knowledge, skills and attitudes required for safe and effective provision of nursing care.

Definitions:

Competent – The ability to demonstrate an integration of the knowledge, attitudes, and skills necessary to function in a specific role and work setting. (Modified from American Association of Critical-Care Nurses, *Preceptor Handbook*).

Deliberate practice – Focused learning with an engaged learner that involves repetitive performance of psychomotor or cognitive skills, coupled with rigorous assessment, informative feedback, and the opportunity for reflection.

Orientation – The process of introducing staff to the philosophy, goals, policies, procedures, role expectations, and other factors needed to function in a specific work setting. Orientation takes place both for new employees and when changes in nurses' roles, responsibilities, and practice settings occur. (ANA's *Scope and Standards of Practice for Nursing Professional Development*).

Preceptor – A competent nurse who has received formal training for the preceptorship role.

Preceptorship – A formal relationship between a qualified preceptor and a newly licensed nurse that facilitates active learning and transition into practice.

Transition to Practice – A formal program of active learning, implemented across all settings, for all newly licensed nurses (registered nurses and licensed practical/vocational nurses) designed to support their progression from education to practice.

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

For more information, please contact Nancy Spector, PhD, RN at 312.525.3657 or nspector@ncsbn.org.

Attachment G

Transition to Practice Verification Form

Transition to Practice Verification Form	
NAME:_____	License #: _____
ADDRESS: _____	
CITY/STATE/ZIP: _____	PHONE DAY:_____
SSN: _____ DOB: _____	PHONE EVE:_____
SCHOOL OF NURSING:_____	
OCCUPATION/EMPLOYER: _____	
PRECEPTOR NAME:_____	TITLE: _____
PHONE: _____	
TRANSITION PROGRAM SUCCESSFULLY COMPLETED & FULL REQUIREMENTS OF TRANSITION TO PRACTICE WERE MET.	
EMPLOYER:_____	DATE:_____
NURSE: _____	DATE:_____

Attachment H

Transition to Practice Article

Toward an Evidence-Based Regulatory Model for Transitioning New Nurses to Practice

NCSBN is developing an evidence-based regulatory model for transitioning new nurses to practice. Several factors have inspired this inquiry, most notably, the Institute of Medicine's reports of medical errors and the need to transform health care education. In addition, there is an increased complexity of care for sicker patients with multiple conditions, a continued need for systems thinking and an exponential growth of technologic advances. Furthermore, the shortage of nurses and nursing faculty is expected to continue into the future, thus affecting the transition of new nurses to practice.

There have been some national calls for a formal transition program for new nursing graduates, including from the Joint Commission (Joint Commission White Paper, 2002), the draft of the Carnegie study of nursing education recommendations and in a synthesis of national reports (Hofler, 2008). Several standardized transition programs around the country have been very successful and worldwide transition programs are being designed (NCSBN, 2008a). Additionally, the Commission on Collegiate Nursing Education (CCNE) has developed an accreditation process for residency programs.

Last year NCSBN's Transition to Practice Committee identified the evidence that supports a transition regulatory model *(see model below).* Committee members will continue to work this year to refine the model, making it feasible for boards of nursing to implement and develop consensus for the model across regulation, education and practice. (Please refer to the Transition Evidence Grid [NCSBN, 2008a] and the NCSBN Transition to Practice Report [NCSBN, 2008b] for an explication of the available evidence supporting the NCSBN's transition regulatory model.)

NCSBN's transition regulatory model will be implemented through regulation, though collaboration across education, regulation and practice will be essential for this model to be successful. Educators are the experts in curriculum design and evaluation and will be able to assist with the design of transition modules. Practice provides a crucial link that will equip new graduates with planned, precepted practice experiences. Regulators provide new graduates with information on their scope of practice, the Nurse Practice Act and maintenance of their license throughout their careers.

Regulation will enforce the transition program through licensure. This is an inclusive model, which would take place in all health care settings that hire newly graduated nurses at all educational levels of nursing, including practical nurse, associate degree, diploma, baccalaureate and other entry-level graduates. It is also intended to be flexible so that many of the current standardized transition programs will meet the requirements of this model.

The new graduate must first take and pass the NCLEX®, obtain employment and then enter the transition program. The preceptors in this model will be trained to work one-on-one with newly graduated nurses. A preceptor will work with the same graduate throughout the six-month transition program. This model is highly dependent on a well-developed preceptor–nurse relationship; the importance of this relationship is supported in the research. Novice nurses will understand the importance of learning from a seasoned, dedicated preceptor, thus encouraging these nurses to serve as preceptors to new nurses in the future. Therefore, it is hoped that this will bring about cultural change in nursing whereby becoming a preceptor and mentor will be an expected part of professional nursing.

Orientation, defined as being instructed on the policies and procedures of the workplace as well as role expectations, is required before entering the transition program. Therefore, orientation, according to this model, is **separate** from the concept of transition to practice, which is defined as a formal program designed to support new graduates during their progression into practice.

The eight transition modules supported in the literature (NCSBN, 2008a; NCSBN, 2008b) for this model include: delegating/supervising; role socialization; utilization of research; prioritizing/organizing; clinical reasoning; safety; communication; and specialty content. These modules could be presented at the institution where the new nurse works, in a collaborative program with other institutions or via the Internet. The Transition to Practice Committee envisions the development of a Web site with online learning modules, as well as a way to connect new nurses to preceptors in those settings or regions of the country where preceptors are in short supply.

The time period for this Transition Regulatory Model will be six months, though it is expected that the new graduate will have ongoing support for an additional six months. At the end of the year, the new nurse is expected to have met the Quality and Safety Education for Nurses (QSEN) competencies. The QSEN competencies (www.QSEN.org), developed by experts across the health care disciplines, were based on the IOM competencies and include: patient–centered care; teamwork and collaboration; evidence-based practice; quality improvement; safety; and informatics.

NCSBN's transition regulatory model will be implemented through regulation, though collaboration across education, regulation and practice will be essential for this model to be successful.

Lastly, feedback and reflection are essential parts of this model and must be integrated throughout the entire transition program. This should be built into the preceptor–nurse relationship, while also being maintained after the six-month transition period is complete.

It is the vision of this model that new nurses will be required to provide their board of nursing with evidence of completing all the requirements of this standardized transition program in order to maintain their license after their first year in practice. This model will be voted on at the NCSBN Annual Meeting in 2009. If this regulatory transition model is adopted, each jurisdiction will decide whether or not to implement it or to adapt it to meet the particular needs of their state or territory.

Please contact Nancy Spector, PhD, RN, at nspector@ncsbn.org for further information.

Transition to Practice Regulatory Model

REFERENCES

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NCSBN. (2008a). Transition evidence grid. Retrieved October 6, 2008, from www.ncsbn.org/Final_08_Transition_grid.pdf.

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Attachment I

Transition Evidence Grid

Project	Description	Elements	Measurement	Length	Status/Results
1 Canadian Nurses Association's Guide to Preceptorship and Mentoring Report Online: http://www.cna.aiic.ca/CNA/nursing/education/mentorship/default_e.aspx Entitled, "Achieving Excellence in Professional Practice" **International**	General guide for setting up a mentoring and preceptorship for novice nurses.	▪ Relevant terms defined ▪ Benefits cited ▪ Costs explored ▪ Steps for developing a successful program identified ▪ Preceptor/mentoring competencies identified	Reviewed literature	N/A	From literature identified increased satisfaction, increased confidence, increased retention, and improved patient care.
2 Flying Start in Scotland Information available: http://www.flyingstart.scot.nhs.uk/ **International**	Web-based transition program launched in January 2006. Over 1,200 new nurses have taken part in the program. Approximately 200 hours of didactic content, taking about 2-5 hours per week. Uniqueness in being a Web-based program.	▪ Mentors are assigned ▪ Connections with peers/mentors can be accomplished online ▪ Online modules include: - Communication - Clinical skills - Teamwork - Safe practice - Research for practice - Equality and diversity - Policy - Reflective practice - Professional development - Career pathways	Currently they are interviewing with an independent research team to evaluate the program.	1 year	Have agreed to send us the research tender specification so that we can see what they're intending to evaluate; along with that they'll send us their literature review. The full evaluation won't be completed for 24 months.

Project	Description	Elements	Measurement	Length	Status/Results
3 Ireland Background available online with document entitled: "Report of the Commission of Nursing," 1998. For regulation, this document, also available online, would be helpful: "Requirements and Standards for the Midwife Registration Education Programme," 2000. **International**	In Ireland they transferred from an apprenticeship 3-year program to a 4-year program in 2002. Their implementation committee recommended a 36-week rostered year in the final year of the program.	Students are paid on the first point of their scale for staff nurses during the transition program. During this period the students are still in their education program. This is accomplished through regulatory mandate.		36 weeks	There is no data available at this point, though we are in touch with them, and they will provide data when they have it.
4 Portugal "Nursing Internate" Report not available yet. **International**	Through regulation, the country of Portugal is beginning to develop a regulatory transition model.	This program is being designed from a regulatory mandate.			As soon as their report is approved they have promised to send it to us, and they'd like to see a copy of NCSBN's Transition Model.
5 Advisory Board Company Berkow, S., Virkstis, K., Stewart, J. & Conway, L. (2008). Assessing new graduate performance. *JONA*, 38(11), 468-474. [National Executive Center (2008). Bridging the Preparation-Practice Gap: Volume I: Quantifying New Graduate Nurse Improvement Needs: Washington DC: The Advisory Board Company; National Executive Center (2008). Bridging the Preparation-Practice Gap: Volume II: Best Practices for Accelerating Practice Readiness of Nursing Students. Washington DC: The Advisory Board Company.] **National**	A typical nursing staff now comprises more than 10% new graduates, and while 90% of academic leaders believe their students are fully prepared to practice, only 10% of the hospital and health system nurse executives believe their new nurses are fully prepared to provide safe and effective care. The findings provide ideas for promising opportunities for improving practice readiness.	They triaged the 36 critical nurse competencies, looking at relative curricular emphasis, versus new graduate proficiency. Of the 36 competencies, the following had the least relative curricular emphasis and the least new graduate nurse proficiency: ▪ Follow up ▪ Initiative ▪ Understanding quality improvement ▪ Completion of tasks within expected timeframe ▪ Track multiple responsibilities ▪ Conflict resolution ▪ Delegation	The Center developed parallel survey tools for academic and frontline nursing leaders using an iterative process, incorporating input from 100 experts. At the heart of both survey tools was a common set of 36 nursing competencies. Center researchers collected results via an online survey tool from 5,700 frontline nurse leaders and more than 400 nursing school deans, directors, and department chairs.	A specific length of a program was not promoted, though best practices for accelerating practice readiness were presented. Best practices (which included detailed components on implementation) were: 1. Targeted clinical rotations 2. Expert clinical instruction 3. Exceptional student experiences The 2006 publication from the Nursing Executive Center presented exemplars for transition programs. Of the 9 programs highlighted, 6 had 1-year programs; 1 had a 7-month program; 1 was 22 weeks; 1 was 14.5 weeks.	▪ It is not necessary to customize an entirely different transition strategy for each new graduate. A rather consistent approach (such as a standardized transition program) would be possible. ▪ It is important to prioritize new graduate's most pressing needs (See Elements above). ▪ Recommend partnerships between practice and education. ▪ While many programs have been posthire, collaborative prehire initiatives are important.

Project	Description	Elements	Measurement	Length	Status/Results
6 2002 American Health Care Association Survey Reported available at: http://www.ahcancal.org/Pages/Default.aspx, under Research and Data. Updated information expected in spring of 2008. **National**	Survey completed by 6,155 U.S. nursing homes.	N/A	Collected information from 6 nursing staff positions on: ▪ The number of vacant positions as of June 30, 2002 ▪ The number of employees who have left these facilities from Jan. 1 through June 30, 2002 ▪ Relative difficulty in recruiting key nursing staff	N/A	▪ Annual turnover of RNs, LPNs, and DONs is 50% ▪ 2/3 of facilities reported it was harder to recruit RNs and LPNs in 2002, compared to previous year.

Project	Description	Elements	Measurement	Length	Status/Results
7 AHRQ: Medical Errors: The Scope of the Problem: An Epidemic of Errors Report from Agency for Healthcare Research and Quality, retrieved February 23, 2009, from: http://www.ahrq.gov/qual/errback.htm **National**	Publication No. AHRQ 00-P037	N/A	Summary of reports on national governmental data.	N/A	▪ Errors occur in settings other than hospitals, including physician's offices, nursing homes, pharmacies, urgent care centers, and care delivered at home. For example, investigations from the MA State Board of Registration in Pharmacy estimate that 2.4 million prescriptions are filled improperly each year in that state. ▪ Medical errors cost the nation approximately $36 billion annually, with about $17 billion being related to preventable errors. ▪ From IOM 1999 report "To Err is Human: Building A Safer Health System," 44,000 to 98,000 people die each year from medical errors. ▪ According to a national poll, 42% of respondents have been affected by a medical error, either personally or through a friend or relative; 32% of the respondents indicate the error had a permanent negative effect on the patient's health; respondents rated the health care system as moderately safe (4.9 on a scale of 1-7), with 7 being "very safe." ▪ In another survey, Americans are "very concerned" about being given the wrong medication (61%); being given medications that negatively interact (58%). ▪ A landmark study on medical errors found that 70% were preventable; another study showed that 54% of surgical errors were preventable.

Project	Description	Elements	Measurement	Length	Status/Results
8 Beecroft, P.C., Dorey, F. & Wenten, M. (2007). Turnover intention in new graduate nurses: a multivariate analysis. *Journal of Advanced Nursing*, 62(1), 41-52. **National**	This national study of the Versant Residency program reported on the relationship of new nurse turnover intent with individual characteristics, work environment variables, and organizational factors and to compare new nurse turnover with actual turnover in the 18 months of employment following completion of a residency. As background evidence, a 35-60% turnover rate for new graduates was reported from the literature. They presented data of the influence of turnover decreasing patient safety and health care outcomes. Further, changes in staffing decrease the effectiveness of team-based care on patient units, resulting in less effective working relationships and ultimately affecting patient care.	Versant's program (see details under Versant).	A prospective design was used with data collected from 1999 to 2007 (seven years of data were used). The study respondents (n=889) participated in a standardized residency program. Tools included: Skills Nursing Competencies Rating Scale: Self Report; Slater Nursing Competencies Rating Scale: Self-Report; Corwin's Nursing Role Competency Scale; Ways of Copying Revised; Conditions for Work Effectiveness Questionnaire; Schutzenhofer Professional Nursing Autonomy Scale; Clinical Decision-Making Scale; Work Satisfaction Scale; Nurse Job Satisfaction Scale; Leader Empowerment Behaviours Scale; Group Cohesion Scale; Organizational Questionnaire; Turnover Intent; and actual turnover.	18-22 weeks	▪ There was an increased likelihood of turnover intent for older new graduates who did not get their choice of units. ▪ Stress was reported as an important issue for new graduates (in one study 58% of new graduates were highly stressed). Seeking social support led to turnover intent, and the explanation may be this reflected failure to obtain the necessary support within the system. ▪ Lower scores on skills self-confidence and perceptions of competency contributed to turnover intent. Reported that other studies show preceptor support, reasonable expectations, praise and opportunities for interaction build confidence. ▪ Lower scores for enjoyment in one's job contributed to turnover intent. ▪ When nurses are satisfied with their jobs and pay and feel committed to the organization, the odds of turnover intent decrease. ▪ 24-month employment following this program ranged from 83%-98% (overall 84%).

Project	Description	Elements	Measurement	Length	Status/Results
9 Behrens, Michael J. September 10, 2000, investigative report, *Chicago Tribune* **National**	Analyzed 3 million state and federal computer records to create a database that quantifies the role nurses play in medical errors.	N/A	Federal and state computer records reviewed, though author acknowledges that they are incomplete.	N/A	▪ From 1995-2000 at least 1,720 hospital patients have been accidentally killed and 9,584 others injured by nurses across the country. For example: ▪ 418 killed, and 1,356 injured, by RNs operating infusion pumps incorrectly. ▪ 216 patients were killed, and 429 injured, by RNs who failed to hear alarms of lifesaving equipment. ▪ 119 patients killed, and 564 injured, by unlicensed, unregulated nurse aides, not adequately supervised by RNs. ▪ Author concludes that these deaths and injuries are due to cuts in staff and other resources. ▪ Illinois state disciplinary records show an increasing focus of investigations on temporary (agency, traveling) nurses, and most were linked to lack of knowledge or unfamiliarity with patients.

Project	Description	Elements	Measurement	Length	Status/Results
10 Carnegie study Some information about the study on their Web site: http://www.carnegiefoundation.org/ A partial report was published here: Benner, P., Sutphen, M. & Leonard-Kahn, V. (2008). Formation and everyday comportment. *American Journal of Critical Care*, 17(5), 473-476. **National**	Part of larger, national study. Research design was qualitative ethnography, utilizing interviews (total of 588 individual interviews), focus groups, review of curricula, and observations in the classroom and clinical facilities, in excellent nursing programs. Furthermore 3 national surveys were conducted with members of the American Association of Colleges of Nursing, the National League of Nursing, and the National Student Nurse Association.	Recommendation 9.b. states: We recommend residency training programs lasting at least one year focused on one area of nursing care to be offered in all health care delivery institutions. ▪ Residency should focus on at least one area of specialty so the nurse has the opportunity to develop in-depth clinical patient population knowledge in that area. ▪ Improved follow-through evaluation of nursing graduates that identify practice-educational gaps. ▪ Evaluation of the residency program should include patient outcomes. ▪ To offset the costs of these programs, they recommend lower entry-level salaries for the residency year (similar to physical therapy residencies).	1. Ethnographic qualitative study 2. Survey of the AACN members 3. Survey of NSNA members	1 year	Conclusions related to this initiative: ▪ 3 apprenticeships were studied, including cognitive, clinical judgment and know-how, and ethical comportment. It was found that these apprenticeships must be integrated. ▪ Students and faculty alike pointed to need for yearlong residency programs. ▪ Nearly no planned interdisciplinary experiences took place in prelicensure programs. ▪ Few students reported confidence in detecting subtle clinical changes in their patient's condition and little follow-through was possible in prelicensure programs. ▪ Recommend students continue to care for 1-2 patients in their prelicensure program; researchers think larger patient care assignments will create a gap in the student's understanding of the nurse patient relationship due to insufficient time for learning and reflection.

