Pioneering the Path for Public Protection

PORTLAND, OREGON

AUG. 11 - 13, 2010

2010 ANNUAL MEETING

Pioneering the Path for Public Protection

About this Illustration

This illustration blends the message of this year's theme, ***Pioneering the Path for Public Protection***, with the natural beauty and history of Portland, Ore., the 2010 NCSBN Annual Meeting host city.

The graphic was designed to honor Portland's past, reflect its vibrant present and bring to light its brilliant future. Each element was selected to not only bring meaning to the theme, but also acquaint new visitors with Portland's heritage and culture. The **woodcut look** of the illustration pays homage to the folk art tradition of Pacific Northwest artisans. **Green** was chosen as the dominant color to symbolize nature, growth and potential. This color also honors Portland's reputation as the "greenest" city in the U.S.

Serving as the centerpiece and heart of the illustration is the **human element**, which embodies the **seeker** who looks to the future, while remaining mindful of the past.

Because Portland is the City of Roses, the **rose** is featured prominently in the design. The rose icon can be found everywhere in the metro area, on signage and metalwork, and as the names of stores, businesses and locally-produced products.

The compass serves as a directional guide; a tool for the seeker to utilize in pioneering a path forward.

Featured in the design are the **Willamette** and **Columbia rivers** that run dramatically through the city and reinforce the concept of forging a trail despite all obstacles.

Mountains and **pine trees** are landscape elements native to the area and represent the challenges faced on the journey. The **sun** is an enlightening, positive symbol emblematic of the goal of safeguarding the public.

2010 NCSBN Annual Meeting

SECTION I: 2010 NCSBN ANNUAL MEETING

SECTION II: COMMITTEE REPORTS

Reports with Recommendations

Membership

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

Mission

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

Vision

Building regulatory expertise worldwide.

Values

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

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

Quality: Pursuing excellence in all endeavors.

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

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

Purpose

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

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

Section I

2010 NCSBN Annual Meeting

SECTION I: 2010 NCSBN ANNUAL MEETING

Business Agenda of the 2010 Delegate Assembly

Wednesday, Aug. 11, 2010

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 2010 Slate of Candidates
- Nominations from Floor
- Approval of the 2010 Slate of Candidates

PRESIDENT'S ADDRESS

CEO'S ADDRESS

Friday, Aug. 13, 2010

9:00 am–12:00 pm

BOARD OF DIRECTORS' RECOMMENDATIONS
- Adopt the proposed revisions to the NCSBN Bylaws.
- Adopt the proposed revision to the NCSBN Mission Statement.
- Adopt the proposed 2011–2013 Strategic Initiatives.
- Adopt the College of Licensed Practical Nurses of British Columbia as Associate Members of NCSBN.
- Adopt the proposed revisions to Chapter III and Chapter XI of the NCSBN Model Practice Act and Administrative Rules.
- Adopt the proposed Guiding Principles for Continued Competence.

NCLEX® EXAMINATION COMMITTEE RECOMMENDATION
- Adopt the proposed 2011 NCLEX-PN® 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 Wednesday, August 11, 2010 at 4:30 pm. Resolution or motion-makers are encouraged to submit motions and resolutions to the Resolutions Committee for review before this deadline.

   D. The Resolutions Committee will convene its meeting on Wednesday, August 11, 2010, at 4:30 pm and schedule a mutually agreeable time during the meeting to meet with each resolution or motion-maker. The Resolutions Committee shall meet with the resolution or motion-maker to prepare resolutions or motions for presentation to the Delegate Assembly and to evaluate the resolution or motion in accordance with the criteria in its operating policies and procedures. The Committee shall submit a summary report to the Delegate Assembly of the Committee's review, analysis, and evaluation of each resolution and motion referred to the Committee. The Committee report shall precede the resolution or motion by the maker to the Delegate Assembly.

   E. If a member of the Delegate Assembly wishes to introduce a non-procedural main motion or resolution after the deadline of 4:30 pm on Wednesday, August 11, 2010, 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 pm on Wednesday, August 11, 2010.

E. Election for officers, directors, and members of the Leadership Succession Committee shall be held Thursday, August 12, 2010, 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. 10, 2010

2:00–6:00 pm
Ballroom Foyer
Ballroom Level

Registration Opens

Visit the registration desk to receive your registration materials and name badge. Name badges must be worn at all times in order to enter the NCSBN Annual Meeting sessions.

2:00–5:00 pm
Directors Suite
3rd Floor

New Candidate Interviews with the Leadership Succession Committee (LSC)

Those candidates anticipating being nominated from the floor must submit a nomination form and meet with the LSC.

2:00–6:00 pm
Parlor A-C
Ballrooom Level

Nurse Licensure Compact Administrators (NLCA) Meeting

Open to members of the NLCA and NCSBN only.

4:30–5:30 pm
Senate Suite
3rd Floor

Resolutions Committee Meeting

Open to committee members only.

6:00–7:30 pm
Broadway
Plaza Level

Delegate Orientation

Open to all Annual Meeting attendees.

WEDNESDAY, AUG. 11, 2010

7:15–8:30 am
Galleria
Ballroom Level

Breakfast

7:15 am–3:30 pm
Ballroom Foyer

Registration

Visit the registration desk to receive your registration materials and name badge. Name badges must be worn at all times in order to enter the NCSBN Annual Meeting sessions.