Project	Description	Elements	Measurement	Length	Status/Results
11 "Evidence-Based Nursing Education for Regulation (EBNER)," 2006, and related Systematic Review of Studies on Nursing Education Outcomes: An Evolving Review," 2006, are available here: https://www.ncsbn.org/208.htm Related research, NCSBN Research Brief Vol. 24, "A National Survey on Elements of Nursing Education" is available here: https://www.ncsbn.org/360.htm **National**	Report of the 2006 Practice, Regulation and Education (PR&E) Committee, after being charged by the Board of Directors to identify evidence for the rules and regulations at boards of nursing. It was developed following a rigorous systematic review of related nursing education research outcomes and NCSBN research on nursing education.	Identified these education broad areas that are supported by the evidence: ▪ Adjunctive teaching methods; ▪ Assimilation to the role of nursing; ▪ Deliberate practice with actual practice; ▪ Faculty-student relationships; and ▪ Teaching methodologies (specified in the report).	Methodology available in the final report. Utilized the following levels of evidence: I. RCT, meta-analyses, systematic or integrative review – strongest level of evidence. II. Quasi-experimental, correlational, descriptive, survey, evaluation and qualitative designs – next strongest level. III. Expert opinion and consensus statements – weakest level, but adds value to professional research, especially when there isn't available evidence.	N/A	Systematic review identified: ▪ Assimilation to the role of nursing was identified as a major element, and this includes transition to practice programs. ▪ The systematic review identified feedback and reflection as integral threads in pre-and postlicensure learning.

Project	Description	Elements	Measurement	Length	Status/Results
12 Fink, R., Krugman, M., Casey, K. & Goode, C. (2008). The graduate nurse experience: Qualitative residency program outcomes. *JONA*, 38(7/8), 341-348. **National**	These are qualitative results from the UHC/AACN residency program; data have been generated since 2002, using 37 academic sites with more than 5,000 graduate nurses. The purposes of this study were to analyze the qualitative data from larger study and to determine if the themes they identified could be used convert open-ended questions to quantitative questions. A convenience sample of 1,058 graduates hired between May 2002 and September 2003 and who had fully completed the program were used. Of those respondents, 434 completed the surveys for all three periods. Excellent examples of student "stories" and comments were provided.	See the University HealthSystem Consortium/ American Association of Colleges of Nursing report for specifics of the residency.	Casey-Fink Graduate Nurse Experience Survey	Residency program is one year long.	▪ Reported difficulty with skills, particularly as they moved into a more independent role and more complex situations. ▪ 24% were stressed at baseline; 11% were stressed at 6 months; 18% were stressed at 12 months. ▪ 8% reported no role difficulties at baseline; 28% had none at 6 months, and 58% had none at 1 year. ▪ Transition difficulties included role changes, lack of confidence, workload, fears, and orientation issues. ▪ When asked what could be done to help residents feel more supported, 24% at baseline, 34% at 6 months and 43% at 12 months reported they already felt supported. Some areas where they expressed needing more support included feedback, mentorship, manager support, preceptor support, skills practice, time management, patient case discussion, gradually increased ratios, and introductions to physicians and staff. ▪ The UHC/AACN residency quantitative and qualitative data support that outcome measures dip at 6 months, making this a "critical" period for graduate nurses. ▪ Graduate residents expressed high satisfaction with their chosen career. ▪ Frustration with work environment, including unrealistic ratios, tough schedule, futility of care, and lack of support from ancillary personnel. ▪ Consistent with other studies, new nurses are developmentally unable to exercise intuition about subtle changes in patients.

Project	Description	Elements	Measurement	Length	Status/Results
13 Hofler, L. D. 2008. Nursing education and transition to the work environment: A synthesis of national reports. *Journal of Nursing Education*, 47(1), 5-12. **National**	2-part process to identify reports and to analyze their content. First organizations were identified (using experts), and then each site was used to retrieve and analyze their work. They purposely did not include regulatory agencies and NCSBN because "their mission is to protect the public." They identified 15 organizations and 35 reports.	Reports identified were between 1995-2005. For inclusion, each report: ▪ Was published by a nursing professional organization. ▪ Included recommendations about nursing education and the transition of nurses to the work environment. ▪ Did not focus primarily on regulatory issues.	The data were reviewed for themes, which were then cross-compared from each report to develop an understanding of the recommendations. Five thematic categories were identified.	N/A	Themes identified were: ▪ Standards, credentialing, regulation and accreditation, including recommendations on regulation, accreditation, standardization via licensure, and standardization of professional credentialing. This theme was most closely related to our work, and synthesis of the recommendations included differentiation of practice through accreditation and licensure; articulation of competence for differentiated roles; development of political activism; and funding at the national, state and local levels. Other themes included: ▪ Capacity and infrastructure of the educational system. ▪ Collaboration and integration with others, including those outside of nursing. ▪ Incentives in the health care delivery system for the development of a highly educated workforce. ▪ Transition to work environment includes recommendations that describe the transition of new nurses from an academic to a practice setting. That is, they are recommending more collaboration between education and practice.

Project	Description	Elements	Measurement	Length	Status/Results
14 Joint Commission White Paper (2002), entitled: "Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis" Report available: http://www.jointcommission.org/Nurses/ **National**	23 esteemed healthcare professionals, from nursing and other disciplines, representing education, practice and regulation, developed a white paper that calls for a "standardized, post-graduate nursing residency program," similar to that from ACGME, with funding to support the training.	Suggested areas of emphasis include: ▪ Team training ▪ Support of nursing orientation ▪ Support of in-service and continuing education ▪ Creation of career ladders ▪ Seek federal support for the transition programs			Reported on the high cost of nurse turnover; assuming a turnover rate of 20 percent, with a hospital employing 600 nurses, it will cost about $5,520,000 to replace them (research shows it costs $46,000 to replace a medical/surgical nurse and $64,000 to replace a critical care nurse). Cites evidence from the Illinois state disciplinary records that cite temporary nurses having increasingly more medical error investigations (relates patient safety to retention rates). Provides data to support new nurses receiving little orientation/transition. Flexner Report of 1910 made medical residencies obligatory, no such requirement exists for nursing. Medical residencies are partly paid for by medicare monies and are standardized through ACGME.

Project	Description	Elements	Measurement	Length	Status/Results
15 Krugman, M., Bretschneider, J., Horn, P.B., Krsek, C.A., Moutafis, R.A. & Smith, M.O. (2006). The national post-baccalaureate graduate nurse residency program. *Journal for Nurses in Staff Development*, 22(4), 196-205. **National**	This was a description of the UHC/AACN residency program with background literature that supports transition to practice. Increased stress in the new graduate, the education-practice gap, and first-year turnover were discussed; they reported literature that estimates the cost of replacement of a nurse as high as $81,000; indirect costs include preceptor exhaustion, decreased morale, time managers spend interviewing.	See the University HealthSystem Consortium/ American Association of Colleges of Nursing report for specifics of the residency. Each site commits to a 0.5 to 1.0 FTE funded coordinator position.	McCloskey Mueller Satisfaction Scale; Gerber Control Over Practice Scale; Casey-Fink Graduate Nurse Experience Survey; UHC Demographic Database; Investigator Developed Residency Evaluation Form	1-year; phase one 1:1 baccalaureate prepared preceptor; phase two for second 6 months the resident continues with monthly seminars with a resident facilitator. In phase two the residents are encouraged to find a mentor and construct a career plan.	▪ These were preliminary results (first 6 sites); more up-to-date results were provided in the UHC/AACN section. However, this report found: ▪ The importance of the cohort group role, with the importance of the monthly support sessions. ▪ Turnover rate for this early report of the residency program was 8%. ▪ Report goal for establishing a national model with goal of obtaining federal reimbursement. ▪ Transition to practice is not completed for 9-12 months, particularly because of stress, self-perceived competency, setting priorities, and these are related to safety. ▪ Cost of residency is less than costs to recruit new nurses.

Project	Description	Elements	Measurement	Length	Status/Results
16 Lynn, M. R. (2007). "Initial Evaluation HRSA-Funded Residency and Internship Programs." Funded by HRSA Contract: HH- SH2302 00632050C This preliminary report is available from HRSA or NCSBN. **National**	Evaluative study of the aggregate of transition programs they fund, though participation is voluntary. 12 of the HRSA-funded sites agreed to take part. Questions: Are there differences between ▪ Hospital vs. home health ▪ Length (less than 6 mos. vs. more than 6 mos.) ▪ Classification of residents (new graduates vs. reentry) ▪ Degree ▪ Magnet status ▪ Unit of employment ▪ HRSA vs. UHC/AACN	N/A This wasn't one planned residency, but instead it consisted of many different types.	▪ Gerber's Control Over Nursing Practice Scale ▪ McCloskey/Mueller Satisfaction Scale ▪ Casey-Fink Graduate Nurse Experience Survey ▪ These tools were also used in the UHC/AACN study	10 weeks - 3 years	Many of the groups did not have large numbers. They found significant differences between: ▪ Program start and finish, which supports these programs. ▪ No differences between hospital and home health residents; this provides some support for including all settings. ▪ No differences between less that 6-month-long programs and over 6-months (except shorter programs felt they were better paid), though numbers were small. ▪ There were differences between new graduates and nurses who change specialties. ▪ No differences between educational groups. ▪ Residents in magnet hospitals were more satisfied. ▪ There were differences across specialties. ▪ There were differences between the HRSA and UHC/AACN residents.
17 NCSBN's Analysis of Nursys® Disciplinary Data from 1996 – 2006 (December 2007) Unpublished report available from NCSBN **National**	Report of 59,695 nurses reported by 44 boards of nursing for disciplinary action between January, 1996, and the end of December, 2006.	N/A	Nursys® electronic information system	10 years of disciplinary data	Trend of increasing discipline over the 10 year period.

Project	Description	Elements	Measurement	Length	Status/Results
18 NCSBN Employer Survey (2004) Research Brief is available: https://www.ncsbn.org/360.htm Vol. 14, "Report of Findings from the 2003 Employers Survey" **National**	Surveys completed by 1,230 employers from all settings.	N/A	Survey was investigator constructed.	N/A	Employers answered "Yes definitely" to overall preparation to provide safe, effective care: ▪ ADN – 41.9% (n=321) ▪ BSN – 41.9% (n=239) ▪ Diploma – 48.8% (n=106) ▪ LPN – 32.9% (n=237)
19 NCSBN Interim Results of Post-Entry Study: Preliminary report available from NCSBN. Full report is due in September 2008. **National**	Longitudinal, qualitative study of new nurses with 1,111 e-mail responses to date. LPN responses not coded yet.	N/A	Email responses with qualitative analysis about how competence develops	N/A	Implications for transition to practice: ▪ The diversity of practice settings and extreme acuity of hospital settings suggest a site-specific transition program with a preceptor for the first year. ▪ The narratives demonstrated a real need for novice nurses to revisit action and decisions and reflect on alternate pathways (i.e., need to debrief and reflect). ▪ Need for role clarification relative to LPNs and PCAs. Supervision of LPNs or PCAs was either minimal or totally absent.
20 NCSBN's Transition Study (2006) Research Brief available at: https://www.ncsbn.org/360.htm Vol. 22 – "Report of Findings from the Practice and Professional Issues Survey; Transition to Practice: Newly Licensed RN and LPN/VN Activities." April 2006 **National**	NCSBN conducted a survey on 628 new nurses and 519 new LPNs related to transition to practice issues. Survey was investigator constructed.	N/A	Survey was investigator constructed.	N/A	▪ LPNs assigned to care for patients earlier and caseload heavier ▪ 38.9% of RNs participated in "ships" + orientation ▪ 16.2% of LPNs participated in "ships" + orientation ▪ Graduates of ADN programs were more likely than BSN graduates not to have a "ship" ▪ Across nation, transition programs were quite variable ▪ Research Brief is available online

Project	Description	Elements	Measurement	Length	Status/Results
21 NCSBN data presented at a national forum, entitled "Transition of New Nurses to Practice: A Regulatory Perspective," in Chicago, February 22, 2007. **National** – PNs	400 new LPNs/VNs; 231 preceptors; non-experimental, comparative, nurse-preceptor dyad design. Aims: ▪ To describe the transition experience of newly licensed LPNs/VNs ▪ To identify factors that influence transition to practice of LPNs/VNs ▪ To examine the impact of the transition experience on clinical competence and safe practice issues of newly licensed LPNs/VNs	N/A	Design: non-experimental, comparative, nurse-preceptor dyad. ▪ Clinical competence defined by 35 questions on core set of functions, with validation by preceptors. ▪ Cronbach's alpha=.93 ▪ Content validity and construct validity established. ▪ Tool for practice errors contained 21 items.	N/A	▪ Transition experiences vary, with those in hospitals more likely to have internship experiences and longer programs. ▪ More likely to make practice errors when they reported they were less competent and/or more stressed. ▪ Average length of a transition program was 4.7 weeks. Because effect size (mean length of transition programs) was so small, there was not much evidence to be gleaned from those in transition programs vs. those without programs.

Project	Description	Elements	Measurement	Length	Status/Results
22 NCSBN data presented at a national forum, entitled "Transition of New Nurses to Practice: A Regulatory Perspective," in Chicago, February 22, 2007. **National**- RNs	▪ N=560 new nurses; N=231 preceptors ▪ Non-experimental, comparative, nurse-preceptor dyad design. ▪ To describe the transition experience of newly licensed nurses ▪ To identify factors that influence transition to practice ▪ To examine the impact of the transition experience on clinical competence and safe practice issues of newly licensed RNs	N/A	▪ NCSBN's Clinical Competency Assessment Scale – 35 items assessing 4 dimensions of clinical competence ▪ NCSBN's Practice Errors Survey – 21 items measuring practice errors. ▪ Survey was investigator constructed and validation and reliability established	N/A	▪ Preceptors and new graduate ratings were similar with competence ratings (no significant differences); conversely, new RNs reported significantly more practice errors than their paired preceptor did. ▪ Areas new nurses acknowledge weaknesses: utilize research; recognize when demands exceed capability; delegating and supervising. ▪ Vulnerable period (less competent; more stress) was 3-6 months when new graduates were less supervised ▪ During first 3 months, those with a primary preceptor rated themselves as performing at significantly higher levels than those without the primary preceptor. ▪ When more competent in clinical reasoning ability – significantly fewer errors ▪ When more competent in communication and interpersonal relationships – significantly fewer errors ▪ When transition programs (in hospital setting) addressed specialty, significantly fewer errors. ▪ Stress was positively related to practice errors. ▪ Highest stress levels occurred in 3-6 months of practice. ▪ 19% who had an internship program reported they were likely to leave their position within 6 months; 33% without an internship program reported they were likely to leave their position within 6 months.

Project	Description	Elements	Measurement	Length	Status/Results
23 National Survey of Nursing Home Workforce Satisfaction (2006) Report available online: http://www.myinnerview.com/downloadPDF.php?pdf=miv/reports/MIV_NHWS07_FA.pdf **National**	Collected satisfaction data from 106,858 staff working in 1,933 nursing homes in every state, except Alaska.	N/A	Utilized confidential surveys completed by employees and returned to MyInnerView during 2006. Psychometrics of the instrument were good. To delve more deeply into employee concerns, they identified priority items. Then they calculated a priority rating on how each item ranked, both in terms of its average score and the strength of its correlation with workplace recommendation. These top ratings (see results column) reflect areas where most nursing homes need improvement and where the greatest impact in satisfaction is likely.	N/A	▪Generally found good satisfaction of nursing home employees. ▪The priority listings were very relevant for our transition work: 1) help with job stress; 2) management listens; 3) management cares; 4) training to deal with difficult residents; and 5) training to deal with difficult family members.

Project	Description	Elements	Measurement	Length	Status/Results
24 Smith, J. & Crawford, L. (2003). Medication errors and difficulty in first patient assignments of newly licensed nurses. *JONA's Healthcare Law, Ethics, and Regulation*, 5(3), 65-67. **National**	This was an NCSBN national study new graduate RNs and LPNs with a focus on medical errors. The surveys were sent to stratified random samples of 1000 RNs (65.5% return rate) and 1000 LPNs/VNs (62.3% return rate).	N/A	Investigator designed tool with new nurse self reports.	N/A	▪ 40% of the new LPN/VN graduates were employed in long-term care facilities, with 38% in hospitals and 17% in community or ambulatory care settings. ▪ 87% of the new RN graduates were employed in hospitals, with 6% in long-term care facilities and 4% in community or ambulatory care settings. ▪ 63% of the new RN graduates were employed in urban/ metropolitan areas, while 47% of the new LPN/VN graduates were employed in urban/ metropolitan areas. ▪ 49% of the new RN graduates and 41% of the new LPN/VN graduates made errors or were involved in errors. ▪ Of the errors, 75% of the new RN graduates and 71% of the new LPNs/VN graduates were involved with medication errors. Forty percent of the new RN graduates and 47% of the new LPN/VN graduates were involved with errors related to patient falls. ▪ Some of the reasons for errors included inadequate staffing (74% of the new LPN/VN graduates and 70% of the new RN graduates), communication (44% of new RN graduates and new LPN graduates), and inadequate orientation (27% of the new LPN/VN graduates and 18% of the new RN graduates. ▪ In hospitals new RN graduates cared for an average of 3 patients in their first assignment, and that occurred on an average of 8 days after being hired. New LPN graduates cared for an average of 4 patients and that occurred on an average of 6 days after being hired. ▪ In nursing homes new RN graduates averaged 25 patients at the start, whereas LPNs/ VNs cared for an average of 26 patients on their first assignment.

Project	Description	Elements	Measurement	Length	Status/Results
25 University HealthSystem Consortium/American Association of Colleges of Nursing (UHC/AACN): Williams, C.A., Goode, C.J., Krsek, C., Bednash, G.D. and Lynn, M. R. (2007). Postbaccalaureate nurse residency 1-year outcomes. *JONA*. 37(7/8), 357-365. **National**	This is another national, standardized model that is being implemented in 34 sites in university healthcare settings in 24 states.	▪ Core curriculum with focus on leadership, research based practice, professional development, communication, critical thinking, patient safety, and skills. ▪ Clinical guidance with a preceptor. ▪ Access to a resident facilitator for role development and guidance. ▪ Residents also participate in usual orientation procedures for that institution. ▪ Program designed for BSN graduates, though many agencies have developed alternative programs for ADN and diploma graduates.	They collect data on skill development and support, perceptions of control over practice, job satisfaction, retention, and demographics. Tools include: ▪ Casey-Fink Graduate Nurse Experience Survey ▪ Gerber's Control Over Nursing Practice Scale ▪ McCloskey Mueller Satisfaction Scale	12 months	Ongoing ▪ Turnover of 12%, compared to literature reports from 36%-55%. ▪ Weren't able to gather reliable cost data ▪ Similar to our transition study, showed vulnerability at 4-6 months (dip in scores, with recovery after 6 months). ▪ Dynamics of what occurs during a residency program are complex. ▪ Significant increments were seen on the Casey-Fink scales for Organize and Prioritize and Communication-Leadership. One of the two cohorts showed significant increases in the Support Scale.
26 Versant: Beecroft, P.C., Kunzman, L. and Krozek, C. (2001). RN internship: Outcomes of a one-year pilot program. *JONA*. 31(12), 575-582. www.versant.org **National**	Implemented in over 30 organizations nationwide, and they have over 5 years of data (over 3,000 residents). Unique in that it supports a cultural change by incorporating committees within the agency to oversee and plan activities; by including preceptors, mentors, and trained facilitators; being based on a business model; and being a national, standardized model.	Developed using Ohio State University's DACUM method; includes some specialty curriculum. ▪ Protected time. ▪ Looping where residents go to other units. ▪ Use a portal Web where competencies are validated. ▪ One-to-one preceptors. ▪ Mentor who is non-evaluative. ▪ Support groups with trained facilitators for a safe, confidential environment. ▪ Classroom and skills lab education.	Some of the tools used include: ▪ Professional Subscale from Corwin's Nursing Role Conception Scale ▪ Schutzenhofer Professional Nursing Autonomy Scale ▪ Skills Competency Self-Confidence Survey (investigator designed) ▪ The Slater Nursing Competencies Rating Scale ▪ The Organizational Commitment Questionnaire (OCQ) ▪ The Anticipated Turnover Scale (ATS)	18-22 weeks (while the program lasts only 18-22 weeks, from personalcommunication we found that the preceptorship and/or mentoring often continue)	▪ Cost benefit positive ▪ ROI (%) of 67.3 ▪ Increases retention (6% turnover) ▪ Increase competency While the 2001 publication is fairly true to the program, there have been changes (such as from 6 months to 18-22 weeks). Other publications are in process, from personal communication.