7:30 am–5:00 pm
Galleria

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
Grand Ballroom
Ballroom Level

Delegate Assembly: Opening Ceremony

Welcome from the Oregon State Board of Nursing.

- Opening Ceremony
  - Introductions
  - Announcements
- Opening Reports
  - Credentials
  - Adoption of the Standing Rules
- Adoption of Agenda

SCHEDULE AND LOCATIONS ARE SUBJECT TO CHANGE.

8:30–10:00 am
Grand Ballroom
Ballroom Level

Delegate Assembly: Opening Ceremony, Continued

- Report of the Leadership Succession Committee
  - Presentation of the 2010 Slate of Candidates
  - Nominations from Floor
  - Approval of the 2010 Slate of Candidates

President's Address

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

CEO's Address

Kathy Apple, MS, RN, FAAN, CEO, NCSBN

10:00–10:15 am
Galleria
Ballroom Level

Break

10:15 am–12:00 pm
Grand Ballroom

Candidate Forum

Barbara Morvant, MN, RN, Chair, 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
Pavilion Ballroom
Plaza Level

Lunch

1:00–1:15 pm
Grand Ballroom

Finance Committee Forum

Randall Hudspeth, MS, APRN-CNS/NP, FRE, FAANP, Treasurer, NCSBN Board of Directors

1:15–1:35 pm
Grand Ballroom

NCLEX® Examination Committee Forum

Patricia Spurr, EdD, MSN, RN, Chair, NCLEX® Examination Committee

Discussion of the proposed 2011 NCLEX-PN® Test Plan and timeline for implementation.

1:35–1:55 pm
Grand Ballroom

Continued Competence Committee Forum

Katie Daugherty, MN, RN, Chair, Continued Competence Committee

1:55–2:10 pm
Grand Ballroom

Bylaws Committee Forum

Nathan Goldman, JD, Chair, Bylaws Committee

2:10–2:25 pm
Grand Ballroom

Disciplinary Resources Committee Forum

Sandy Evans, MAEd, RN, Chair, Disciplinary Resources Committee

2:25–2:40 pm
Galleria

Break

2:40–3:30 pm
Grand Ballroom

Board of Directors Forum

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

The NCSBN president will present and discuss Board of Directors issues and recommendations to the Delegate Assembly.

3:30–5:00 pm
Grand Ballroom

Nurse Licensure Models – Where We Are Today

Shirley Brekken, MS, RN, Executive Director, Minnesota Board of Nursing

Richard Masters, JD, Attorney, Masters, Mullins & Arrington

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

Joey Ridenour, MN, RN, FAAN, Executive Officer, Arizona State Board of Nursing

Objectives:

1. Discuss the three nurse licensure models currently used in the U.S.
2. Describe how interstate compacts are used in the U.S.
3. Identify NCSBN resources related to licensure models.

3:30–5:00 pm
Executive Suite
3rd Floor

Parliamentarian Office Hours

Take this opportunity to ask the Parliamentarian questions and/or submit resolutions.

4:30–5:30 pm
Executive Suite
3rd Floor

Resolutions Committee Meeting

Open to committee members only.

6:00–8:00 pm

NCSBN Welcome Reception: Oregon Historical Society

NCSBN would like to welcome all attendees to Portland, Ore., for the 2010 Annual Meeting. Please join us at the Oregon Historical Society for a networking reception and take advantage of this opportunity to meet the candidates running for office.

Tickets will be included in the registration packets of those who opted to attend during online registration. Shuttles depart at 5:30 pm. Attendees must bring tickets to enter reception.

THURSDAY, AUG. 12, 2010

7:30–8:30 am
Galleria
Ballroom Level

Breakfast

7:30 am–12:00 pm
Ballroom Foyer
Ballroom Level

Registration

7:30 am–5:00 pm
Galleria

Exhibit Showcase

7:30–8:30 am
Council Suite
3rd Floor

Election Voting

8:30–11:30 am

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:

Parlor A-C, Ballroom Level
- NCSBN Executive Officers (Open to NCSBN Executive Officers only)

Broadway I & II, Plaza Level
- NCSBN Board Presidents (Open to NCSBN Board Presidents only)

Pavilion East, Plaza Level
- Regulatory Network (Open to Board Staff, Board Members and External Organizations)

11:30 am–12:00 pm
Galleria

Break

12:00–3:30 pm

Area Lunch Meetings: NCSBN Members Only

NCSBN Area Lunch Meetings I-IV are open to NCSBN members and staff only. Note that there is a lunch meeting open to external organizations. Associate Members may attend one of the four Area Meetings of their choice.

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

Broadway III & IV, Plaza Level
- Area I members include: Alaska, American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Northern Mariana Islands, Oregon, Utah, Washington and Wyoming

Broadway I & II, Plaza Level
- Area II members include: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, West Virginia and Wisconsin

Parlor A-C, Ballroom Level
- Area III members include: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and Virginia

Alexander's Restaurant, 23rd Floor
- 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

Pavilion East

External Organizations Lunch Meeting

Join other external organizations for a networking lunch. Open to all NCSBN nonmember attendees.