Project	Description	Elements	Measurement	Length	Status/Results
27 California Institute for Nursing and Health Care Information available here: http://www.cinhc.org/ **Statewide**	A collaborative project in California where they are working to redesign nursing education. Their work groups include: ▪ Academic/Service Partnerships; ▪ Professional and Clinical Role Development; ▪ Economical Models for Funding Education; ▪ Collaborative Education; ▪ Faculty Recruitment and Development; ▪ Simulation; ▪ New Graduate Transition: Residencies; ▪ Out of the Box – Big Bold Steps for Innovation and Evaluation; and ▪ Synthesis Advisory Team.	Regarding the transition programs only: ▪ Using medical terminology of "attending" nurse who will be with new nurses for 3 years. ▪ Developing collaborative partnerships. ▪ Goal is to go across all settings. ▪ Using the Oregon Model for inspiration, would like a seamless movement from ADN to BSN degrees in nurses. ▪ Are exploring long-term funding. ▪ Study demonstration models. ▪ Compile standards for new graduates based on evidence.	N/A	Recommend 1 year of transition, and 3 years to move to proficiency	Are in the process of writing a white paper and making recommendations formal. Further, there is a partnership of service in California looking into residency programs. It is being led by nurse leaders from the Association of California Nurse Leaders, with participation from nurse leaders at Tenet Healthcare and Scripps. There is interest in the dedicated nursing education unit that's being used at the University of Portland, Oregon.
28 Kentucky's legislation Information available here: http://www.kbn.ky.gov/education/pon/entry/ **Statewide**	Legislation for 120 hours of precepted experience within nursing program (directly before graduation) and 120 hours after graduation with the employer, but before fully licensed.	▪ Education and practice are both responsible. ▪ Monitored through regulation. ▪ Must pass NCLEX within 6 months. ▪ Integrated practicum in education and clinical internship following graduation. ▪ Across settings and education levels.	NCSBN and a Kentucky University measured outcomes.	120 hours of precepted experiences before and after graduation.	Outcomes being measured, and NCSBN will review the results.

Project	Description	Elements	Measurement	Length	Status/Results
29 Massachusetts Department of Public Health Board of Registration in Nursing: "A Study to Identify Evidence-Based Strategies for the Prevention of Nursing Errors" – Preliminary Data Report available from NCSBN. **Statewide**	Descriptive study of nursing errors found in 78 complaint cases involving 34 RNs and 44 LPNs who practiced in nursing homes in Massachusetts; sampling technique was presented.	N/A	Used a case analysis format, with data being collected using a modified Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP™) audit instrument.		▪ Seven of the 44 LPNs were licensed for 12 months or less; there were no novice RNs in the analysis. ▪ Applicable to the Transition to Practice initiative, errors were linked to inexperience to particular clinical events; lack of familiarity with the practice setting; lack of consistently assigned preceptors and the adequacy of the novice nurse's transition program. ▪ Interruptions challenged the novice LPNs who made errors, thus effecting their organizational, prioritizing, communication, delegation, and task completion skills. ▪ Study calls attention to the potential patient safety benefit of a novice nurse transition program that provides sufficient time, supervision, and support to new nurses.
30 Mississippi Office of Nursing Workforce Nurse Residency Program Information available: www.monw.org **Statewide**	6-month residency/ internship program, which is implemented through the Mississippi Office of Nursing Workforce.	▪ Coordinator ▪ Weekly meetings/ seminars ▪ 2 weeks of a general orientation ▪ Includes NCLEX reviews ▪ Unit orientation (or specialty content) included ▪ Work up to a full patient load ▪ Preceptors will mentor 1-2 residents/interns	Factor Analysis of Tool (Halfer-Graf Job/Work Environment Nursing Satisfaction Survey): ▪ Resourcefulness – 4 items ▪ Mutual respect – 3 items ▪ Empowerment – 4 items ▪ Nonjudgmental work environment – 2 items ▪ Becoming part of a team – 3 items ▪ Lifelong learner – 3 items ▪ Degree of job fit – 2 items	3-6 months	▪ Savings of over $4 million through elimination of agency/travel nurses ▪ Savings of $1.1 million through decreased turnover ▪ Reduction of vacancy by 47% ▪ Reduction of turnover by 10% ▪ Patient satisfaction increased 10% ▪ 80% of residents completed program

Project	Description	Elements	Measurement	Length	Status/Results
31 North Carolina's Transition program Information is available here: http://www.ffne.org/transition.cfm **Statewide**	Long-range goal is to create a regulatory model for transitioning new nurses in NC by 2015. Our Research Department is using our transition tools, so these results should enrich our 2006 study results.	Phase I – studying the current transition practices and their impact on newly licensed nurses. Phase II – will focus on developing evidence-based, population-specific transition programs for NC.	Phase I ▪ NCSBN's Clinical Competency Assessment Scale – 35 items assessing 4 dimensions of clinical competence. ▪ NCSBN's Practice Errors Survey – 21 items measuring practice errors. ▪ NCSBN's Risk for Practice Breakdown tool – Error index will be generated based on above tool.	N/A	Data collection taking place now, and study will be completed by summer of 2008.
32 Vermont Nurse Internship Program (VNIP) Information available: http://www.vnip.org/ **Statewide**	A standardized, statewide internship program that incorporates all levels of education (from LPN through BSN) and takes place in all settings. The model has been used in over 20 agencies across the state, in both acute and long-term care. To date over 500 interns have been enrolled in the program. Unique aspects of this program include that it has been used across all settings; that they have a standard program whereby they train their preceptors; and this is a collaborative project between regulation, practice and education.	▪ Educate their preceptors and have started a statewide cred (approximately 200 hours of educator time for each internship cohort and/or session). ▪ Program components include: managed care, standards of care, cultural competence, quality improvement, IVs, medications, pain management.	COPA model for competencies Retention rates Recruitment Satisfaction	Minimum 10 weeks; specialty care internships sometimes require up to 12 months	▪ Pre-internship retention was 75%, after program is 93%. ▪ 48% of interns were recruited from out of state. ▪ Increased satisfaction. ▪ Informal survey of longterm settings showed positive response to the transition program.

Project	Description	Elements	Measurement	Length	Status/Results

33
Wisconsin Nurse Residency Program (WNRP)
 	
Information available here: http://wnrp.org/
 	
Statewide
	Statewide with 40 plus hospitals, including a large rural group, which is a unique aspect of this program. They have enrolled over 300 new graduates in this program.	▪ Clinical coach
		▪ Learn to think like a professional
		▪ Meet once a month
		▪ Reflection and feedback
		▪ Focus on:
		  ▪ Critical thinking
		  ▪ Systems
		  ▪ Failure to rescue
		  ▪ Best practice
		  ▪ EBP
		  ▪ Delegation
		  ▪ Communication
			They look at job stress, organization commitment, clinical decision-making, and behavior in the professional role. Tools include:
			▪ Porter and Steers Organizational Commitment
			▪ Jenkins's clinical decision-making
			▪ Professional Nursing Behavior
				12 months	Just finished 3 year HRSA report and have a grant for another 3 years. Are looking to possibly collaborate with NCSBN on use of our transition tool. Will focus on preceptors this time. Increase of retention; rural settings found it highly beneficial.

34 Bjørk, I.T. and Kirkevold, M. (1999). Issues in nurses' practical skill development in the clinical setting. Journal of Nursing Care Quality. 14(1), 72-84. **Individual**	▪ Longitudinal, videotaped interviews of 4 nurses from 8-14 months after licensure ▪ Interviews with patients and nurses ▪ Practicing skills of dressing changes and ambulation	N/A	▪ Videotapes ▪ Interviews with patients and nurses	Had short orientation of 3 weeks	While the nurses became more efficient, they made the same omissions after 14 months: ▪ Contaminated wounds ▪ Misuse of gloves ▪ Failed to wash hands ▪ Dangerous tube removal ▪ Interviews with patients showed caring over the year ▪ Inadequate physical support during ambulation ▪ Privacy not maintained Conclusion: Limited orientation/transition program did not allow for reflection and/or feedback so that the same errors were made. Results are relevant for regulation and public protection.

Project	Description	Elements	Measurement	Length	Status/Results

35
Children's Memorial Hospital, Chicago:
 	
Halfer, D. (2007). A magnetic strategy for new graduate nurses. Nursing Economics. 25(1), 6-11.
 	
Individual
	Designed an internship program to bridge the gap between the academic and service settings. Based on Benner's and Kramer's classic research. Program includes 80 hours of classroom content. Unique aspects include: Web-based delivery of content; professional transitioning that allows for a safe environment for sharing mistakes they made or almost made; opportunities to rotate throughout clinical areas; phased preceptor model; preceptors receive 5% hourly pay differential; code debriefing for support.	▪ Classroom learning:
		  ▪ Family
		  ▪ Assessment
		  ▪ Safety
		  ▪ Pain
		  ▪ Abuse
		  ▪ Diversity
		▪ Skills labs
		▪ Precepted orientation
		▪ Professional transitioning sessions
		▪ Clinical learning exchanges
		▪ Clinical mentors
		▪ Code debriefing
			Recruitment and retention	1-year program	▪ Recruitment increased by 28%.
					▪ 7% reduction in nurse vacancy rate.
					▪ Decrease in turnover from 29.5% to 12.3%.
					▪ Cost savings of $707,608 per year.
					▪ Steadily improved nurse satisfaction.

36
Dartmouth-Hitchcock Transition program:
 	
Beyea, S.C., von Reyn, L., and Slattery, M.J. (2007). A nurse residency program for competency development using human patient simulation. *Journal for Nurses in Staff Development*. 23(2), 77-82.
 	
Individual
	To date, 375 residents have been through this residency program. There is a didactic portion of the program and various tracks of the program. Classes include about 40 hours of didactic content and 40 hours of simulated learning. The uniqueness of this program is the focus on simulation, and especially for low frequency, but high risk events.	▪ Preceptor assigned in first week.
		▪ Ongoing support of preceptor, clinical education, clinical specialist after program ends.
		▪ Didactic includes: health systems, information management, safety, and clinical/functional.
		▪ Focus on improving novice response to "failure to rescue."
		▪ Reflection/debriefing focus.
		▪ Focus on high-risk, low frequency situations, as well as high frequency, commonly occurring clinical events.
		▪ Didactic concepts include:
		  ▪ Systems
		  ▪ Information management
		  ▪ Safety
		  ▪ Functional
			▪ Weekly self-rating of confidence, competence, readiness for independent practice.
			▪ Nurse Resident's Readiness for Entry into Practice Competence Questionnaire, adapted from Babenko-Mould's Self-Efficacy for Professional Nursing Competencies Instrument.
			▪ Weekly simulator evaluation.
				12 weeks, though institution provides ongoing support	▪ Personal communication: Hospital mortality and cardiac arrests fell after program instituted… however these data should be cautiously considered because at the same time the organization started an early response team.
					▪ All three measures of confidence, competence, and readiness to practice increased significantly after the program.
					▪ Great improvement in IV medications, use of equipment and response to physiologic emergencies after program (attributed to simulations).

Project	Description	Elements	Measurement	Length	Status/Results
37 del Bueno, 2005. A crisis in critical thinking. Nursing Education Perspectives. 26(5), 278-282. **Individual**	Description of ongoing work with the Performance Based Development System (PBDS), used in 350 health care agencies and 46 states.	▪ Clinical reasoning/critical thinking. ▪ Clinical coaching. ▪ Nontraditional strategies (not spelled out). ▪ Patient situations that require application, analyzing, and synthesis.	Analysis of PBDS tools	10-12 weeks find positive results	▪ 35% of graduates met employer expectations for clinical judgment. ▪ Examples given where 50% of the new nurses would miss recognizing life-threatening situations.
38 Ebright, Urden, Patterson and Chalko (2004). "Themes Surrounding Novice Nurse Near-Miss and Adverse-Event Situations" **Individual**	Purpose of the study was to identify the human performance factors that characterized novice nurse near-miss/adverse-event situations in acute care. Experience since completion of a nursing program ranged from 6 months to 12 months.	N/A	8 Retrospective interviews of novice nurses about details of near-miss or adverse-event situations. Interview team consisted of: ▪ Faculty member with expertise in complexity ▪ Faculty member with expertise in critical care and the human performance framework ▪ PhD prepared engineer with expertise in human performance	Findings suggest support up to 1 year following graduation.	Themes surrounding near-miss/adverse-event cases: ▪ Clinically focused critical thinking ▪ Seeking assistance from experienced nurses ▪ Knowledge of unit and workflow patterns ▪ First-time experiences ▪ Time constraints ▪ Hand-offs ▪ Influence of peer pressure and social norms ▪ Losing the big picture ▪ Novice assisting novice Of the 12 recruited participants, 7 had at least 1 near-miss event, and 1 provided 2 events. Most, but not all, errors were related to medication administration. Study pointed out the importance of novice nurses being able to reflect about their own patient situations and those of others.

Project	Description	Elements	Measurement	Length	Status/Results
39 Elfering, A., Semmer, N.K. & Grebner, S. (2006). Work stress and patient safety: Observer-rated work stressors as predictors of characteristics of safety-related events reported by young nurses. *Ergonomic*, 49(5-6). 457-469. **Individual**	Study conducted in 19 hospitals in Switzerland for a period of 2 working weeks on 23 novice nurses (first 18 months). Stressful events were recorded by the novice nurses, and chronic work characteristics were rated by trained observers, thus providing more validity to this study than those with only self-reports.	N/A	Participants were instructed to document every stressful situation they experienced, requiring an open-ended discussion followed by quantitative items. Compliance with safety regulations was measured with one item, and observers rated chronic job stressors and control on the Instrument for Stress Oriented Task Analysis. Observations were complemented by interviews with the employee, supervisors, and colleagues and consulting with organization documents, if necessary.	N/A	▪ 62 events, or 2.65 events per person, were related to patient safety ▪ Safety events included: documentation, near misses with medication, incomplete patient briefing, delays in care, patient casualties (falls, etc.). ▪ Stressors, most notably concentration demands and lack of control, related endangered patient safety. ▪ Recommendation: training of novice nurses should address the association between workload and patient safety and should education nurses in self-management strategies for stress.
40 Halfer, D., Graf, E. & Sullivan, C. (2008). The organizational impact of a new graduate pediatric mentoring program. *Nursing Economics*, 26(4), 243-249. **Individual**	This is further research from the Children's Memorial Hospital program in Chicago, Illinois. The study compared 84 new graduates that were in the pre-implementation group (hired between September 2001 and August 2002) and 212 in the post-implementation group of the internship program (hired between September 2003 and August 2005). This study was unique in that it compared graduates who had an internship program with those who did not. They reported from the literature a high replacement cost of replacing nurses who leave ($44,000 or their annual salary).	See the Children's Memorial report for specifics on the internship program.	Halfer-Graf Job Work Enviroment Satisfaction Survey; reliability and validity had been established.	1 year in length	▪ Job satisfaction was significantly higher when the new graduates had participated in the internship program than when they had not. ▪ Pre-internship turnover was 20% compared to post-internship of 12%. ▪ It took 18 months for satisfaction to increase in some areas.

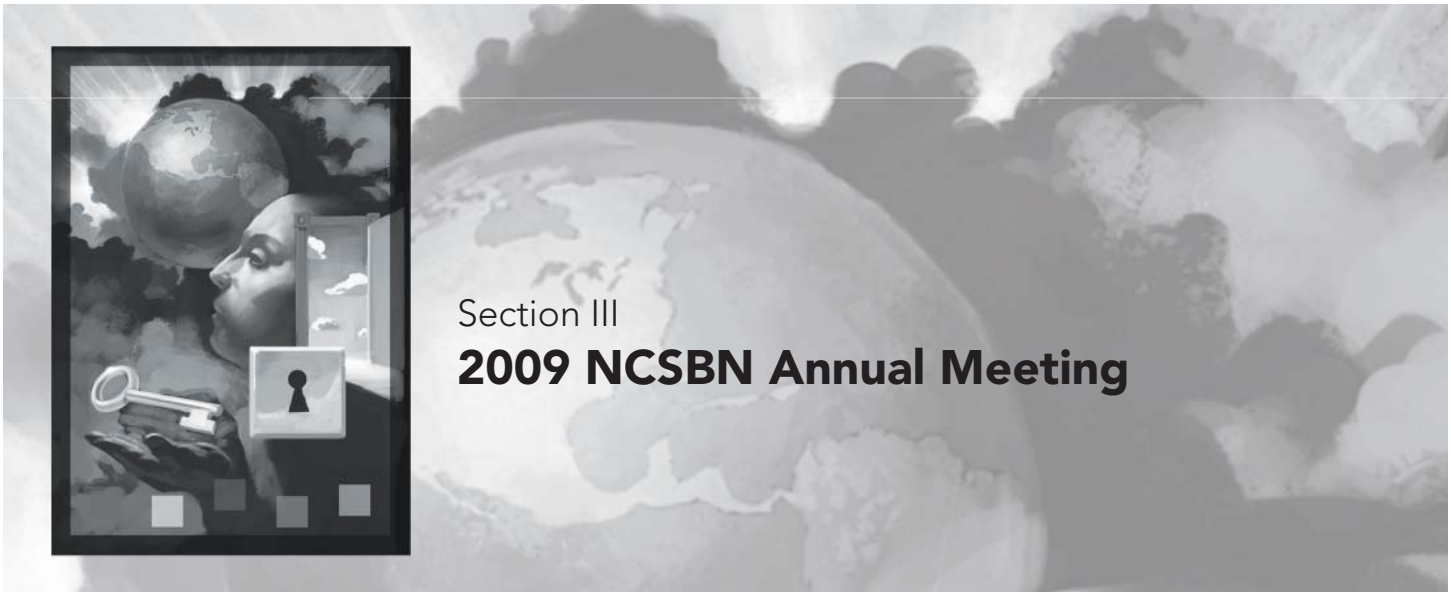
Project	Description	Elements	Measurement	Length	Status/Results
41 Johnstone, M. J. and Kanitsaki, O. (2006). Processes influencing the development of graduate nurse capabilities in clinical risk management: An Australian study. **Individual**	Exploratory-descriptive case study approach, with qualitative and quantitative data collection and analysis.	Elements (from literature) of opportunities putting graduate nurses at risk for error: ▪ Inadequate education ▪ Inadequate supervision ▪ Workplace bullying ▪ Hierarchical structures inhibiting performance ▪ Poor planning and scheduling of work ▪ Poor skill mix ▪ Heavy workload ▪ Time pressure	Over a 12-month period and in 5 phases, 6 questionnaires, focus groups, and interviews. The 4 sampling units included: graduate nurses, key stakeholders, patient outcome data, and literature. Data were analyzed using content and thematic analysis strategies. A total of 63 questionnaires were completed. Additionally, 35 focus group and individual interviews were completed with new graduates and key stakeholders. Patient outcome data included: variance analysis of planned care against outcome; number of incident reports, patient complaints and patient feedback.	N/A	▪ "Deficit education" is not appropriate for teaching new graduates to avoid errors. That is, don't provide education with the idea that there is a knowledge deficit. Instead, the experiential aspects must be stressed. ▪ None of the graduates, having been introduced to clinical risk management, was directly involved in a preventable adverse event resulting in patient harm. ▪ New graduates personal characteristics for managing risks include: ▪ Being (hyper)vigilant of limitations as a beginner. ▪ Asking for assistance without fearing they'd be perceived as "not coping." ▪ Actively seeking supportive supervision. ▪ Actively seeking to decrease their workload.