6:00–6:30 pm
Plaza Foyer
Plaza Level

Awards Reception

Evening Cocktail Attire

6:30–9:00 pm
Pavilion Ballroom
Plaza Level

Awards Dinner

Evening Cocktail Attire

FRIDAY, AUG. 13, 2010

7:30–8:30 am
Galleria
Ballroom Level

Pearson VUE Sponsored Breakfast

8:30–9:30 am
Grand Ballroom
Ballroom Level

Keynote Speaker

Susan Hassmiller, PhD, RN, FAAN, Senior Adviser for Nursing, Robert Wood Johnson Foundation, and Director of the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine

Hassmiller will address the regulatory interface in this examination of the capacity of the nursing workforce to meet the demands of a reformed health care and public health system.

9:30–10:00 am
Galleria

Break

10:00 am–12:00 pm
Grand Ballroom

Delegate Assembly

12:00–1:00 pm
Pavilion Ballroom
Plaza Level

Lunch

1:00–4:00 pm
Grand Ballroom

Delegate Assembly Resumes

New business and closing ceremonies.

4:00–6:00 pm
Forum Suite
3rd Floor

Post-Delegate Assembly Board of Directors Meeting

Open to Fiscal Year 2011 (FY11) Board of Directors members only.

SCHEDULE AND LOCATIONS ARE SUBJECT TO CHANGE.

Summary of Recommendations to the 2010 Delegate Assembly with Rationale

This document provides a summary of recommendations that the NCSBN Board of Directors (BOD), NCLEX® Examination Committee (NEC) and Leadership Succession Committee (LSC) propose to the 2010 Delegate Assembly. Additional recommendations may be brought forward during the 2010 Annual Meeting.

Board of Directors' Recommendations

1. ***Adopt the proposed revisions to the NCSBN Bylaws.***

   Rationale:
   The proposed revisions clarify election by acclamation when there is one candidate for an elected position. The proposed language is consistent with the concepts of Robert's Rules of Order. The proposed revision further clarifies the role of the LSC and nominations from the floor.

   Fiscal Impact:

   Incorporated into the fiscal year 2011 (FY11) budget.

2. ***Adopt the proposed revision to the NCSBN Mission Statement:***

   Through collaborative leadership, NCSBN provides education, service, and research to promote regulatory excellence for patient safety and public protection.

   Rationale:
   The current mission statement has been in place since 2003. The standard practice for nonprofit associations is to review mission statements every five to seven years; the policy of NCSBN is to review the mission statement every six years. The BOD reviewed and discussed the purpose of a mission statement as a declaration of purpose that drives other elements of the organization and the current environmental drivers influencing the role and function of nursing regulation. The proposed draft mission statement has been presented to the membership for feedback during the fiscal year.

   Fiscal Impact:
   None.

3. ***Adopt the proposed 2011–2013 Strategic Initiatives.***

   - ***NCSBN promotes evidence-based regulation.***
   - ***NCSBN advances the engagement and leadership potential of all members through education, information and networking.***
   - ***NCSBN provides state-of-the-art competence assessments.***
   - ***NCSBN collaborates to advance the evolution of nursing regulation worldwide.***
   - ***NCSBN optimizes nursing regulation through efficient use of technology.***

   Rationale:
   The BOD developed the proposed 2011–2013 Strategic Initiatives through a facilitated strategic planning process and solicited feedback from the membership during the fiscal year. The proposed plan identifies critical strategic direction for the next three years for fulfillment of the NCSBN Mission and Vision.

   Fiscal Impact:

   The strategic initiatives will serve as a basis for allocating financial resources for the next three years. Annual operating budgets will be developed to fund strategic objectives and performance measures designed to carry out the strategic plan.

4. ***Approve the College of Licensed Practical Nurses of British Columbia as an Associate Member 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 application for Associate Membership meets the qualifications as stated in the NCSBN Bylaws.

   Fiscal Impact:
   Upon acceptance, the new associate member will pay a $1,500 annual fee.

5. ***Adopt the proposed revisions to Chapter III and Chapter XI of the NCSBN Model Practice Act and Administrative Rules.***

   Rationale:
   In 2008-2009, the Discipline Resources Committee published an updated booklet on sexual misconduct as a resource for the Member Boards. For that project the committee members surveyed the Member Boards about their needs related to sexual misconduct cases. Many boards of nursing (BONs) felt that they needed more specific statutory and rule language related to sexual misconduct and boundary violations. Therefore, the BOD charged the 2009-2010 Discipline Resources Committee with developing model rules on boundaries and sexual misconduct.

   Fiscal Impact:
   None.

6. ***Adopt the proposed Guiding Principles for Continued Competence.***

   Rationale:
   The Guiding Principles of Continued Competence lay the foundation for future work in continued competence and establishes a basis for a regulatory standard to assist Member Boards.

   Fiscal Impact:
   None.

NCLEX® Examination Committee Recommendation

1. ***Adopt the proposed 2011 NCLEX-PN® Test Plan.***

   Rationale:
   The NEC reviewed and accepted the *Report of Findings from the 2009 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (NCSBN, 2010) as the basis for recommending revisions to the *2008 NCLEX-PN® Test Plan* to the Delegate Assembly. Empirical evidence from the practice analysis, feedback from Member Boards and legal counsel, and the professional judgment of the NEC provide support for the recommendation to the Delegate Assembly to adopt the 2011 NCLEX-PN® Test Plan.

   Fiscal Impact:
   Incorporated into the FY11 budget.

Leadership Succession Committee Recommendation

1. ***Adopt the 2010 Slate of Candidates.***

   Rationale:
   The LSC has prepared the 2010 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 a personal statement for each candidate is posted in the Business Book under the Report of the Leadership Succession Committee. Candidates will present themselves at the Candidate's Forum on Wednesday, Aug. 11, 2010.

   Fiscal Impact:
   Incorporated into the FY11 budget.

Report of the Leadership Succession Committee

Recommendation to the Delegate Assembly

1. ***Adopt the 2010 Slate of Candidates.***

   Rationale:

   The Leadership Succession Committee (LSC) has prepared the 2010 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. Candidate will present themselves at the Candidate's Forum on Wednesday, Aug. 11, 2010.

Background

The LSC was created by a revision to the NCSBN Bylaws at the 2007 Delegate Assembly. The concept embedded in the bylaw revision was to ensure that leadership development and succession planning are built into the structure of the organization. Organizational leadership must be seen as a critical and strategic process. An organization is only as good as its leaders, and leaders must be developed through careful planning, cultivation, orientation, education and involvement. Organizational leadership must build upon the diversity and expertise of the membership.

Current LSC members were elected or appointed by the NCSBN Board of Directors (BOD) following the 2009 Delegate Assembly and have the following charges:

1. Recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning.
2. Present a slate of candidates through determination of qualifications and geographic distribution for inclusion on a ballot for the election of the BOD and LSC.

The LSC continued further development of the competency framework for governance leadership. The LSC identified and then refined specific leadership competencies needed to guide the organization. The LSC believes that candidates for NCSBN leadership positions should be individuals who possess knowledge of regulation, are committed to the mission, vision and values of the organization, and who possess competencies in the areas of self-knowledge and governance leadership.

The LSC concluded that the success of an organization and its mission is inextricably tied to the strength of its leadership and leadership resources. Leaders of an organization must possess self-knowledge and governance leadership competencies to successfully guide and advance the organization.

The LSC determined that there is a deliberate path to identify and nurture individuals to secure a legacy of leadership at all levels to advance and sustain the organization. That path supports the ongoing performance and growth of NCSBN and includes a defined organizational strategy to leadership succession. It is essential that the organization creates and sustains a path to develop leaders.

LEADERSHIP SUCCESSION DEFINED

Leadership succession is the deliberate, ongoing process of identifying and developing qualified leaders who:

- Serve the purpose, mission, vision and values of the organization;
- Advance and promote excellence in nursing regulation;

Members

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

Mary Blubaugh, MSN, RN
Kansas, Area II,
Designated Member

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

Rick García, MS, RN, CCM
Florida, Area III Representative
(Resigned April 1, 2010)

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

Patricia Lane, MBA, RN, HCA
Virginia, Area III,
Designated Member

David Mangler, MS, RN
Delaware, Area IV Representative

Paula Meyer, MSN, RN
Washington, Area I,
Designated Member

Staff

Kathy Apple, MS, RN, FAAN
CEO

Kate Jones
Manager, Executive Office

Meeting Dates

- Nov. 9-11, 2009
- Jan. 4-6, 2010
- March 8, 2010
- April 29-30, 2010

- Sustain and evolve continued success and viability of NCSBN; and
- Embrace and cultivate a culture of service and stewardship.

ESSENTIAL COMPETENCIES

Candidates for NCSBN positions are individuals who possess knowledge of regulation, are committed to the mission, vision and values of NCSBN, and who demonstrate:

Self-knowledge

- Particularly in relation to honesty, integrity and courage;
- Ability to deal with ambiguity and complexity;
- Flexible and adaptable;
- Cultural competence—the ability to work effectively cross culturally; and
- Interpersonal and communication effectiveness.

Governance leadership

- Stewardship—selecting service to greater good over self-interest;
- Strategic and futuristic thinking;
- Fiduciary knowledge;
- Evidence-based decision making;
- Consensus building through strategic alliances, networks and partnerships;
- Effective change and risk management, including accountability and transparency;
- Diplomatic and politically savvy relationship building; and
- Creativity and innovation.

LEADERSHIP DEVELOPMENT

The LSC spent considerable time describing an ongoing, structural leadership development plan for the organization. The purpose is to cultivate and recognize leadership within the organization to ensure sustained, progressive viability of the organization. The overall goal of the leadership development plan is to build leadership within and throughout the organization. The ultimate focus is to have a pool of available, diverse and qualified candidates for election to the LSC and BOD to meet the challenges of the future.

The LSC proposes leadership building through three objectives:

1. Early Connectivity: Members are engaged quickly with NCSBN to understand its purpose, function, products and services, and their role in relation to the organization.
2. Building Self-Knowledge – Self-Discovery: Members participate in opportunities for enhancing leadership knowledge, skills and ability.
3. Building Board and Organizational Governance Expertise: Members participate in opportunities to build governance expertise.