Project	Description	Elements	Measurement	Length	Status/Results
42 Johnstone, M. J. and Kanist-saki, O. Johnstone, M. and Kanitsaki, O. In press. Patient safety and the integration of graduate nurses into effec-tive organisational clinical risk management systems and processes: an Australian study. Quality Management in Health Care [Accepted 21 May, 2007] **Individual**	Exploratory descriptive case study: ▪ 2 cohorts of graduate nurses undertaking a 12-month graduate nurse transition program ▪ Key stakeholders ▪ Outcomes data ▪ Literature review	N/A	Quantitative and qualitative data collection and analysis strategies were used. 12-month period in 5 phases. 6 survey questionnaires and 35 in-depth individual and focus group interviews.	Sample took part in a 12-month transition program. Clinical risk management was integrated by students within 3-4 months.	▪ Novice nurses were able to integrate patient safety with the system, during this 12-month program, within 3-4 months. ▪ Incident reporting increased from 2.6% at first to 9.8% over the 12 months because at first the novice nurses were reluctant to report incidents, but with support in learning about risk management they learned to complete incident reports. ▪ Key indicators validating that novice nurses developed this integration included familiarity with: ▪ Geographical layout of hospital ▪ Hospitals' policies regarding patient risk assessment tools ▪ Processes of evidence-based practice ▪ Incident reporting
43 Johnstone, M. J., Kanitsaki, O. and Currie, T. (2008). The nature and implications of support in graduate nurse transition programs: An Australian study. Journal of Professional Nursing, 24(1), 46-53. **Individual**	Exploratory-descriptive case study approach, incorporating both qualitatitve and quantitative analysis. The study was conducted over 12 months.	N/A	Used 6 survey questionnaires to neophyte nurses. Descriptive data was sought on: graduate nurse self reported confidence and competence, particularly with safety, evidence-based practice, managing risk in patients, seeking advice, recognizing limitations, making decisions, reporting incidents, and understanding risk management. Additionally, 35 individual and focus group interviews were conducted.	The period of support was largely dependent on the graduate, though they recommended at least 4 months duration.	Definition of support (p. 52): A process that aids, encourages, and strengthens and thereby gives courage and confidence to a new graduate nurse or a group of new graduates to practice competently, safely, and effectively in the levels and areas they have been educationally prepared to work." Support themes: ▪ Availability ▪ Approachability ▪ Being able to ask questions ▪ Prompted to engage in best practices ▪ Benevolent surveillance ▪ Feedback ▪ Given reassurance ▪ Backup ▪ Reflection (they call it "debriefing")

Project	Description	Elements	Measurement	Length	Status/Results
44 Latham, C., Hogan, M., Ringl, K. (2008). Nurses supporting nurses: Creating a mentoring program for staff nurses to improve the workforce environment. *Nursing Administration Quarterly*, 32(1), 27-39. **Individual**	A 3-year academic-hospital partnership was developed to create a mentoring program for nurses to improve the workplace environment: Nurses Supporting Nurses. This program was targeted for new graduates and new hires, though any staff RN was welcome to apply for the mentee role. Ninety two mentor-mentee teams were formed. The program was particularly focused on changing the culture of the workplace. Two hospitals with quite different organizational characteristics were utilized for the project. The purpose was to identify future bedside leaders who would assume supportive roles, thereby changing the culture of the unit.	▪ Hospital liaison to champion the project, and this liaison was key to the success. ▪ Interactive workshops on culture mindedness, which included team building. ▪ Creation of detailed Web pages, including videoclips of mentors. ▪ Sociometric analysis of RN camaraderie and informal leadership. ▪ Educational sessions on nurses supporting nurses. ▪ Cultural competence was presented. ▪ Speed meetings to help select mentors. ▪ Other sessions included team building, conflict resolution, communication, time management, healthcare system, financial concerns, quality care, patient satisfaction, and safety. ▪ Quarterly mentor support meetings.	▪ Overall nurse satisfaction ▪ Decisional involvement ▪ Cultural communication competency ▪ Retention and vacancy ▪ Patient satisfaction with nursing care ▪ 3 nurses sensitive areas, including falls, pressure ulcer prevention, and proper use of restraints	3-year	▪ Personality and learning styles are not the basis of successful mentor-mentee teams. ▪ Most nurses believed they were culturally competent and that the environment supported cultural sensitivity. ▪ Most nurses wanted more control over their working conditions. ▪ Improvements in patient and nurse satisfaction. ▪ Improvement in nurse vacancy and turnover. ▪ Improvement related to fall and pressure ulcer prevention and on the proper use of restraints. ▪ Using $100,000 per RN replacement charge, the 2 hospitals had a cost savings of $2.5 million.

Project	Description	Elements	Measurement	Length	Status/Results
45 Launch into Nursing: a collaboration between the University of Texas M.D. Anderson Cancer Center and The University of Texas Health Science Center at Houston, School of Nursing. Keller, J. L., Meekins, K. and Summers, B.L. (2006). Pearls and pitfalls of a new graduate academic residency program. *JONA.* 36(12), 589-598. **Individual**	Describe the design of a collaborative academic residency program for graduate nurses.	▪ Academic leadership course has become cornerstone. Also included simulations, including "Friday Night in the ER." ▪ Introduction to workplace resources, which included projects, small group discussions, introductions to a variety of roles, etc. ▪ Socialization was very important, as it has been cited as linked to retention and safety. ▪ Each was matched to a trained "clinical coach." Describes their curriculum map in detail. Will be helpful with module design. Areas from curriculum map include: ▪ Communication ▪ Systems thinking ▪ Safety ▪ EBP ▪ Socialization ▪ QI	Outcomes measured, with various tools: ▪ Progress to competent nurse (Benner) ▪ Knowledge ▪ Retention ▪ Intent to leave ▪ Job satisfaction ▪ Employee engagement ▪ Competence in clinical leadership ▪ Comprehension of Magnet essentials ▪ Evidence-based practice techniques ▪ Commitment to lifelong learning ▪ Culture of support ▪ Cultural competency ▪ Role as patient advocate ▪ Successful acculturation ▪ Accountability	12 months	▪ Education, at its best, cannot prepare for acculturation into a work group, using a newly learned language in practice, becoming proficient in a wide range of absolutely necessary skills, and gaining a sense of the wider world of health care. ▪ Incorporates reflection and feedback ▪ Turnover at 1 year was 10.8% ▪ Cost was $1,000 per resident ▪ Estimated that cost of replacing 1 nurse was $60,000
46 Merry, M.D. & Brown, J.P. (2001). From a culture of safety to a culture of excellence: Quality science, human factors, and the future of healthcare quality. Journal of Innovative Management , 7(2), 29-46. **Individual**	Report of the sigma gap in health care, which is the gap between performance and potential performance.	N/A	N/A	N/A	Airlines – 0.43 deaths per million passengers Hospitalizations – 2,300 deaths due to error per million admits

Project	Description	Elements	Measurement	Length	Status/Results
47 Orsolini-Hain, L. and Malone, R. E. (2007). Examining the impending gap in clinical nursing expertise. Policy, Politics & Nursing Practice. 8(3), 158-169. **Individual**	Literature review describing the impending expertise gap in clinical nursing, as a result of the nursing shortage, the aging and retiring workforce, nursing's desirability as a profession, the aging faculty, and the faculty shortage.	N/A	Excellent review of the literature, with citing of evidence and figures to make their point.	Recommend a state-mandated yearlong mentorship or residency program for new graduate nurses.	▪ From literature review concluded that graduates need "several months" (p.162) to become minimally proficient and to feel confident about decision making. ▪ When new graduates miss life-threatening events (as cited above from del Bueno research), they can put patients at risk. Cite statistics where once CPR is needed, 27% of adults and 18% of children survive. ▪ In the late 1980s 4.5% of nurses were employed outside of nursing; by 2004 that has risen to 16.8%.
48 Methodist Hospital of Houston and the University of Texas, Houston, Health Science Center: Pine, R. and Tart, K. (2007). Return on investment: Benefits and challenges of a baccalaureate nurse residency program. Nursing Economics. 25(1), 13-18, 39. **Individual**	▪ Has joined the UHC/AACN Consortium, so participants are BSN educated. A unique aspect of this UHC/AACN program is that ADN/diploma educated nurses have also had a precepted program for up to 6 months.	See UHC/AACN for elements.	See UHC/AACN.	1-year program	Besides aggregate results as reported by UHC/AACN, for this particular organization: ▪ Turnover The return of investment was $823,680 (benefit) ÷ $93,100 (cost) =8.847 or ROI (%) of 884.7
49 Sir Charles Gairdner Hospital Centre for Nursing Education, Australia **Individual**	Designed to guide the newly graduated registered nurse through the first year of practice. It provides a supportive and structured learning environment, allowing nurses to develop. This program is unique in that nurses must meet their outcomes and then receive a certificate for satisfactory performance.	▪ Specific program and participant outcomes ▪ Specific prerequisites ▪ 6 months of surgery and 6 months of medical ▪ Study days and graduate seminars ▪ Assigned preceptor	Professional development journal contains: ▪ Checklists ▪ Self-evaluation ▪ Preceptor feedback ▪ Skills acquisition sheet ▪ Self-directed learning package record ▪ Specialty achievement record	12-18 months of practice	No results yet, but will forward them to NCSBN.

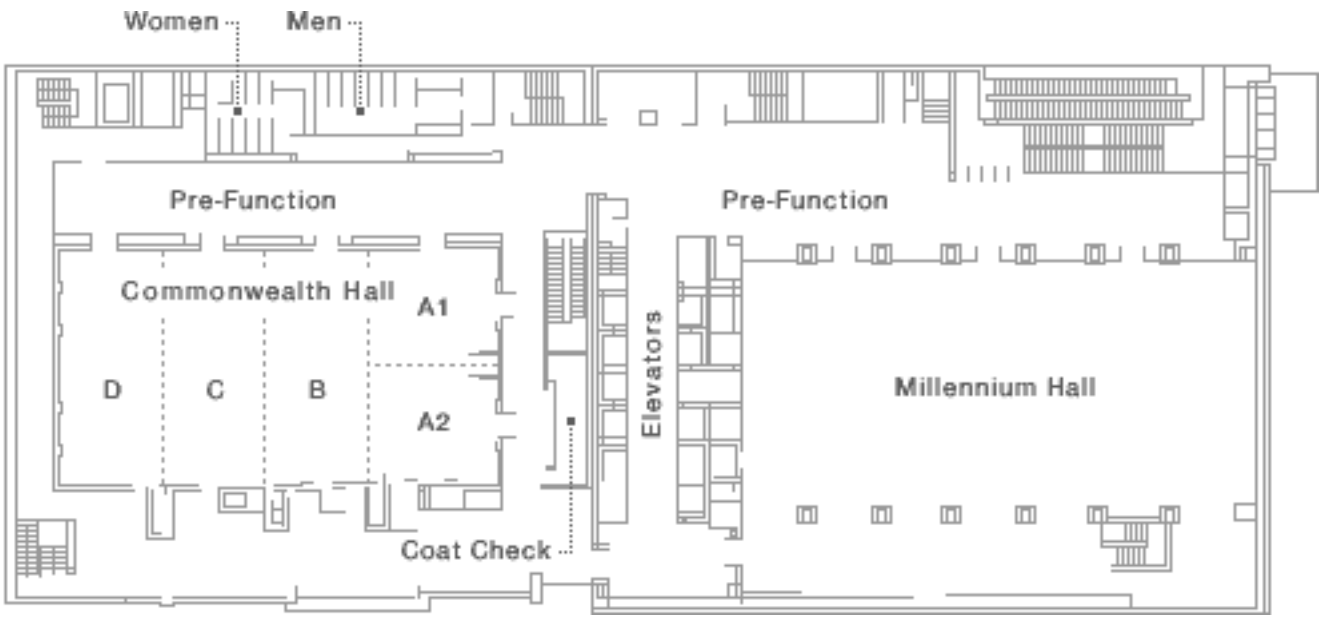


Section III

2009 NCSBN Annual Meeting

SECTION III: RESOURCES AND GENERAL INFORMATION

Loews Philadelphia Hotel Map



Orientation Manual for Delegate Assembly Participants

The purpose of the Orientation Manual is to provide information about the mission, governance and operations of NCSBN. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants, as well as the Board of Directors (BOD) 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 (BONs) 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.

BONs 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 BONs, 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 (NCSBN®).

Following the establishment of NCSBN, the bylaws, test plans and advanced practice registered nurse (APRN) model continue to be revised and adopted by the NCSBN Delegate Assembly. In 1995 Member Boards began to submit electronic data to the Disciplinary Data Bank. In 1996 the Delegate Assembly requested that the BOD continue developing the concept of a regulatory model to incorporate the characteristics of a multistate license.

In 1997, the Nurse Licensure Compact (NLC) was adopted and the NCLEX®, NCLEX-RN®, NCLEX-PN® became registered trademarks of NCSBN. NCSBN's first Midyear Meeting was held in 1999 and public access to Nur*sys*® was implemented in 2002. The current mission statement was adopted in 2003.

Last year's 2008 Delegate Assembly approved the Nebraska Board of Advanced Practice Registered Nurses as its first APRN BON, becoming the 60th Member Board. NCSBN also welcomed British Columbia as its first Associate Member. In addition to these historic events, the APRN Model Rules were adopted.

Organizational Mission, Strategic Initiatives and Outcomes

NCSBN, composed of Member Boards, provides leadership to advance regulatory excellence for public protection.

NCSBN currently has six strategic initiatives, one of which is to assist Member Boards in their role in the evaluation of initial and continued nurse and nurse aide competence. Another is to assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role. NCSBN also seeks to analyze the changing health care environment to develop state, national, and international strategies to impact public policy and regulation effecting public protection. NCSBN will develop information technology solutions valued and utilized by Member Boards to enhance regulatory sufficiency. Lastly, NCSBN seeks to support the education and development of Member Board staff, board members and BOD to lead in nursing regulation.

To achieve its strategic initiatives, NCSBN identifies expected outcomes, under which performance measures for achieving these outcomes are developed, assessed and refined each fiscal year, and provide the organization with a flexible plan within a disciplined focus. Annually, the BOD evaluates the accomplishment of strategic initiatives and objectives, and the directives of the Delegate Assembly.

Organizational Structure and Function

MEMBERSHIP

Membership in NCSBN is extended to those BONs 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, Guam, American Samoa and the Northern Mariana Islands. BONs may become Member Boards upon approval of the Delegate Assembly, payment of the required fees and execution of a contract for using the NCLEX-RN examination and/or the NCLEX-PN examination. Revisions to the bylaws by the membership in 2007 also allow for advanced practice nurse boards to become full members.

Member Boards maintain their good standing through remittance of fees and compliance with all contract provisions and bylaws. In return, they receive the privilege of participating in the development and use of NCSBN's licensure examinations. Member Boards also receive information services, public policy analyses and research services. Member Boards that fail to

adhere to the conditions of membership may have delinquent fees assessed or their membership terminated by the BOD. They may then choose to appeal the BOD's decision to the Delegate Assembly.

Associate Members are authorized nurse regulatory bodies from other countries that must be approved for membership by the Delegate Assembly and pay an annual membership fee. The College of Registered Nurses of British Columbia is an Associate Member.

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 four elected directors-at-large. (See Glossary for list of jurisdictions by area.)

DELEGATE ASSEMBLY

The Delegate Assembly is the membership body of NCSBN and comprises of delegates who are designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates. The Delegate Assembly meets at NCSBN's Annual Meeting, traditionally held in early August. Special sessions can be called under certain circumstances. Regularly scheduled sessions are held on a rotation basis among areas.

At the Annual Meeting, delegates elect officers, directors and members of the Leadership Succession Committee by majority and plurality vote respectively. They also receive and respond to reports from officers and committees. They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly adopts the mission statement, strategic initiatives of NCSBN, and approves the substance of all NCLEX examination contracts between NCSBN and Member Boards, adopts test plans to be used for the development of the NCLEX examination, and establishes the fee for the NCLEX examination.

OFFICERS AND DIRECTORS

NCSBN officers include the president, vice president and treasurer. Directors consist of four area directors and four directors-at-large. Only members or staff of Member Boards may hold office, subject to exclusion from holding office if other professional obligations result in an actual or perceived conflict of interest.

No person may hold more than one elected office at the same time. The president shall have served as a delegate, a committee member or an officer prior to being elected to office. An officer shall serve no more than four consecutive years in the same officer position.

The president, vice president and treasurer are elected for terms of two years or until their successors are elected. The president, vice president and treasurer are elected in even-numbered years.

The four area directors are elected for terms of two years or until their successors are elected. Area directors are elected in odd-numbered years. Four directors-at-large will be elected for terms of two years. Two directors-at-large will be elected in even-numbered years or until their successors are elected and two directors at-large will be elected in odd-numbered years or until their successors are elected.

Officers and directors are elected by ballot during the annual session of the Delegate Assembly. Delegates elect area directors from their respective areas.

Election is by a majority vote. Write-in votes are prohibited. In the event a majority is not established, the bylaws dictate the reballoting process.

Officers and directors assume their duties at the close of the session at which they were elected. The vice president fills a vacancy in the office of president. Board appointees fill other officer vacancies until the term expires.

BOD

The BOD, the administrative body of NCSBN, consists of 11 elected officers. The BOD is responsible for the general supervision of the affairs of NCSBN between sessions of the Delegate Assembly. The BOD authorizes the signing of contracts, including those between NCSBN and its Member Boards. It also engages the services of legal counsel, approves and adopts an annual budget, reviews membership status of noncompliant Member Boards and renders opinions, when needed, about actual or perceived conflicts of interest.

Additional duties include approval of the NCLEX examination test service, appointment of committees, monitoring of committee progress, approval of studies and research pertinent to NCSBN's purpose, and provision for the establishment and maintenance of the administrative offices.

MEETINGS OF THE BOD

All BOD meetings are typically held in Chicago, with the exception of the pre- and post- Annual Meeting BOD meetings that are held at the location of the Annual Meeting. The call to meeting, agenda and related materials are mailed to BOD 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 BOD action needed accompanies items for BOD discussion and action. Motion papers are available during the meeting and are used so that an accurate record will result. Staff takes minutes of the meeting.

Resource materials are available to each board officer and director for use during BOD 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 BOD

Communication between BOD meetings takes place in several different ways. The CEO communicates weekly with the president regarding major activities and confers as needed with the treasurer about financial matters. Monthly updates are provided to the full BOD by the CEO.

LEADERSHIP SUCCESSION COMMITTEE

The Leadership Succession Committee consists of one member from each area, elected for two-year terms in even-numbered years, and two designated members. Designated members will be elected for two-year terms in odd-numbered years, and will be a current or former chair; or a board member of a Member Board. Members will be elected by ballot with a plurality vote. The member receiving the highest number of votes shall serve as vice chair in the first year of the member's term and as chair in the second year of the term. The first meeting of the committee is held concurrent with the first meeting of the BOD in the subsequent fiscal year.

The Leadership Succession Committee's function is to recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; and present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the BOD and the Leadership Succession Committee. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

COMMITTEES

Many of NCSBN's objectives are accomplished through the committee process. Every year, the committees report on their activities and make recommendations to the BOD. At the present time, NCSBN has two standing committees: NCLEX examinations and Finance. Subcommittees, such as the NCLEX® Item Review Subcommittee, may assist standing committees.

In addition to standing committees, special committees are appointed by the BOD 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 BOD. Committee membership is extended to all current members and staff of Member Boards, consultants and external stakeholders.

In the appointment process, every effort is made to match the expertise of each individual with the needs of NCSBN. Balanced representation among areas, board members and staff, registered nurses (RNs), licensed practical/vocational nurses (LPN/VNs) and consumers is also considered is whenever possible. Nonmembers may be appointed to special committees as consultants to provide specialized expertise to committees or as external stakeholders to promote collaboration. A board 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 for in NCSBN policy. Each role works collaboratively to facilitate committee work and provide support and expertise to committee members to complete the charge. Neither the board liaison nor the NCSBN staff are entitled to a vote, but respectively can advise the committee regarding the strategic or operational impact of decisions and recommendation.

Description of Standing Committees

NCLEX® EXAMINATION COMMITTEE

The NCLEX® Examination Committee is comprised of at least nine members. One of the committee members shall be an LPN/VN or a board or staff member of an LPN/VN BON. The committee chair shall have served as a member of the committee prior to being appointed as chair. The purpose of the NCLEX® 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 committee advises the BOD on matters related to the NCLEX examination process, including psychometrics, item development, test security and administration, and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation, oversight of test service transitions, and preparation of written information about the examinations for Member Boards and other interested parties. The committee also regularly evaluates the licensure examinations by means of item analysis and test, and candidate statistics.

One of NCSBN's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is a key component of this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: (1) whether or not the examination actually measures competencies required for safe and effective job performance; and (2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation.

There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe and effective practice.

The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills and abilities (KSA) statements or competency statements, which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a passing standard to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected to recommend a series of passing standards for this process. Judges are trained in conceptualizing the minimally competent candidate (performing at the lowest acceptable level) and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in identification of a series of recommended passing standards. Taking these recommendations, along with other data relevant to identifying competency levels, the BOD sets a passing standard that distinguishes between candidates who do and do not possess the essential competencies; thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes, and utilizing item construction and test delivery processes based on sound psychometric principles, constitute the best legal defense available for licensing examinations. For most of the possible challenges that a candidate might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

FINANCE COMMITTEE

The Finance Committee comprises 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 BOD with a proposed annual budget prior to each new fiscal year.

NCSBN STAFF

NCSBN staff members are hired by the CEO. Their primary role is to implement the Delegate Assembly's and BOD's 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 BOD and CEO, and approved by the BOD. 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 which contains the agenda, reports requiring Delegate Assembly action, reports of the BOD, reports of special and standing committees, and strategic initiatives and objectives is provided to all Annual Meeting registrants.

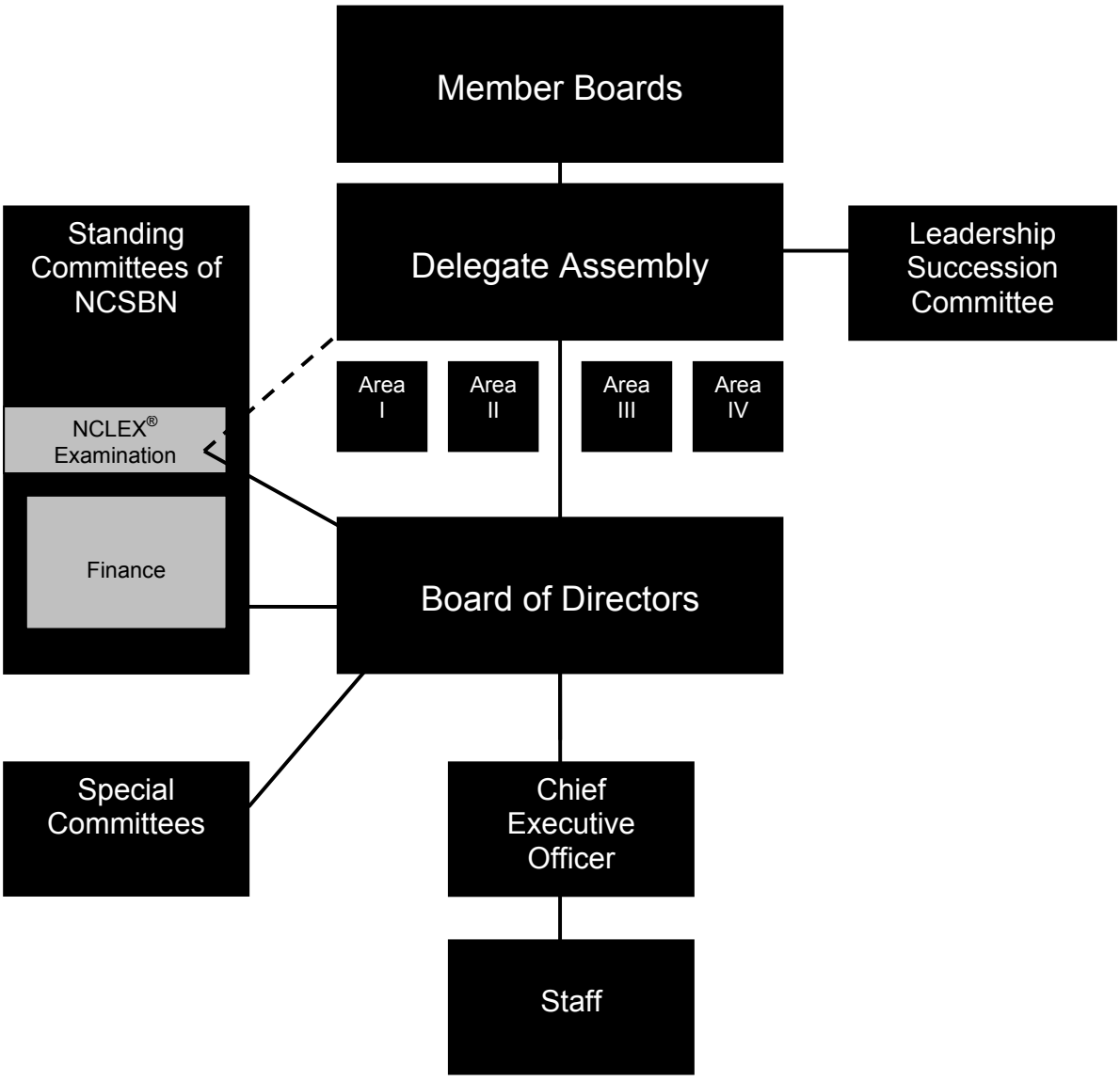
Prior to the annual session of the Delegate Assembly, the president appoints the credentials, resolutions and elections committees, as well as the Committee to Approve Minutes. The president must also appoint a timekeeper, a parliamentarian and ushers.

The function of the Credentials Committee is to provide delegates with identification bearing the number of votes to which the delegate is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and the Leadership Succession Committee. The Elections Committee conducts all elections

that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits, and evaluates all other resolutions 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 CEO, who serves as corporate secretary.

NCSBN Organizational Chart



NCSBN Bylaws

Revisions adopted - 8/29/87
Amended - 8/19/88
Amended - 8/30/90
Amended - 8/01/91
Revisions adopted - 8/05/94
Amended - 8/20/97
Amended - 8/8/98
Revisions adopted – 8/11/01
Amended – 08/07/03
Revisions adopted – 08/08/07

Article I

NAME

The name of this organization shall be the National Council of State Boards of Nursing, Inc. (NCSBN®).

Article II

PURPOSE AND FUNCTIONS

Section 1. Purpose. The purpose of the NCSBN is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

Section 2. Functions. The NCSBN's functions shall include but not be limited to providing services and guidance to its members in performing their regulatory functions regarding entry into nursing practice, continued safe nursing practice and nursing education programs. The NCSBN provides Member Boards with examinations and standards for licensure and credentialing; promotes uniformity in standards and expected outcomes in nursing practice and education as they relate to the protection of the public health, safety and welfare; provides information, analyses and standards regarding the regulation of nursing practice and nursing education; promotes the exchange of information and serves as a clearinghouse for matters related to nursing regulation.

Article III

MEMBERS

Section 1. Definition.

(a) *State Board of Nursing*. A state board of nursing is the governmental agency empowered to license and regulate nursing practice in any state, territory or political subdivision of the United States of America.

(b) *Member Board*. A Member Board is a state board of nursing, which is approved by the Delegate Assembly as a member of NCSBN.

(c) *Associate Member*. An Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory, which is approved by the Delegate Assembly.

Section 2. Qualifications. To qualify for approval, as a Member Board, a state board of nursing that regulates registered nurses and/or practical/vocational nurses must use one or more NCSBN

Licensing Examinations (the "NCLEX® examination") for licensure of registered nurses and/or practical/vocational nurses, and execute a membership agreement with NCSBN specifying the terms and conditions for the use of the NCLEX® examination(s) where applicable.

Section 3. Admission. A state board of nursing shall become a member of the NCSBN and be known as a Member Board upon approval by the Delegate Assembly, as described in Article IV, payment of the required fees and execution of a contract for using the NCLEX® examination where applicable.

Section 4. Areas. The Delegate Assembly shall divide the membership into numbered geographical Areas. At no time shall the number of Areas be less than three nor more than six. New members shall be assigned to existing Areas by the Board of Directors. The purpose of this division is to facilitate communication, encourage regional dialogue on NCSBN issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. Fees. The annual membership fees, for a Member Board and an Associate Member shall be set by the Delegate Assembly and shall be payable each October 1.

Section 6. Privileges. Member Board privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. Noncompliance. Any member whose fees remain unpaid after January 15 is not in good standing. Any member who does not comply with the provisions of the bylaws, and where applicable, the membership agreement, shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. Appeal. Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. Reinstatement. A member in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

Article IV

DELEGATE ASSEMBLY

Section 1. Composition.

(a) *Designation of Delegates.* The Delegate Assembly shall be comprised of no more than two (2) delegates designated by each Member Board as provided in the Standing Rules of the Delegate Assembly ("Standing Rules"). An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges.

(b) *Qualification of Delegates.* Members and employees of Member Boards shall be eligible to serve as delegates until their term or their employment with a Member Board ends. A NCSBN officer or director may not represent a Member Board as a delegate.

(c) *Term.* Delegates and alternates serve from the time of appointment until replaced.

Section 2. Voting.

(a) *Annual Meetings.* Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting.

(b) *Special Meetings.* A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards

a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the corporate secretary of the NCSBN or a delegate of another Member Board to cast its votes.

Section 3. Authority. The Delegate Assembly, the membership body of the NCSBN, shall provide direction for the NCSBN through resolutions and enactments, including adoption of the mission and strategic initiatives, at any Annual Meeting or special session. The Delegate Assembly shall approve all new NCSBN memberships; approve the substance of all NCLEX® examination contracts between the NCSBN and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; and establish the fee for the NCLEX® examination.

Section 4. Annual Meeting. The NCSBN Annual Meeting shall be held at a time and place as determined by the Board of Directors. The Delegate Assembly shall meet each year during the Annual Meeting. The official call to that meeting, giving the time and place, shall be conveyed to each Member Board at least 90 days before the Annual Meeting. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the NCSBN.

Section 5. Special Session. The Board of Directors may call, and upon written petition of at least ten Member Boards made to the Board of Directors, shall call a special session of the Delegate Assembly. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least ten days before the date for which such special session is called.

Section 6. Quorum. The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Section 7. Standing Rules. The Board of Directors shall present and the Delegate Assembly shall adopt Standing Rules for each Delegate Assembly meeting.

Article V

OFFICERS AND DIRECTORS

Section 1. Officers. The elected officers of the NCSBN shall be a president, a vice president and a treasurer.

Section 2. Directors. The directors of the NCSBN shall consist of four directors-at-large and a director from each area.

Section 3. Qualifications. Board Members of Member Boards and employees of Member Boards shall be eligible to serve as NCSBN officers and directors until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 4. Qualifications for President. The president shall have served NCSBN as either a delegate, a committee member, a director or an officer before being elected to the office of President.

Section 5. Election of Officers and Directors.

(a) *Time and Place*. Election of officers and directors shall be by ballot of the Delegate Assembly during the Annual Meeting.

(b) *Officers and Directors-at-Large*. Officers and directors-at-large shall be elected by majority vote of the Delegate Assembly.

(c) *Area Directors*. Each area shall elect its area director by majority vote of the delegates from each such area.

(d) *Run-Off Balloting*. If a candidate for officer or director does not receive a majority vote on the first ballot, reballoting shall be limited to the two candidates receiving the highest numbers of votes for each position. In the case of a tie on the reballoting, the final selection shall be determined by lot.

(e) *Voting*. Voting for officers and directors shall be conducted in accordance with these bylaws and the Standing Rules. Write in votes shall be prohibited.

Section 6. Terms of Office. The president, vice president, treasurer, area directors, and directors-at-large shall be elected for a term of two years or until their successors are elected. The president, vice president treasurer, and two directors-at-large shall be elected in even numbered years. The area directors and two directors-at-large shall be elected in odd numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.

Section 7. Limitations. No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the NCSBN, as determined by the Leadership Succession Committee before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors win an election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.

Section 8. Vacancies. A vacancy in the office of president shall be filled by the vice president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting and a successor is elected. The Delegate Assembly shall elect a person to fill any remainder of the term.

Section 9. Responsibilities of the President. The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and speak on behalf of and communicate the policies of the NCSBN.

Section 10. Responsibilities of the Vice President. The vice president shall assist the president, perform the duties of the president in the president's absence, and fill any vacancy in the office of the president until the next Annual Meeting.

Section 11. Responsibilities of the Treasurer. The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors, and that annual financial reports are provided to the Delegate Assembly.

Article VI

BOARD OF DIRECTORS

Section 1. Composition. The Board of Directors shall consist of the elected officers and directors of the NCSBN.

Section 2. Authority. The Board of Directors shall transact the business and affairs and act on behalf of the NCSBN except to the extent such powers are reserved to the Delegate Assembly as set forth in these bylaws and provided that none of the Board's acts shall conflict with resolutions or enactments of the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly and approve the NCLEX® examination test service.

Section 3. Meetings of the Board of Directors. The Board of Directors shall hold its annual meeting in association with the Annual Meeting. The Board may schedule other regular meetings of the Board at other times as necessary to accomplish the work of the Board. Publication of the dates for such regular meetings in the minutes of the Board meeting at which the dates

are selected shall constitute notice of the scheduled regular meetings. Special meetings of the Board of Directors may be called by the president or shall be called upon written request of at least three members of the Board of Directors. At least twenty-four hours notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Section 4. Removal from Office. A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly or the Board of Directors. The individual shall be given 30 days written notice of the proposed removal.

Section 5. Appeal. A member of the Board of Directors removed by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two thirds-vote of the Delegate Assembly.

Article VII

LEADERSHIP SUCCESSION COMMITTEE

Section 1. Leadership Succession Committee

(a) *Composition.* The Leadership Succession Committee shall be comprised of eight members elected by the Delegate Assembly. Four of the eight elected positions shall be designated members to include a past Board of Directors member, a current or former NCSBN committee chair, a board member of a Member Board and an employee of a Member Board. The remaining four members shall be elected from each of the four areas.

(b) *Term.* The term of office shall be two years. One-half of the Committee members shall be elected in even-numbered years and one-half in odd-number years. A committee member shall serve no more than two consecutive terms. Members shall assume duties at the close of the Annual Meeting at which they are elected.

(c) *Election.* The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. The chair shall be selected by the Board of Directors.

(d) *Limitation.* A member elected or appointed to the Leadership Succession Committee may not be nominated for an officer or director position during the term for which that member was elected or appointed.

(e) *Vacancy.* A vacancy occurring in the committee shall be filled from the remaining candidates from the previous election, in order of votes received. If no remaining candidates can serve, the Board of Directors shall fill the vacancy with an individual who meets the qualifications of Section 1a. of this Article. The person filling the vacancy shall serve the remainder of the term.

(f) *Duties.* The Leadership Succession Committee shall recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

(g) *Eligibility.* Any board member of a Member Board or employee of a Member Board is eligible to serve as a member of the Leadership Succession Committee.

Article VIII

MEETINGS

Section 1. Participation.

(a) *Delegate Assembly Session.*

- (i) *Member Boards.* Members and employees of Member Boards shall have the right, subject to the Standing Rules of the Delegate Assembly, to speak at all open sessions and forums of the Delegate Assembly, provided that only delegates shall be entitled to vote and only delegates and members of the Board of Directors may make motions at the Delegate Assembly, except the Examination Committee may bring motions to approve test plans pursuant to Article X, Section 1(a).
- (ii) *Public.* All sessions of the Delegate Assembly held in accordance with Sections 4 and 5 of Article IV of these bylaws shall be open to the public, except executive sessions, provided that the minutes reflect the purpose of, and any action taken in, executive session.

(b) *Delegate Assembly Forums.* Participation in forums conducted in association with the Annual Meeting shall be governed by the Standing Rules of the Delegate Assembly.

(c) *Meetings.* NCSBN, including all committees thereof, may establish methods of conducting its business at all other meetings provided that the meetings of the Board of Directors and committees are open to members and employees of Member Boards.

(d) *Interactive Communications.* Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the NCSBN office.

(e) *Manner of Transacting Business.* To the extent permitted by law and these bylaws, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

Article IX

CHIEF EXECUTIVE OFFICER

Section 1. Appointment. The chief executive officer shall be appointed by the Board of Directors. The selection or termination of the chief executive officer shall be by a majority vote of the Board of Directors.