The plan describes various activities for leadership development, including identification of current resources and potential resources needed in the future. The plan is consistent with the proposed 2011-2013 Strategic Initiatives draft.

The additional intent of describing the activities is to aid interested individuals in building their leadership competence for their own interest, serving NCSBN on the BOD and/or the LSC through self-selection of relevant activities. These opportunities described are not an all-inclusive list nor do they imply mandatory participation; rather, the activities are offered based on an individual's own personal goals.

BUILDING THE SLATE OF CANDIDATES

The LSC has further developed an iterative process to select the best nominees for placement on the Slate of Candidates for the BOD and LSC. For fiscal year 2010 (FY10), the LSC interviewed all nominees. Interview questions were developed and designed to elicit information on the essential competencies, and were provided to all nominees prior to their interview. The LSC paid particular attention to providing the membership with a balanced slate of candidates.

POLICY DEVELOPMENT

The LSC reviewed and revised the committee policy by embedding a new standard and a different vision of leader expectations. The policy also includes the LSC's vision of engagement rather than recruitment that reflects the shared responsibility within the entire membership to identify and engage competent leaders.

FY10 Highlights and Accomplishments

- The committee discussed and reorganized the leadership development plan document identifying the purpose, goals and objectives, and merging the plan with the Essential Competency Framework document. Current NCSBN activities and external resources were identified, including potential resources needed for the future. Kathy Apple had the NCSBN Leadership Team review the document, and committee members solicited membership input for review and comment.
- The committee discussed the concept of candidate selection criteria and evaluation, and reviewed the candidate selection criteria and process used by the American Association of Critical Care Nurses (AACN). Further, the committee revised the AACN process for exploratory use as a working document by the LSC.
- The committee discussed concerns expressed by members regarding nominations from the floor. The committee believes this is a cultural change for the organization and feels it is important that all nominees be vetted equally and in the same manner.
- The committee met with Dawn Kappel, director, Marketing & Communications, NCSBN, to further discuss a new theme and logo. The committee selected "Advancing Potential – Discover the Leader Within." A brochure was developed with the new theme.
- The committee discussed the survey regarding time commitment and estimated approximately 30 days within a 12-month period as the minimum time commitment to fulfill the responsibilities for a BOD position. Activities beyond that time frame are at the discretion of the individual board member.
- The committee had a long discussion about recruitment and wondered if recruitment is the right concept for its role in the organization. Recruitment implies enlisting a person with an unspoken promise to be on the slate. However, if in the screening process the committee feels the person is not ready, it creates a possible conflict of interest or misunderstanding. The committee believes its role is more an engagement in attracting nominees and is a shared responsibility with the entire membership.
- The committee reviewed and discussed feedback to the draft leadership development plan document identifying internal and external resources needed for the various activities. The draft document was presented to the BOD at its meeting on Feb. 10-12, 2010, and to the membership at the 2010 Midyear Meeting.
- The committee reviewed and revised LSC Policy 1.0.
- The committee met with Alicia Byrd, director, Member Relations, NCSBN, for information about the current membership database in use by NCSBN and its potential for use with the future work of the LSC.

- The committee discussed whether there is any overlap with the work of the Institute of Regulatory Excellence (IRE) Committee. Possible joint committee discussion will be explored in the next fiscal year.
- The committee moved to approve a recommendation to the Bylaws Committee for consideration of additional language that would have nominations from the floor be made after the LSC determines qualifications and geographic distribution for inclusion on the ballot.
- The committee discussed developing a welcome kit for new board members or board staff as part of the early engagement initiative, including a leadership toolkit.
- The committee discussed revising the e-nomination form for fiscal year 2011 (FY11) to include a statement of membership and leadership positions held in professional organizations.
- The committee reviewed and discussed the candidate selection assessment worksheet in preparation for candidate interviews.
- The committee interviewed all nominees who applied for open positions. All nominees were provided the interview questions prior to the interview. There was one nominee who was deemed ineligible at this time based on a perceived or actual conflict of interest as outlined in the NCSBN Bylaws. The nominee was informed directly by the chair of the committee's decision and rationale.
- The committee reviewed the prospective slate and discussed the potential for balancing the slate by encouraging qualified nominees to consider alternative positions.
- The committee determined the 2010 Slate of Candidates based on essential competencies and the NCSBN Bylaws.

Attachments

A. 2010 Slate of Candidates

B. Leadership Development Plan

C. Essential Competencies for Governance Leadership

D. Leadership Succession Committee Interview Questions

E. Candidate Selection Assessment Worksheet

F. Leadership Succession Committee Policy and Procedure

Attachment A

2010 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 2010 Delegate Assembly.