Section 2. Authority. The chief executive officer shall serve as the agent and chief administrative officer of the NCSBN and shall possess the authority and shall perform all duties incident to the office of chief executive officer, including the management and supervision of the office, programs and services of NCSBN, the disbursement of funds and execution of contracts (subject to such limitations as may be established by the Board of Directors). The chief executive officer shall serve as corporate secretary and oversee maintenance of all documents and records of the NCSBN and shall perform such additional duties as may be defined and directed by the Board.

Section 3. Evaluation. The Board of Directors shall conduct an annual written performance appraisal of the chief executive officer, and shall set the chief executive officer's annual salary.

Article X

COMMITTEES

Section 1. Standing Committees. NCSBN shall maintain the following standing committees:

(a) *NCLEX® Examination Committee.* The NCLEX® Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The committee chair shall have served as a member of the committee prior to being appointed as chair. The NCLEX® Examination Committee shall advise the Board of Directors on matters related to the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.

(b) *Finance Committee.* The Finance Committee shall be comprised of at least four members and the treasurer, who shall serve as chair. The Finance Committee shall review the annual budget, the NCSBN's investments and the audit. The Finance Committee shall recommend a budget to the Board of Directors and advise the Board of Directors on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

Section 2. Special Committees. The Board of Directors may appoint special committees as needed to accomplish the mission of the NCSBN and to assist any standing committee in the fulfillment of its responsibilities. Special committees may include subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. Delegate Assembly Committees. The president shall appoint such Delegate Assembly Committees as provided in the Standing Rules and as necessary to conduct the business of the Delegate Assembly.

Section 4. Committee Membership.

(a) *Composition.* Members of standing and special committees shall be appointed by the Board of Directors from the membership, provided, however, that Associate Members may not serve on the NCLEX® Examination, Bylaws, or Finance Committees. Committees may also include other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, one representative from each area shall be selected unless a qualified member from each area is not available considering the expertise needed for the committee work. The president, or president's designee, shall be an ex-officio member of all committees except the Leadership Succession Committee. Associate Members shall have full voting rights as committee members.

(b) *Term.* The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for re-appointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

(c) *Vacancy.* A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

Article XI

FINANCE

Section 1. Audit. The financial records of the NCSBN shall be audited annually by a certified public accountant appointed by the Board of Directors. The annual audit report shall be provided to the Delegate Assembly.

Section 2. Fiscal Year. The fiscal year shall be from October 1 to September 30.

Article XII

INDEMNIFICATION

Section 1. Direct Indemnification. To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney's fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.

Section 2. Insurance. To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. Additional Rights. Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

(a) not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and

b) continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIII

PARLIAMENTARY AUTHORITY

The rules contained in the current edition of "Robert's Rules of Order Newly Revised" shall govern the NCSBN in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the NCSBN.

Article XIV

AMENDMENT OF BYLAWS

Section 1. Amendment and Notice. These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly upon:

(a) written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting; or

(b) written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present and voting.

In no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.

Section 2. Bylaws Committee. A bylaws committee composed of board members from Member Boards and/or employees of Member Boards may be appointed by the Board of Directors to review and make recommendations on proposed bylaw amendments as directed by the Board of Directors or the Delegate Assembly.

Article XV

DISSOLUTION

Section 1. Plan. The Board of Directors at an annual, regular or special meeting may formulate and adopt a plan for the dissolution of the NCSBN. The plan shall provide, among other things, that the assets of the NCSBN be applied as follows:

Firstly, all liabilities and obligations of the NCSBN shall be paid or provided for.

Secondly, any assets held by the NCSBN which require return, transfer or conveyances, as a result of the dissolution, shall be returned, transferred or conveyed in accordance with such requirement.

Thirdly, all other assets, including historical records, shall be distributed in considered response to written requests of historical, educational, research, scientific or institutional health tax exempt organizations or associations, to be expended toward the advancement of nursing practice, regulation and the preservation of nursing history.

Section 2. Acceptance of Plan. Such plan shall be acted upon by the Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. A majority of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.

Section 3. Conformity to Law. Such plan to dissolve must conform to the law under which NCSBN is organized and to the Internal Revenue Code concerning dissolution of exempt corporations. This requirement shall override the provisions of Sections 1 and 2 herein.

NCSBN Glossary

A

Accredit
To recognize (such as an educational institution or certification agency) as maintaining standards that qualify the graduates for admission to higher or more specialized institutions or for professional practice.

Accrediting Agency
An organization that establishes and maintains standards for professional nursing programs and recognizes those programs that meet these standards.
See Nursing School Accrediting Agency entry.

Administrative Rules
Used by boards of nursing to promulgate rules/regulations to further interpret and implement the Nursing Practice Act, as authorized in most jurisdictions. Rules/regulations cannot conflict with law and once adopted, have the force and effect of law.

Advanced Practice Registered Nurse (APRN)
A nurse:

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

APRN 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.

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.

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

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1. American Academy of Nurse Practitioners Web site. *About AANP*. Retrieved 2 March 2009, from http://www.aanp.org/AANPCMS2/AboutAANP/
2. American Association of Colleges of Nursing Web site. *About AACN*. Retrieved 2 March 2009, from http://www.aacn.nche.edu/ContactUs/index.htm
3. American Association of Critical Care Nurses Web site. *AACN fact sheet*. Retrieved 2 March 2009, from http://classic.aacn.org/AACN/mrkt.nsf/vwdoc/CNFactSheet?opendocument
4. American Association of Nurse Anesthetists Web site. *About AANA*. Retrieved 2 March 2009, from http://www.aana.com/AboutAANA.aspx?ucNavMenu_enuTargetID=7&ucNavMenu_nuTargetType=4&ucNavMenu_TSMenuID=6&id=46
5. American College of Nurse-Midwives Web site. *About us*. Retrieved 2 March 2009, from http://www.midwife.org/about.cfm
6. American Dental Association Web site. *ADA mission & values*. Retrieved 2 March 2009, from http://www.ada.org/ada/about/mission/index.asp
7. American Dietetic Association Web site. Retrieved 2 March 2009, from http://www.eatright.org
8. AILA.org Web site. *About AILA*. Retrieved 2 March 2009, from http://www.aila.org/content/default.aspx?docid=1021
9. American Medical Association Web site. *Our mission*. Retrieved 2 March 2009, from http://www.ama-assn.org/ama/pub/about-ama/our-mission.shtml

(asking a candidate to identify an area on a picture or graphic); an exhibit format (where candidates are presented with a problem and use the information in the exhibit to answer the problem); and a drag-and-drop item type (requiring a candidate to move and sequence 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)
A full-service professional membership organization in the U.S. for nurse practitioners of all specialties.[1]

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.[2]

American Association of Critical Care Nurses (AACN)
The largest specialty nursing organization in the world, representing the interests of more than 500,000 nurses who are charged with the responsibility of caring for acutely and critically ill patients. The association is dedicated to providing their members with the knowledge and resources necessary to provide optimal care to critically-ill patients.[3]

American Association of Nurse Anesthetists (AANA)
A professional association representing more than 37,000 certified registered nurse anesthetists (CRNAs) and student nurse anesthetists nationwide. The AANA promulgates education, practice standards and guidelines, and affords consultation to both private and governmental entities regarding nurse anesthetists and their practice.[4]

American College of Nurse Midwives (ACNM)
A professional association that 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).[5]

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.[6]

American Dietetic Association (ADA)
The nation's largest organization of food and nutrition professionals committed to improving the nation's health and advancing the profession of dietetics through research, education and advocacy.[7]

American Immigration Lawyers Association (AILA)
A national association of more than 11,000 attorneys and law professors who practice and teach immigration law. AILA member attorneys represent U.S. families seeking permanent residence for close family members, as well as U.S. businesses seeking talent from the global marketplace. AILA members also represent foreign students, entertainers, athletes and asylum seekers, often on a pro bono basis.[8]

American Medical Association (AMA)
The national professional organization for all physicians; helps doctors help patients by uniting physicians nationwide to work on the most important professional and public health issues.[9]

American Midwifery Certification Board (AMCB)
The national certifying body for certified-nurse midwives (CNMs) and certified midwives (CMs); formerly known as the ACNM Certification Council, Inc. (ACC). ACC's mission is to protect and serve the public by providing the certification standard for individuals educated in the profession of midwifery.[10]

American Nurses Association (ANA)
The only full-service professional organization representing the interests of the nation's 2.9 million registered nurses. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying Congress and regulatory agencies on health care issues affecting nurses and the public.[11]

American Nurses Credentialing Center (ANCC)
A subsidiary of the American Nurses Association, the ANCC provides credentialing programs that certify nurses in specialty practice areas; recognizes healthcare organizations for promoting safe, positive work environments; and accredits providers of continuing nursing education.[12]

American Organization of Nurse Executives (AONE)
A subsidiary of the American Hospital Association and a national organization of nearly 6,000 nurses who design, facilitate and manage care. AONE provides leadership, professional development, advocacy and research to advance nursing practice and patient care, promote nursing leadership excellence and shape public policy for health care.[13]

Americans for Nursing Shortage Relief (ANSR)
ANSR is comprised of 49 national nursing organizations that have united to address the nursing shortage and the nursing faculty shortage while working to change public policy in order to alleviate the nursing shortage.[14]

Americans with Disabilities Act (ADA)
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.[15]

Annual Report
A yearly summary of both financial accounting information and the activities of the organization. It highlights the strategic plan and future goals, as well as discussing the environmental context in which NCSBN operations. Its primary function is to serve as a marketing communications tool to reinforce branding efforts to NCSBN's diverse target audiences.

Application for License
The form(s) an individual submits to a board of nursing to request a license to practice nursing in that state or jurisdiction.

Application Packet
All information necessary to apply to a board of nursing for a nursing license.

APRN Annual Certification Program Survey
Results of an annual survey to APRN certification programs regarding their certification examination. Contains information such as accreditation status, credential granted, exceptions and pass rates.

APRN Certification Programs
Certification programs developed for APRNs. In January 2002, the NCSBN Board of Directors approved criteria for both certification programs that were developed by the Advanced Practice Task Force. The *Requirements for Accrediting Agencies* and the *Criteria for Certification Programs* represent required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses.

10. AMCB Web site. *About us.* Retrieved 2 March 2009, from http://www.amcbmidwife.org/c/104/about-us
11. ANA Nursing World Web site. *About the ANA.* Retrieved 2 March 2009, from http://www.nursingworld.org/FunctionalMenuCategories/AboutANA.aspx
12. American Nurses Credentialing Center Web site. Retrieved 2 March 2009, from http://www.nursecredentialing.org/
13. Hospitalconnect.com: AONE Web site. *Welcome to AONE.* Retrieved 2 March 2009, from http://www.aone.org/aone/about/home.html
14. AWHONN: Association of Women's Health, Obstetric and Neonatal Nurses Web site. *Health policy & legislation.* Retrieved 2 March 2009, from http://www.awhonn.org/awhonn/content.do?name=05_ealthPolicyLegislation%2F5E1_ANSR.htm
15. EEOC U.S. Equal Employment Opportunity Commission Web site. *Facts about the Americans with disabilities act.* Retrieved 2 March 2009, from http://www.eeoc.gov/facts/fs-ada.html

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.

APRN Criterion Comparison Paper (Members Only)
A comparison of APRN certification examinations with the NCSBN criteria.

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-RN	Kansas	Georgia-RN	Maine
California-VN	Michigan	Georgia-PN	Maryland
Colorado	Minnesota	Kentucky	Massachusetts
Guam	Missouri	Louisiana-RN	New Hampshire
Hawaii	Nebraska	Louisiana-PN	New Jersey
Idaho	Nebraska APRN Board	Mississippi	New York
Montana	N. Dakota	N. Carolina	Pennsylvania
Nevada	Ohio	Oklahoma	Rhode Island
New Mexico	S. Dakota	S. Carolina	Vermont
N. Mariana Islands	W. Virginia-RN	Tennessee	U.S. Virgin Islands
Oregon	West Virginia-PN	Texas	
Utah	Wisconsin	Virginia	
Washington			
Wyoming			

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.

Assessment Strategies
Test service for Canadian Nurses Association.

Associate Member
An Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory, which is approved by the Delegate Assembly.

Awards Committee
A committee of NCSBN charged with selection of annual award recipients and continuous review of the awards program.

B

Blueprint
The organizing framework for an examination that includes the percentage of items allocated to various categories. Also known as a test plan.

Board Members Knowledge Network at Delegate Assembly
Provides an opportunity at Delegate Assembly for board members from the boards of nursing to network, share information and discuss emerging regulatory issues.

Board of Nursing (BON)
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.

Business Book
The Business Book contains the annual proceedings of Delegate Assembly, including the Business Agenda and Standing Rules, committee recommendations, rationale and fiscal impact statement, slate of candidates, and annual reports of the president, board of directors, each standing committee, and test services.

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 RNs.

Canadian Registered Nurse Examination (CRNE)
The Canadian Nurses Association nurse licensure examinations.

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
The voluntary process by which a nongovernmental entity grants a time-limited recognition and use of a credential to an individual after verifying that he or she has met predetermined and standardized criteria. It is the vehicle that a profession or occupation uses to differentiate among its members using standards sometimes developed through a consensus-driven process based on existing legal and psychometric requirements.[16]

Certification Program
An examination designed by a certifying body to evaluate candidates for advanced practice nursing.

Certified Funds
Certified Check, Cashiers Check or Money Order are the forms of certified funds acceptable to NCSBN.

Certified Nurse Midwife (CNM)
Certified nurse-midwives (CNMs) are RNs with additional training around delivering babies and providing prenatal and postpartum care to women. To become certified, CNMs 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.[17] *See Advanced Practice Registered Nurse entry.*

Certified Registered Nurse Anesthetist (CRNA)
Anesthesia professionals who safely administer approximately 30 million anesthetics to U.S. patients each year.[18]
See Advanced Practice Registered Nurse entry.

Certifying Body for Nurses
A nongovernmental agency that validates by examination, based on predetermined standards, an individual nurse's qualifications and knowledge for practice in a defined functional or clinical area of nursing.

Citizen Advocacy Center (CAC)
A non-profit, non-partisan community legal organization dedicated to building democracy for the 21st century. Center community lawyers and volunteers focus on strengthening the citizenry's capacity and motivation to participate in civic affairs, building community resources and improving democratic protocols within our community institutions. Through public education, community organizing, issue advocacy and precedent-setting litigation in state and federal courts, the Center forges ahead with programs to advance civic life. The Center is a free public resource to the community.[19]

Clinical Nurse Specialist (CNS)
An APRN who has graduate preparation (master's or doctorate) in nursing as a clinical nurse specialist.
See also Advanced Practice Registered Nurse entry.

Commission on Collegiate Nursing Education (CCNE)
An autonomous accrediting agency contributing to the improvement of the public's health. CCNE ensures the quality and integrity of baccalaureate and graduate education programs focused on preparing effective nurses. CCNE serves the public interest by assessing and identifying programs that engage in effective educational practices. As a voluntary, self-regulatory process, CCNE

16. *National Organization for Competency Assurance Web site. NOCA's Basic Guide to Credentialing Terminology*. Retrieved 2 March 2009, from http://www.noca.org/portals/0/nocasbasicguidetocredentialingterminology.pdf
17. *All Nursing Schools Web site. Become a certified nurse-midwife.* Retrieved 2 March 2009, from http://www.allnursingschools.com/faqs/cnm.php
18. 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/aboutaana.aspx?ucNavMenu_nuTargetID=179&ucNavMenu_nuTargetType=4&ucNavMenu_TSMenuID=6&id=265&terms=Certified+Registered+Nurse+Anesthetist+SMenuTargetID=179&ucNavMenu_nuTargetType=4&ucNavMenu_TSMenuID=6&id=265&terms=Certified+Registered+Nurse+Anesthetist+
19. Citizens Advocacy Center Web site. *About us.* Retrieved 2 March 2009, from http://www.citizenadvocacycenter.org/about.html

accreditation supports and encourages continuing self-assessment by nursing education programs and the continuing growth and improvement of collegiate professional education.[20]

CGFNS International
An immigration-neutral non-profit organization that is internationally recognized as an authority on credentials evaluation pertaining to the education, registration and licensure of nurses and other health care professionals worldwide. It provides products and services that validate international professional credentials and supports international regulatory and educational standards for health care professionals. CGFNS International protects the public by ensuring that nurses and other health care professionals educated in countries other than the U.S are eligible and qualified to meet licensure, immigration and other practice requirements in the U.S.[21]

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.

Compendium on NCSBN Policy and Position Statements
Collection of NCSBN policy and position statements; updated twice a year. Currently it is only available in hard copy, but it will be available on the Web soon. A CD of this document is available upon request.

Computerized Adaptive Testing (CAT)
A testing methodology used to administer NCLEX on a computer. The computer selects the items candidates receive as they take the examination, which gives them the best opportunity to demonstrate their competence. Each examinee's test is dynamically constructed, with each item selected to provide the maximum possible information, given responses made to previous items.

Continued Competence Accountability Profile (CCAP)
No longer active, this project provided a framework for the licensed nurse to document learning needs, learning plans and goals/objectives, strategies for development and evaluation of the achievements of goals/objectives. It is an expected activity of all licensed nurses to reflect upon lifelong learning activities and their application to daily practice. The profile was, in essence, the application of the nursing process to one's own competence, professional development and accountability.

Continuous Quality Improvement Survey (CQI)
Results of this annual survey sent to Member Boards are analyzed for program and service improvements.

Continuing Education Unit (CEU)
Represents 10 contact hours in a formal education program.

CORE Committee
A committee of NCSBN whose purpose is to provide oversight and guide development of a performance measurement system to be utilized by boards of nursing and to identify of best practices.

CORE Reports
Provides information and resources to NCSBN Member Boards to assist them in the development and implementation of a performance measurement system.

Council Connector
One of the main sources for information on what is happening at NCSBN. The bimonthly, online 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 on Certification of Nurse Anesthetists (CCNA)
Responsible with protecting and serving the public by assuring that individuals who are credentialed have met predetermined qualifications or standards for providing nurse anesthesia services.[22]

Council on Licensure, Enforcement and Regulation (CLEAR)
An organization of regulatory boards and agencies.

20. American Association of Colleges of Nursing (AACN) Web site. *CCNE accreditation*. Retrieved 2 March 2009, from http://www.aacn.nche.edu/Accreditation/
21. CGFNS International Web site. *Who we are/what we do*. Retrieved 2 March 2009, from http://www.cgfns.org/sections/about/
22. American Council of Nurse Anesthetists Web site. *Council on certification*. Retrieved 2 March 2009, from http://www.aana.com/Credentialing.aspx?ucNavMenu_nuTargetID=111&ucNavMenu_nuTargetType=4&ucNavMenu_TSMenuID=6&id=138&terms=Council+on+Certification+of+Nurse+Anesthetists

D

Delegate Assembly (DA)
The membership body of NCSBN that comprises of 60 Member Boards. Provides direction through adoption of the mission and strategic initiatives; approves all new memberships; the substance of all NCLEX examination contracts between the NCSBN and Member Boards; adopts test plans to be used for the development of the NCLEX examination; and establishes the fee for the NCLEX examination. Each Member Board is entitled to two votes.