Board of Directors

President

Vice President

Treasurer

Director-at-Large (two positions)

Leadership Succession Committee

Area I Member

None

Area II Member

Area III Member

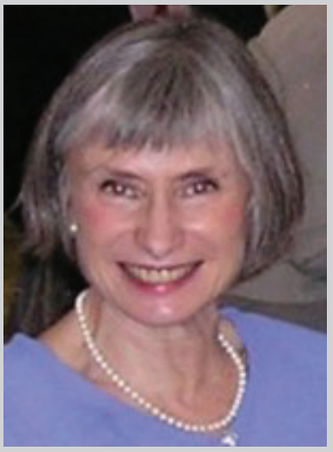
Area IV Member

None

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

President

Myra Broadway, JD, MS, RN

Board Staff, Maine, Area IV

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

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 December 08-August10; Area 4 Director, Nov-Dec 08; Area 4 Director, 2003-2007; Director-at-Large, 2000-2002; Board Liaison to Disciplinary Resources Committee 2009-2010; 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 2002-2003; Board Liaison to Commitment to Excellence 2001-2002; Model Rules Subcommittee Liaison 2001-2002; Model Rules Subcommittee Liaison 2001-2002; Awards Advisory Panel Liaison 2000-2001; Delegate Assembly Advisory Group Liaison 2000-2001; Commitment to Excellence Advisory Group, 1999-2000; Resolutions Committee 1999; Mutual Recognition Member Board Operations Analysis Tool Working Group 1998; Nurse Licensure Compact Administrators Executive Committee, 2002-2003; United States Air Force: 9019th Air Reserve Squadron 1976-1998; Colorado Air National Guard 1972-1975; Active Duty 1968-1971

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 boards' challenges to do more with less in conjunction with a majority of states' budget shortfalls; further, a scarcity of nursing workforce and faculty is predicted if not already in existence. 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 in various NCSBN activities in order to inform our decision making and to reflect, discuss and address issues confronting us with our collective wealth of education and experience; exercising our unique 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 fostering decision making that is consistent with the mission, compliant with the vision and in concert with the strategic initiatives. Serving as president requires listening well to all perspectives, deliberating and discussing openly the

challenges and issues that confront us as a national organization and as member boards. Further, I believe it is necessary to maintain flexibility in implementing the strategic initiatives so that as our environment changes we may respond accordingly and in kind by adapting strategy to meet the mission. Of great importance is the need to have critical and respectful discussion on difficult subjects. My leadership competencies include: openness, objectivity, directness, enthusiasm and a desire to debate with integrity and forthrightness, as well as to understand others' points of view. I am neither afraid of asking nor of hearing challenging and hard questions. Among colleagues 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 serve as your president.

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Vice President

Shirley Brekken, MS, RN

Board Staff, Minnesota, Area II

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

I began my journey in carrying out the mission of the National Council as a board member of the Minnesota Board of Nursing. Since that time, I have served on 12 committees/task forces as either chair or committee member. Each experience has increased my knowledge and commitment to the purposes of regulation; however, the following opportunities to partner with others to advance regulation have been the most rewarding: participating in the implementation of computer adaptive testing as a member of the Board of Directors (Area II director); initial development of Nur*sys*® as a member of the Nur*sys*® Advisory Group; contributing to the framework and content for conferences related to Member Board Leadership and the Institute of Regulatory Excellence through the Member Board Leadership Development Advisory Group; and advancing performance measurement and best practices through the Commitment to Ongoing Regulatory Excellence initiative. My passion for evidence-based nursing regulation has resulted in experiences as a co-investigator, collaborator or national advisory group member in research studies involving: congruence among LPN regulation, education, and practice; LPN practice regulation and outcomes of nursing home care; comparing state regulations affecting nursing homes and implications for culture change; and an HRSA-funded nurse residency program. Additionally, this commitment has led to my involvement in CORE to develop a performance measurement system for nursing regulation. I value collaboration in the interest of public protection, patient safety, and the education of nurses. Thus, I have been a partner in several state efforts related to: patient safety and advancing a "just culture" (Minnesota Alliance for Patient Safety); nursing excellence (Stratis Health Institute); nursing workforce (MN Center for Nursing BOD, MN Colleagues in Caring and MN Health Education and Industry Partnership Steering Committees); technology (Governor's e-Licensing Steering Committee); and nursing leadership (MN Organization of Leaders in Nursing). Experiences as a member of a school board, church planning committee, and other community organization boards have been occasions for community service.

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

State boards of nursing are challenged today to maintain relevance to the purposes of regulation and to do so with decreasing resources. The National Council's guiding principles and services provide structures and means to help member boards achieve their mission. For something to be relevant, it must serve as a means to a given purpose. Thus, the regulatory activities of boards should be based on evidence that result in protection of the safety of recipients of nursing care. National Council's research in the areas of practice breakdown, discipline methodology, remediation and substance abuse help to provide that evidence. CORE helps boards establish benchmarks for board operations and identify best practices that promote efficiencies and efficacy. Standardized licensure requirements will help ensure competence. Continued competence that is focused on performance improvement can be accomplished by developing linkages among various regulatory agents. Open and ethical debate will share innovation and solutions to do the right thing for the right reason. Active engagement in National Council's initiatives and utilization of services will help member boards to carry out their statutory mandate of public protection in spite of decreasing resources. 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

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

Leadership requires one to be passionate about a cause and a commitment to engagement and service. My passion for excellence in nursing regulation has resulted in opportunities to serve the purpose, mission, vision and values of the National Council. Length of service has given me sensitivity to the history of the organization keeping me grounded in the variety of needs of member boards. While member boards have a similar purpose, the means to accomplish public protection and governance structures vary. I endeavor to be respectful of these differences. Before drawing a conclusion, I consult with and listen to the people who will be impacted. I strive to find a way to bring diverse points of view in service to the common good. While historical knowledge is important, it should not interfere with vision for the future. I embrace change and encourage others to explore new options needed for an evolving regulatory landscape. I am supportive of forging constructive partnerships within and external to the National Council through candor, respect and honest communication. Leadership involves sincerity and personal integrity. I am committed to doing the right thing for the right reason and challenge others to do the same. I encourage and empower others to help solve problems. I believe in open and healthy debate and encourage discussion toward advancement of effective nursing regulation. I acknowledge the National Council not just as an organization that counsels together. It is an organization that must thrive in order to assist member boards to evolve their role in public protection.

Date of expiration of term:
Dec. 31, 2005

Eligible for reappointment:
Yes

Vice President

Rose Kearney-Nunnery, PhD, RN

Board Member, South Carolina, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

I have been a nurse educator since 1976 serving as faculty, program director, department head, and college dean at five different institutions educating nurses at the undergraduate (BSN, ADN & PN) and (MSN) graduate levels. I have also been a member of the South Carolina Board of Nursing since 2000 with three years' service as board president. I have also had the privilege to be involved in NCSBN attending many of the delegate assembly meetings since 2000, and serving as a delegate at five of these meetings. In addition I have served as a NCSBN committee member and on the NCSBN Board as follows: Area III Director (2005-2007), Continued Competence Task Force (August – Sept. 2005, chair), and Practice, Regulation & Education Committee (2001-2005, member). I have also served on professional and community boards and committees.

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

Collaboration with other professional groups and improving the practice culture with constant attention to public protection is a major challenge to nursing regulation. Disciplinary issues and differentiating between competency and workplace issues along with promoting a valid, reliable means to demonstrate continued competence among professionals and to the public are another major issue for nursing regulation. We also have an increased interest in nursing education and the development and expansion of nursing education programs and promoting appropriate education for competent practice with the challenges of limited clinical sites and qualified faculty. Added to this is the evolution of various educational routes and the demand for ongoing education, skill refinement, and role definition. The environment and the public are further challenged with assistive personnel along the path to improved health or care outcomes. Keeping abreast of current knowledge and best practices is a strategy to address these challenges. Another critical strategy is constantly attending to refining and enhancing personal communication skills while reaching out to other professionals and consumers of health care. NCSBN, as composed of its member boards, can facilitate identification, research, collaboration, and consistent sharing and use of evidence-based practices in these areas. As a NCSBN Officer, an essential strategy is identifying and delving into issues faced by the member boards. This requires openness, sensitivity, and a commitment to listen and collaborate to advance both regulation and safe, competent practice for effective healthcare for our consumers and constituents.

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

Leadership competencies important to this position are vision, critical analysis of all issues, effective interpersonal communication, and encouragement of others. I believe these are essential skills for service on the Board of Directors and to the membership as Vice President. A constant focus must be on the vision, values, and mission of NCSBN and the fair and impartial consideration of all issues. These issues of concern must address the concerns of the member boards throughout the country and territories and our associate members in order to advance regulatory excellence. I provide a commitment to the constant demonstration and further refinement of these competencies and a thorough investigation of all facets of issues and thoughtful discussion and decisions that reflect area, national, and global concerns for public protection and the enhancement of nursing practice.

Treasurer

Doreen Begley, MS, RN

Board Member, Nevada, Area I

Date of expiration of term: October 31, 2012

Eligible for reappointment: No

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY,AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

Three years ago I had the pleasure to be elected to the NCSBN Board of Directors as a Director-at-Large. I was serving the last year of my first term as an appointed board member to the Nevada State Board of Nursing. Because I was uncertain about my pending reappointment, I was unable to run again at that time. Since then, I have been happily reappointed to my second four-year term, I am serving my second year as the President of the Nevada State Board of Nursing, and I am a current fellowship participant in the 2013 cohort for the Institute of Regulatory Excellence. Since my involvement in nursing regulation six years ago, I have totally embraced the vision and mission of NCSBN, and have appreciated the opportunities to expand my knowledge and participation. The first 30 years of my nursing career were in the Emergency Department. From 1994-2000, I served on the Board of Directors for the Emergency Nurses Association (ENA), my last term as their Treasurer. To add to my fiduciary experience, for the past six years I have been employed as the director of a nurse practitioner community health clinic, financial sustainability being one of the greatest challenges. Through careful financial management we made budget every year! I am very familiar with working under serious financial constraints, but I feel there is an enhanced responsibility for fiscal management when financial resources are available. Being fiscally responsible and the careful management of our resources is paramount to continued financial success. Because of my past experiences, I am well aware of the responsibilities of NCSBN Treasurer. I hope that my dedication and performance will encourage you to once again, provide your support (and your vote) for me to be elected as your Treasurer.