Delegate Orientation
Online continuing education course offered through NCSBN Interactive. This course is designed for boards of nursing staff members and board members who are new delegates and require an overview and understanding of the NCSBN Delegate Assembly.

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 between two groups of candidates (e.g., male/female, Caucasian/African-Amerian).

Director-at-Large
NCSBN Board of Directors position. Four directors are elected and represent the perspectives of the membership at large during meetings of the board.

Directory of Nurse Aide Registries
An annual publication of contact information for state nurse aide registries including who maintains the registry and who investigates complaints for the state.

Disciplinary Action Information
Information pertaining to disciplinary actions taken against and reported for a nursing license.

Disciplinary Data Bank (DDB)
An NCSBN data management system used between 1981 and 2000 to provide a database of disciplinary actions reported by Member Boards. The DDB data was incorporated into Nursys®, which continues to provide tracking of disciplinary data reported by boards of nursing.

Discipline
The actions taken, as well as the process used, to investigate and resolve complaints received by boards of nursing regarding the practice and/or conduct of licensed nurses. Boards follow their jurisdiction's Administrative Procedures Act, as well as the State Nurse Practice Act and Nursing Administrative Rules/Regulations in providing due process (i.e., the procedural safeguards for the nurse of receiving notice, having an opportunity to respond to allegations and having a fair and objective decision maker) in the enforcement of nursing laws and rules.

Discipline/Investigator Conference Call
A bimonthly conference call for investigators, attorneys and board staff who work with discipline cases. The format is to have a speaker offer a short presentation, often sending out handouts in advance, and then have the speaker dialogue with the participants.

E

Education Conference Call
A monthly conference call (except in August) for the boards' education consultants and other staff who work with education issues to network and discuss education issues.

Education Information
Information pertaining to an individual's education relative to nursing and licensure.

Education Knowledge Network at Delegate Assembly
A meeting at Delegate Assembly where boards' staff and board members, as well as interested external guests, network and discuss issues related to the regulation of nursing education.

E-mail Alerts
Breaking news targeted for executive officers and/or member board presidents that is beneficial and/or time sensitive as it relates to the work of boards of nursing or the external environment.

Encrypted Cookie
A cookie that is stored as encrypted information so that others are not able to read it.

English as a Second Language (ESL)
NCSBN asks NCLEX candidates to self-identify their primary language. The possible categories are: (1) English; (2) English and another language; (3) another language; and (4) missing. Candidates who report their primary language as "English and another language" or "another language" are considered for research purposes to be ESL candidates.

Examinee Performance Report (EPR)
Detailed report of the candidate's examination performance including item responses and response times.

Executive Officer Coach Program
A one-on-one program intended to enhance the professional development of a new executive officer. The coaching program provides the opportunity for an experienced executive officer to facilitate the learning process for a new executive officer.

Executive Officer Conference Call
Held every other month and designed for the executive officer of each board of nursing or one designee. The call provides for discussion of executive management.

Executive Officer Network
Comprised of executive officers of all boards of nursing or a staff member of the board designated by the executive officer. The network provides peer support and a communications network for executive officers.

Executive Officer Networking Session at Delegate Assembly
Held every August at Delegate Assembly. This session is designed for the executive officer of each board of nursing, or one designee, and provides a peer support group and a communication network for executive officers.

Executive Officer Networking Session at Midyear Meeting
Held annually at the Midyear Meeting. This session is designed for the executive officer of each board of nursing, or one designee, and provides a peer support group and a communication network for executive officers.

Executive Officer Seminar
A two day program for the executive officers of boards of nursing; designed to promote leadership and business management skill development.

F

Federation of Associations of Regulatory Boards (FARB)
An organization made up of an association of licensing boards, FARB provides a forum for individuals and organizations to share information related to professional regulation, particularly in the areas of administration, assessment and law. NCSBN holds a seat on the FARB Board of Directors.

Fellow of Regulatory Excellence Institute (FRE)
A credential bestowed upon an individual who completed the four-year comprehensive educational and professional development curriculum within the Institute of Regulatory Excellence (IRE) Fellowship Program.

Finance Committee
A standing committee of NCSBN charged to review the organization's annual budget, investments and audit.

Fiscal Year (FY)
Oct. 1 to Sept. 30 at NCSBN.

G

Guaranteed Funds
Certified Check, Cashier's Check or a Money Order are the forms of guaranteed funds acceptable by NCSBN.

H

Health Insurance Portability and Accountability Act (HIPAA)
Passed in 1996 to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in

the group and individual markets; to combat waste, fraud and abuse in health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; and to simplify the administration of health insurance and for other purposes.

Health Resources and Services Administration (HRSA)
The agency of the federal government under the Department of Health and Human Services that includes the Practitioner Database Branch and Division of Nursing.

Healthcare Integrity and Protection Data Bank (HIPDB)
A national data collection program mandated and operated by the Health Resources and Services Administration (HRSA) for the reporting of final adverse actions against health care providers, suppliers or practitioners, as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

HIPDB Agent Role
NCSBN is the authorized organization that the various Member Boards have designated to query or report information to HRSA on their behalf.

HIPDB Resource Pack
An assortment of resources to support Member Boards in complying with the federal mandate to report nurse disciplinary actions to the Healthcare Integrity and Protection Data Base (HIPDB).

HIPDB Webinars
A series of conference calls, with documents available online, that were held to support the transition to reporting nurse disciplinary actions to the HIPDB using HIPDB action and basis for action codes.

I

Immigration and Naturalization Services
An agency of the U.S. Department of Justice.

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 to provide science-based advice on matters of biomedical science, medicine and health. The IOM's mission is to serve as adviser to the nation to improve health. IOM provides unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large.[23]

Institute of Regulatory Excellence (IRE)
Created by NCSBN in 2004 to assist regulators in their professional development by providing opportunities for both education and networking. An annual conference is held to provide nurse regulators with regulatory knowledge in the areas of discipline, role development, competency evaluation/remediation strategies and organizational structure/behavior.

Institute of Regulatory Excellence (IRE) Committee
An NCSBN committee that provides an ongoing evaluation of the Institute of Regulatory Excellence program.

Interagency Collaborative on Nursing Statistics (ICONS)
Promotes the generation and utilization of data, information and research about nurses, nursing education and the nursing workforce. ICONS is an association of individuals from a variety of organizations that are responsible for the development, compilation and analysis of data on nurses and the settings in which they practice.

International Council of Nurses (ICN)
A federation of national nurses' associations (NNAs) representing nurses in more than 128 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 nurs-

23. Institute of Medicine of the National Academies Web site. Retrieved 2 March 2009, from http://www.iom.edu/CMS/3239.aspx

ing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce.[24]

International Scheduling Fee
The charge associated with scheduling an NCLEX examination appointment in an international testing center ($150 plus a value added tax [VAT] where applicable). This nonrefundable fee must be paid by credit card and will be charged when a candidate schedules an examination appointment.

International Testing Centers
There are Pearson Professional Center (PPC) test center locations in Australia, Canada, Germany, Hong Kong, India, Japan, Mexico, Puerto Rico, Taiwan, Philippines and United Kingdom that administer the NCLEX for the purposes of domestic licensure.

Interprofessional Workgroup on Health Professions Regulation (IWHPR)
A coalition of organizations representing millions of health care practitioners in more than 15 separate health disciplines.

Interstate Compact
An agreement (or contract, usually adopted by legislation) between two or more states that has the force and effect of statutory law.

Investigator and Attorney Workshop
Sessions focusing on meeting the educational needs of investigators, attorneys and board discipline staff. The two and one-half day meetings are held annually in the spring and present topics of interest related to the investigation, prosecution and resolution of complaints reported to boards of nursing.

IT Summit
The annual IT Summit provides member boards' technical staff the opportunity to learn what technology other boards are using and implementing. Encourages Member Board staff to learn about latest and greatest technologies while networking with their peers from other boards of nursing.

Item
A question on one of the NCLEX examinations.

Item Development
Process by which items for examinations are created, reviewed and validated in order to become operational.

Item Development Panels
Comprised of volunteers who meet specific criteria to participate in the item development process.

Item Response Theory (IRT)
A family of psychometric measurement models based on characteristics of examinees' item responses and item difficulty. Their use enables many measurement benefits.
See also Rasch Measurement Model entry.

Item Reviewers
Individuals who review items developed for the NCLEX-RN® and NCLEX-PN® examinations. Item reviewers must meet specific criteria in order to participate on a panel.

Item Writers
Individuals who write items for the NCLEX-RN and NCLEX-PN examinations. Item writers must meet specific criteria in order to participate on a panel.

Item Writing
Process by which examination items are created.

J

Joint Commission
Accredits and certifies more than 15,000 health care organizations and programs in the U.S. The Joint Commission's mission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.[25]

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 NCSBN and the test service.

JONA's Healthcare Law, Ethics and Regulation
NCSBN has a regular column in this journal on NCSBN initiatives that are of interest to employers, attorneys and regulators. Some examples of content have included: the

24. International Council of Nurses Web site. *About ICN*. Retrieved 2 March 2009, from http://www.icn.ch/abouticn.htm
25. The Joint Commission Web site. *About us*. Retrieved 2 March 2009, from http://www.jointcommission.org/AboutUs/

medication assistant curriculum; discussions of our research; articles on fraud in nursing; and discussions of our initiatives.

Jurisdiction
With regard to boards of nursing, jurisdiction refers to the state or territory that a board of nursing regulates. Most boards of nursing regulate all types of nurses within their states or territories. California, Georgia, Louisiana and West Virginia have separate boards of nursing to regulate RNs and LPNs/VNs.

K

Knowledge, Skill and Ability Statements (KSA)
The attributes required to perform a job and are generally demonstrated through qualifying experience, 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.[26]

L

Leader to Leader
A publication distributed biannually to all nursing programs and boards of nursing, updating educators on NCSBN initiatives relevant to nursing education.

Leadership Succession Committee
Composed of eight members elected by the Delegate Assembly. Duties are to recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning and present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee.

License
In nursing, current authority to practice nursing as an RN, LPN/VN or APRN.

License Information
Information about an individual's nursing license(s), which includes license number, license type, jurisdiction and expiration date.

License Verification
Proof of existing nurse licensure.

License Verification Request
The request for proof of licensure.

Licensed Practical Nurse (LPN)
A nurse who has completed a practical nursing program and is licensed by a state to provide patient care, as defined by the board of nursing.

Licensed Vocational Nurse (LVN or VN)
A graduate of a vocational nursing program who has passed the practical/vocational nursing examination and is licensed to administer care.

Licensing Board
A state's regulatory body responsible for issuing licenses for RN and LPN/VN licensure, as well as APRN licensure/authority to practice.

Licensure
The act or instance of granting a license.

Licensure By Endorsement
The granting of authority to practice based on an individual's licensure in another jurisdiction.

Licensure By Examination
The granting of authority to practice based on an individual's passing of a board-required examination.

Licensure Portability Grant (LPG)
A grant NCSBN received from the Health Resources and Services Administration's (HRSA) Office for the Advancement of Telehealth to work with state boards of nursing to reduce licensure barriers impacting telehealth and interstate nursing practice.

LINK
A publication designed to inform the global community about U.S. states' and territories' work on nurse regulation and licensure. *LINK* is available in hard copy and sent to all the boards of nursing, as well as a variety of stakeholders.

26. U.S. Office of Personnel Management Web site. *Policies and instructions*. Retrieved 2 March 2009, from http://www.opm.gov/qualifications/SEC-II/s2-c-d.asp

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

Medication Aide Certification Exam (MACE™)
The medication aide certification examination owned by NCSBN and administered by Pearson Vue.

Master Pool Items
NCLEX operational items. The bank of test items from which examinations are developed.

Medication Assistant – Certified (MA-C)
A person who is certified to administer medication.

Member Board
A state board of nursing, which is approved by the Delegate Assembly as a member of NCSBN.

Member Board Profiles
An online publication that provides an overview of the regulatory environment in which the 60 boards of nursing function. This has been recently updated to include responses from all 60 boards of nursing.

This NCSBN publication also provides an overview of the regulatory environment in which state boards of nursing function. Includes data by jurisdiction on board structure, educational programs, entry into practice, licensure requirements, continued competency mechanisms, nurse aide competency evaluations and advanced practice. Available on NCSBN's Web site.

Merchant Account
An account that enables a merchant to accept and process credit cards for payment of goods and services.

Midyear Leadership Forum
A forum presented each year at NCSBN's Midyear Meeting for presidents and executive officers with speakers addressing issues of governance and other areas of interest for nursing regulatory leaders.

Midyear Meeting
The spring meeting for all boards of nursing focusing on current initiatives of NCSBN and emerging regulatory issues.

Model Nursing Administrative Rules
Serve to clarify and further interpret and implement the Model Nursing Practice Act. Models can be used to identify essential elements needed for rules/regulations to the Model Nurse Practice Act. Rules must be consistent with the law, cannot go beyond the law and once enacted, have the force and effect of law. Available on NCSBN's Web site.

Model Nursing Practice Act (MNPA)
A publication of NCSBN, approved at the Delegate Assembly in Kansas City, Mo. in 2004 with additional content on assistive personnel adopted in 2005 and on criminal background checks in 2006. The Model Acts and Rules was first adopted in 1983 and created to serve as a guide to boards who were deliberating changes to state nurse practice acts and nursing administrative rules. Some boards look to the models for new ideas and different approaches for regulation. Other boards may use them in evaluating their existing regulatory language. Some boards use the framework and/or language in developing amendments and revisions to state laws and rules. The models may assist in the development of rationale for rules as part of the rule promulgation process. Models can be used to identify essential elements for legislation. While there will always be some variation with state nursing statutes, models are a way to advance a degree of uniformity among the several states to promote a common nationwide understanding of what constitutes the practice of nursing. Available on NCSBN's Web site.

Motion Papers
Available at Annual Meeting and used for accurate record keeping.

Mutual Recognition
A model for nurse licensure that allows a nurse licensed in his/her state of residency to practice in other compact states (both physically and electronically), subject to

each state's practice law and regulation. Under mutual recognition, a nurse may practice across state lines unless otherwise restricted. In order to achieve mutual recognition, each state must enact legislation authorizing the Nurse Licensure Compact. *See also Nurse Licensure Compact entry.*

N

National Association for Practical Nurse Education and Service (NAPNES)
Advocates for the education and practice of practical/vocational nurses. It is the organization responsible for the legislation that provides for the licensure and education of practical nursing.[27]

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.[28]

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; and to make available to African Americans and other minorities health care commensurate with that of the larger society.[29]

National Certification Corporation (NCC)
A nonprofit association that provides a national credentialing program for nurses, physicians and other licensed health care personnel that work in the obstetric, gynecologic, neonatal and telephone nursing specialties, in addition to the subspecialty areas of electronic fetal monitoring, breastfeeding, gynecologic health care and menopause.[30]

National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)
Works towards maximizing the safe use of medications and increasing awareness of medication errors through open communication, increased reporting and promotion of medication error prevention strategies.[31]

National Council Licensure Exam for Licensed Practical/Vocational Nurses (NCLEX-PN® Examination)
Used in the U.S. and by territorial Member Boards to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.

National Council Licensure Exam for Registered Nurses (NCLEX-RN® Examination)
Used in the U.S. and by territorial Member Boards to assess licensure applicants' nursing knowledge, skills and abilities. Boards of nursing use passing the examination to inform licensing decisions.

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

National Council of State Legislatures (NCSL)
A bipartisan organization that serves the legislators and staff of the nation's 50 states, its commonwealths and territories. NCSL provides research, technical assistance and opportunities for policy makers to exchange ideas on the most pressing state issues. NCSL is an effective and respected advocate for the interests of state governments before Congress and federal agencies.[32]

National Federation of Licensed Practical Nurses (NFLPN)
A professional organization for LPNs, LVNs and practical/vocational nursing students in the U.S.[33]

27. National Association for Practical Nurse Education & Services, Inc. (NAPNEP) Web site. *About NAPNES.* Retrieved 2 March 2009, from http://www.napnes.org/about.htm
28. National Association of Hispanic Nurses Web site. Retrieved 3 March 2009, from http://www.thehispanicnurses.org/
29. National Black Nurses Association, Inc. (NBNA) Web site. *Who we are.* Retrieved 2 March 2009, from http://www.nbna.org/index.php?option=com_content&view=article&id=44&Itemid=60
30. National Certification Corporation Web Site. *What is NCC?* Retrieved 2 March 2009, from http://www.nccnet.org/public/pages/index.cfm?pageid=61
31. The National Coordinating Council for Medication Error Reporting and Prevention Web site. *About NCC MERP.* Retrieved 2 March 2009, from http://www.nccmerp.org/aboutNCCMERP.html
32. National Conference of State Legislatures (NCSL) Web site. *About NCSL.* Retrieved 2 March 2009, from http://www.ncsl.org/public/ncsl/nav_aboutNCSL.htm
33. The National Federation of Licensed Practical Nurses, Inc. Web site. *All About NFLPN.* Retrieved 2 March 2009, from http://www.nflpn.org/allaboutnflpn.htm

34. National League for Nursing (NLN) Web site. (n.d.) *National League for Nursing Bylaws*. Retrieved 2 March 2009, from http://www.nln.org/aboutnln/Bylaws/index.htm
35. National League for Nursing Accrediting Commission (NLNAC) Web site. *About NLNAC*. Retrieved 2 March 2009, from http://www.nlnac.org/About NLNAC/whatsnew.htm
36. National Student Nurses Association (NSNA) Web site. Retrieved 2 March 2009, from http://www.nsna.org/

National Institute of Nursing Research (NINR)
Part of the National Institute of Health; works towards improving the health and health care of Americans through the funding of nursing research and research training. Its mission is to promote and improve the health of individuals, families, communities, and populations. This mission is accomplished through support of research in a number of scientific areas. Among those areas of research are chronic and acute diseases, health promotion and maintenance, symptom management, health disparities, caregiving, self-management, and the end-of-life. NINR also supports the training of new investigators who bring new ideas and help to further expand research programs. The ultimate goal of NINR's research is its dissemination into clinical practice and into the daily lives of individuals and families.

National League for Nursing (NLN)
A national organization created to identify the nursing needs of society and to foster programs designed to meet these needs; to develop and support services for the improvement of nursing service and nursing education through consultation, continuing education, testing, accreditation, evaluation and other activities; to work with voluntary, governmental and other agencies, groups, and organizations for the advancement of nursing and toward the achievement of comprehensive health care; and to respond in appropriate ways to universal nursing needs.[34]

National League for Nursing Accrediting Commission, Inc. (NLNAC)
Responsible for the specialized accreditation of nursing education programs, both post-secondary and higher degrees. The NLNAC Board of Commissioners 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.[35]

National Nurse Aide Assessment Program (NNAAP™)
The nurse aide certification examination owned by NCSBN and administered by Pearson VUE.

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). Proposed rules to implement section 1921 were published in March 2006 and final rules are expected in 2007.

National Provider Identifier (NPI)
Planned to be a new, unique eight-character alpha-numeric identifier. Created in response to the posting of rules in the Federal Register on May 7, 1998, which proposed a standard for a national health care provider identifier and requirements for its use by health plans, health care clearing houses and health care providers.

National Student Nurses' Association (NSNA)
With a membership of approximately 50,000 nationwide, NSNA mentors the professional development of future nurses and facilitates their entrance into the profession by providing educational resources, leadership opportunities and career guidance.[36]

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® Candidate Bulletin
Document that serves as a guideline for candidates preparing to take the NCLEX®. Candidate Bulletins contain information regarding registration, scheduling, informa-

tion on the testing experience and other useful information for candidates.

NCLEX® Candidate Services
Pearson VUE's facility for processing registrations, scheduling candidates and responding to inquiries for the NCLEX examinations.

NCLEX® Examination Committee (NEC)
A standing committee of NCSBN that provides general oversight of the NCLEX examination process, including item development, examination security, psychometrics, examination administration and quality assurance to ensure consistency with the Member Boards' need for examinations. This committee also approves item development panels and recommends test plans to the Delegate Assembly.

NCLEX® Examination Department Informational Call
In order to ensure the NCSBN membership is apprised regarding the NCLEX program, the NCSBN NCLEX® Examinations Department hosts two annual informational calls for Member Boards.

NCLEX® Facts Sheets
Documents available to the general public via the NCSBN Web site that provide a brief summary, NCLEX volume and pass rates. It includes the volume of candidates broken out by a few subpopulations of interest, the pass rates for those subpopulations and the volume of candidates coming from other countries (top 5 only).

NCLEX® Invitational
An annual, one-day educational conference that familiarizes attendees with the components of the NCLEX examinations and enlightens them about the development and the administration of the NCLEX-RN and NCLEX-PN examinations. The intended audience is nursing regulators, nursing educators and other stakekholders.

NCLEX® Item Review Subcommittee
An NCSBN committee that assists the NCLEX® Examination Committee with item review.

NCLEX® Member Board Manual
Provides all the information that Member Board staff needs to know regarding the NCLEX examination and the NCLEX process. The Member Board Manual is intended for use by Member Board staff and is located on the members-only side of the NCSBN Web site. The manual is updated as changes occur to the NCLEX program.

NCLEX® Program Reports
Published twice a year for subscribing schools of nursing, the NCLEX® Program Reports provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX examination. Included in the NCLEX® Program Reports is information about a given program's performance by the NCLEX test plan dimensions and content areas, and data regarding the program's rank at both national and state levels.

NCLEX® Quarterly Reports
Reports that summarize the performance of all first-time candidates educated in a given jurisdiction and tested in a given quarter, and the national group of candidates. They also provide a summary of the preceding three quarters' passing rates.

NCLEX® Registration Methods
Method(s) by which NCLEX candidates register for the NCLEX through test service. NCLEX registrations are processed one of three ways: scan form, Internet or phone. The NCLEX registration fee of $200 is due at time of processing.

NCLEX® Quick Results Service
Candidates in select jurisdictions may access their unofficial results via the NCLEX® Candidate Web site or through the NCLEX® Quick Results Line. Unofficial results are available two business days after taking the test. There is a charge for the service.

NCLEX® Regional Workshop
A one-day conference for nurse educators held at the request and in conjunction with a board of nursing. This conference is intended to give the educators information regarding the preparation of students to take the NCLEX exam, including such topics as the test plan, alternate items, psychometrics, program reports and writing questions in the NCLEX style. The NCLEX® Regional is offered in any one of the four areas where

the NCLEX® Invitational in not being held that year.

NCSBN Board of Directors (BOD)
Administrative body of NCSBN, consisting of eleven elected officers whose authority is to transact the business and bylaws of the affairs of NCSBN. The Board is composed of the president, vice president, treasurer, four area directors and four directors-at-large.

NCSBN Interactive
Brand name for the online portal for e-learning offerings for Member Board members and staff and NCSBN staff located at www.ncsbninteractive.org. Types of e-learning offerings include: wikis, online courses, streaming videos, podcasts, recorded Webinars and live Webinars.

NCSBN Learning Extension
The campus for online continuing education (CE) courses for nurses, NCLEX prep for students, and test development and item writing courses for faculty. The purpose of these courses is to promote safe, effective nursing practice and build regulatory awareness. Go to www.learningext.com for the catalog and detailed descriptions of courses. The following are the courses currently being offered:

- Acclimation of International Nurses into U.S. Nursing Practice
- Assessment of Critical Thinking
- Confronting Colleague Chemical Dependency
- Delegating Effectively
- Disciplinary Actions: What Every Nurse Should Know
- Diversity: Building Cultural Competence
- Documentation: A Critical Aspect of Client Care
- End-of-Life Care and Pain Management
- Ethics of Nursing Practice
- Medication Errors: Detection and Prevention
- NCSBN 101
- NCSBN's Review for the NCLEX-PN® Examination
- NCSBN's Review for the NCLEX-RN® Examination
- Nurse Practice Acts CE Courses (Participants: AR, IA, ID, KY, MA, MN, MO, NC, ND, NM, NV, OH, VA, WV-PN/RN)
- Patient Privacy
- Professional Accountability and Legal Liability for Nurses
- Sharpening Critical Thinking Skills
- Test Development and Item Writing

NCSBN Learning Extension Member Board Editorial Advisory Pool (TS)
NCSBN develops several new online continuing education (CE) courses each year on topics that are important to the nursing community. These topics are selected based on feedback from surveys of Member Board executive officers. To simplify the feedback process and to increase Member Board participation, NCSBN retains a pool of volunteers that provide editorial feedback on these courses as they are developed.

NCSBN Member's Only Web Site
The private side of NCSBN's Web site which provides access to nonpublic NCSBN documents, minutes and works in progress. Accessible only by a preassigned password.

NCSBN Public Web site
NCSBN's public Web site (www.ncsbn.org) that anyone can access without a password.

NCSBN Strategic Plan
The strategic initiatives objectives and performance measures covering a three year period of time. Provides the direction of the organization.

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.

Non-Licensure Participating Board of Nursing
A board of nursing that is not supplying license information on a regular basis. However, non-participating boards of nursing do

supply information to Nursys for disciplined nurse licenses and have access to all Nursys information.

North American Free Trade Agreement (NAFTA)
An agreement between Canada, Mexico and the U.S. that addresses trade in services and contains requirements and encouragement related to harmonization of qualifications for professional practice in the three countries.

Nurse Licensure Compact (NLC)
An agreement establishing mutual recognition and reciprocal licensing arrangements between party states for LPN/VNs and RNs. In August 2002, NCSBN delegates voted to expand the compact to include APRNs.

Nurse Licensure Compact Administrators (NLCA)
Organized body of nurse licensing boards that have implemented and administer the Nurse Licensure Compact.

Nurse Practitioner (NP)
An 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. An NP provides some care previously offered only by physicians and in most states, has the ability to prescribe medications. NPs focus largely on health maintenance, disease prevention, counseling and patient education in a wide variety of settings. NPs are educated through programs that grant either a certificate or a master's degree. The scope of an NP's practice varies depending upon each state's regulations. Unnecessary obstacles to an NP's practice contribute to the rising costs and inaccessibility of health care for all Americans.
See Advanced Practice Registered Nurse entry.

Nursing Assistive Personnel (NAP)
Any unlicensed person, regardless of title, who performs tasks delegated by a nurse. Also known as unlicensed assistive personnel (UAP).

Nursing Practice Act (NPA)
Statutes governing the regulation of nursing practice in a jurisdiction, typically empowering a board of nursing to license individuals who meet specified requirements.

Nursing Practice and Education Committee (NP&E)
The former name of a standing committee of NCSBN, now called the PR&E Committee.

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®
A database developed by NCSBN to contain demographic information on all licensed nurses (in the U.S.) 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.

Nursys® Licensure QuickConfirm
Provides online nurse license verification reports to employers and others.

Nursys® Training
Web conferences that are offered to Member Board users, and also by special request, for licensure, discipline, and other board staff, for the purpose of learning how to use Nursys.

O

On-Line Nursys® Verification Request Application
The electronic application that a nurse completes to request verification of existing licenses from participating boards of nursing in Nursys.

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.

Participating Board of Nursing
A board of nursing that is supplying personal, education, license and discipline information to Nur*sys* on a regular basis.

Passing Standard
The minimum level of knowledge, skill and ability required for safe and effective entry-level nursing practice. The NCSBN Board of Directors reevaluates the passing standard once every three years, based upon the results of a standard-setting exercise performed by a panel of experts with the assistance of professional psychometricians; the historical record of the passing standard with summaries of the candidate performance associated with those standards; the results of a standard-setting survey sent to educators and employers; and information describing the educational readiness of high school graduates who express an interest in nursing.

Once the passing standard is set, it is imposed uniformly on every test record according to the procedures laid out. To pass an NCLEX examination, a candidate must exceed the passing standard. There is no fixed percentage of candidates that pass or fail each examination.

PDF
A file format developed by Adobe Systems used to display documents. Adobe Acrobat Reader is a free program that is required to open, view and print PDF documents.

Pearson Professional Centers (PPC)
Pearson Professional Centers are testing locations where candidates take the NCLEX examinations.
See Pearson Professional Testing.

Pearson Professional Testing Network
Network of Pearson Professional Centers (PPCs) where candidates take the NCLEX examinations. There are more than 200 domestic and 18 international PPCs that administer the NCLEX.
See also Pearson VUE entry.

Pearson VUE
Contracted test service provider for NCSBN since 2002 to assist with the NCLEX program.

Pediatric Nursing Certification Board (PNCB)
Provides certification services to nurses and APRNs in pediatric practice through the provision of certification exams and certification maintenance programs. The PNCB is the largest certification organization for pediatric nursing.

Personal Information
Information pertaining to an individual's identity such as name, date of birth and gender.

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.

PN/VN Knowledge Network
Provides an opportunity at Delegate Assembly for members interested in the practice and regulation of practical or vocational nurses to network and share information regarding current and emerging regulatory issues.

Podcasts
Audio programs or content delivered over the Web using streaming media or syndication formats for playback on mobile devices and/or personal computers.

Policy Conference Call
These bi-monthly calls are intended for executive officers (and/or their designated policy contact on staff) and Member Board presi-

dents to focus on policy and government relations issues facing boards of nursing. Additionally, standing agenda items focus on providing members with Nurse Licensure Compact information and other externally related news that could impact nursing regulation.

Policy Perspectives
An internal newsletter intended exclusively for NCSBN membership use and insight. The publication reports on international, national and regional developments bearing on nursing regulation, including key groups and individuals influencing the direction of NCSBN policy and action.

Practice (Job) Analysis
Research study conducted by the NCLEX® Examinations Department that examines the practice of newly licensed job incumbents (RNs, LPN/VNs) or new nursing assistants. The results are used to evaluate the validity of the test plans/blueprints that guide content distribution of the licensure examinations or the nurse aide competency evaluation.

Practice and Professional Issues Survey (PPI)
A survey conducted twice each year to collect information from entry-level nurses on practice activities.

Practice Consultant Conference Call
Monthly calls for boards of nursing practice consultants to discuss practice issues.

Practice Knowledge Network at Delegate Assembly
Provides an opportunity at Delegate Assembly for members interested in practice to network and share information regarding current and emerging regulatory 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.

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.

President's Governance Role on a Board of Nursing
An online course for Member Board presidents and members that facilitates an understanding of the leadership role of the president in the state regulatory environment. Learners earn 6.7 contact hours for completing the course.

Presidents Networking Session at Delegate Assembly
Held every August at Delegate Assembly. It provides an opportunity for presidents to network and share best practices and may include an educational program.

Presidents Networking Sessions at Midyear Meeting
Held annually at the Midyear Meeting. It provides an opportunity for presidents to network and share best practices and may include an educational program.

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.
See also Nurse Licensure Compact entry.

Professional Accountability and Legal Liability for Nurses
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 5.4 contact hours for completing the course.

Professional Boundaries
The space between the nurse's power and the client's vulnerability—the power of the nurse comes from the professional position and access to private knowledge about the client. Establishing boundaries allows the nurse to control this power differential and

allows a safe connection to meet the client's needs. Complimentary professional boundaries materials are available from NCSBN.

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.

Q

Quick Results Service
A service provided to candidates where they can access their unofficial results within two business days of taking their examination via the phone or internet for a fee. This is only available to candidates whose licensure board participates in the service.

R

Rasch Measurement Model
A logistic latent trait model of probabilities, which analyzes items and people independently, and then expresses both item difficulty and person ability on a single continuum. These models are derived not from data but from the structure necessary for measurement. The dichotomous Rasch model is the item response theory (IRT) model used to develop the NCLEX examination measurement scale.

Recorded Webinar
A seminar conducted over the Web for recorded, on-demand playback of audio, video, and/or presentation materials.

Registered Nurse (RN)
A nurse who has graduated from a state-approved school of nursing, has passed the professional nursing state board examination and has been granted a license to practice within a given state.

Reliability
A test statistic that indicates the expected consistency of test scores across different administrations or test forms. For adaptively administered examinations, such as the NCLEX examination, the "decision consistency statistic" is the preferred statistic for assessing reliability. NCSBN uses the Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of the National Nurse Aide Assessment Program (NNAAP).

Resolutions Committee
Comprised of at least four members generally representing each of the four NCSBN geographical areas and includes one member of the Finance Committee. Reviews, evaluates and reports to the Delegate Assembly all resolutions and motions submitted by Member Boards. The committee is governed by the operational policies and procedures, the standing rules and the by-laws.

Resource Manual for International Nurses
User-friendly resource on the members-only NCSBN Web site which includes information on the education, English proficiency and immigration of international nurses.

Respecting Professional Boundaries
Online continuing education course offered through NCSBN Learning Extension; based on NCSBN's video and facilitation package, "Crossing the Line: When Professional Boundaries are Violated." Learners earn 3.9 contact hours for completing the course.

S

Scope of practice
Practicing within the limits of the issued health care provider license.

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.

Standard Setting Panel of Judges
A group of individuals that contributes to the recommendation of potential NCLEX passing standards to the NCSBN Board of Directors.

Standing Committee
A permanent committee established by the NCSBN Bylaws.

Statistical Criteria
Guidelines that all proposed NCLEX items must meet in order to 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.

Streaming Video
Video programs or content delivered over the Web using streaming technology. After a short period of initial buffering, the browser will play the media file and continue to play it while the rest of the file downloads.

T

Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP®)
A data collection instrument designed to collect information for the purpose of identifying the root cause(s) of nursing practice breakdown. The instrument allows for standardized, comprehensive and consistent data collection concerning matters reported to boards of nursing. The aggregate data collected from participating Member Boards will be used by NCSBN for ongoing research allowing for identification of categories of practice breakdown to better enable Member Boards to proactively protect the public health, safety and welfare of its citizens.

Temporary License
Temporary authorization to practice nursing.

TERCAP® Committee
An NCSBN committee charged with the implementation of the TERCAP project.

TERCAP® Users' Conference Calls
Held every two months at 1:00 pm (CST) on the second Tuesday of odd months. Participants include executive officers, investigators, attorneys and board staff who work with discipline cases that are submitted to NCSBN through the online TERCAP data collection instrument. The purpose is to assist participants with any TERCAP related questions, share strategies on successful implementation, and have an opportunity for dialogue with new and experienced TERCAP users.

Test Administrator (TA)
Test service staff person who is responsible for day-to-day operation of the center and for proctoring of examinations.

Test Development
Process by which items for examinations are created, reviewed and validated in order to become operational.

Test 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 examination delivery, examination scoring and reporting. Pearson VUE is the contracted test service for the NCLEX, NNAAP and MACE examinations.

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.[37]

37. U.S. Department of Education Web site. *An overview of the U.S. department of education.* Retrieved 2 March 2009, from http://ed.gov/about/overview/focus/whattoc.html?src=ln

38. U.S. Department of Health & Human Services Web site. *HHS: what we do.* Retrieved 2 March 2009, from http://www.hhs.gov/about/whatwedo.html/
39. Homeland Security Web site. *Department subcomponents and agencies.* Retrieved 2 March 2009, from http://www.dhs.gov/xabout/structure/
40. U.S. Drug Enforecement Administration Web site. *DEA mission statement.* Retrieved 2 March 2009, from http://www.dhs.gov/xabout/structure/

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.[38]

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. More than 87,000 different governmental jurisdictions at the federal, state, and local level have homeland security responsibilities. The comprehensive national strategy seeks to develop a complementary system connecting all levels of government without duplicating effort. Homeland Security is truly a national mission.[39]

U.S. Drug Enforcement Administration (DEA)
Federal agency charged to enforce the controlled substances laws and regulations of the U.S. and bring to the criminal and civil justice system of the U.S., or any other competent jurisdiction, those organizations and principal members of organizations involved in growing, manufacturing or distributing controlled substances appearing in or destined for illicit traffic in the U.S.; recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.[40]

Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements
Developed by NCSBN with APRN stakeholders in 2000; uniform requirements that established the foundation for the APRN Compact.

Uniform Core Licensure Requirements for Registered Nurse/Licensed Practical/ Vocational Nurse
Developed in 1999, the requirements promote consistency in licensure requirements for initial entry into the nursing profession.

Unlicensed Assistive Personnel (UAP)
Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated.

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.

Verification Department
NCSBN employees who process nurse license verifications in Nur*sys*.

Verification Fee
The monetary payment required from an applicant for license verification via Nur*sys*.

***VisaScreen*®**
A screening program that certain health care professionals must successfully complete before receiving an occupational visa, including the H-1B, H-2B, TN status and permanent (green card) visas, as required by Section 343 of the Illegal Immigration Reform and Immigration Responsibility Act of 1996 (IIRIRA). This service is provided by The Commission on Graduates of Foreign Nursing Schools (CGFNS); however, the NCLEX examination(s) maybe used to fulfill one component of the *VisaScreen* process. The *VisaScreen* itself is a trademarked product of CGFNS and currently is the only federally accepted organization to perform screening on nurses immigrating to the U.S.
See also Commission on Graduates of Foreign Nursing Schools (CGFNS) entry.

W

Webcast
A seminar conducted or a program broadcasted over the Web for live, realtime delivery of audio, video and/or presentation materials.

White Paper
A detailed document issued by NCSBN, disseminated to external groups used to educate audiences about a particular topic; to discuss issues; or to encourage dialogue about a particular regulatory subject.

Wiki
A wiki is a Web application that allows users to collaborate on content. Wikis can be permissions-enabled and monitored. Wiki users can set up e-mail notifications, conduct discussions and view/revert to past versions of pages.

Workshop on the Regulation of the Nursing Assistant
Workshop presented by NCSBN each year to provide current information on regulatory issues with unlicensed nursing personnel and to provide a venue for boards of nursing and other interested stakeholders to discuss emerging issues and to network.