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

As a leadership organization, one of the biggest challenges in a worldwide arena is to balance our position to provide NCSBN information and resources with being a respectful world partner. I believe while others may look to NCSBN for visionary leadership, it is our ability to work well with other organizations that will help us bring continued strength and respect dealing with nursing regulatory issues demands. As we move forward into the 21st century (10 years in now) I believe keeping up with the continued exponential growth in technology is paramount to success. Continued financial support will be necessary to remain current with technological advancements. The over arching purpose of NCSBN is to lessen the burden on the states to provide quality nursing regulation. In the past, NCSBN has met this mission very effectively. It would be my goal as a Treasurer to continue to meet the needs expressed by the states, and to continue to explore ways to bridge the economical gap that exists today. There will always be financial challenges to be met. I believe one of our more pressing issues is the direction that needs to be taken to ensure the financial sustainability of our organization. While we are currently stable, we must always keep an eye on what the future holds. It is incumbent upon us to diversify our sources of income and not be dependent upon a sole source. At one time in America, everyone had milk delivered to their door; I need not remind you that there is now no need for milkmen. Let us not become so comfortable in our present that we become blindsided in our future!

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

During my year as Director-at-Large for NCSBN, I was appointed the liaison to the APRN Committee. Working on that huge issue and being able to come to a consensus with not only our membership, but with multiple other national organizations was a perfect example of the visionary leadership NCSBN can provide. I was made to feel like a committee participant, not just

a designated assignee. Working to bring that issue to the delegate assembly was very satisfying, for everyone involved. That is an example of the kind of collaborative leadership I hope to bring with me to the NCSBN board of directors' table. As budgets are developed, they must routinely be examined line by line, and must always reflect the mission of the organization. I am a very positive person, I am an excellent listener, and I remain an eternal optimist about data driven outcomes. That is the spirit I hope to bring to my tenure in the Institute of Regulatory Excellence while completing my four year fellowship project. I have actually adjusted my work schedule to part-time, so that I may fully experience all that nursing regulation has to offer, and so that I may offer more of myself to be able to give back to the organization. Being a term-limited state board member does also limit my window of opportunity to participate on a national level. I continue to participate to the fullest extent in NCSBN activities, and I hope when you cast your vote for Treasurer, you consider casting it for me.

Treasurer

Date of expiration of term: April 30, 2011

Eligible for reappointment: Yes

Randy Hudspeth, MS, APRN-CNS/CNP, FRE

Board Member, Idaho, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

I am the current NCSBN Treasurer. I was elected in 2009 after serving one year as a Director-at-Large of the Board. I am seeking re-election as Treasurer. I bring a working knowledge of fiduciary concepts. I completed the Board Source Financial Governance Modules, have served as treasurer of the Idaho Nurses Association, a current trustee and former treasurer of the Idaho Nurses Foundation, and as treasurer of two community nonprofit boards. In my role as NCSBN Treasurer I chair the Finance Committee. In the past six months I coordinated a special audit for NCSBN, including interviewing and selecting the auditor firm. I analyzed the NCSBN budget, met with the auditors who perform the annual audit and have worked with the CFO to modify the travel policy and discuss the upcoming budget process. I also present the finance committee report at board meetings. I have been a board member of the Idaho Board of Nursing for seven years holding the APRN seat. I served on the APRN Committee for NCSBN for four years and helped write the Vision Paper and the Consensus Document. I completed the four-year fellowship through the Institute of Regulatory Excellence and was among the first group of inducted fellows. I am appointed by the governor of Idaho to the rural health board of directors for the Idaho Department of Health and Welfare (2002-current). I write a quarterly regulatory column in *Nursing Administration Quarterly* magazine.

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

There are many issues, but two issues I see as challenges to NCSBN in the coming years are (1) continuing to financially support member board activities and (2) promoting consistent regulatory practices between jurisdictions. Currently, NCSBN offers more financial aid to member boards than at any time in its history. Engaging with member boards to offer services that support IT structure, facilitate data entry to achieve an unduplicated inventory of nurses, enhance and expand the use of the Nur*sys*® database, promote engagement with TERCAP® and support attendance of member board representatives at delegate assembly, mid-year, IRE and committee meetings has all increased. These additional expenses come at a time when member boards are increasingly constrained in their expenses and limits are being enacted by state governments. It also comes at a time when NCSBN is seeing its own revenue decrease when compared to pervious years. Thus, the NCSBN Treasurer, Board of Directors and staff must all exercise thoughtful fiduciary policy and steward our resources so that we can maintain current level of activity without significant risk to NCSBN. To meet these needs we must: (1) budget accordingly and accurately, (2) safeguard our revenue sources to insure future solvency and (3) minimize risk. Consistency between jurisdictions was identified by the membership as important and thus a committee was formed to help evaluate and craft a plan of engagement to help member boards move toward consistent practices. The print media has focused on differences between boards and drawn attention of practice variation between jurisdictions. NCSBN needs to continue to monitor these activities and to offer media training and tools so the member board staff can develop skills in managing publicly addressed issues.

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

I bring experience with one year as NCSBN Treasurer and two years experience as a member of the NCSBN Board of Directors. I bring the experience of an IRE fellow, attendance at seven delegate assemblies and Midyear meetings, a member board president and vice-president as

well as a currently practicing APRN. I have also published 27 articles in peer reviewed journals in the past four years and I have been a speaker at both the NACNS and AANP annual meetings for the past two years. I have more than 25 years in senior nursing leadership in a medical center where I have maintained responsibility for the administration of multiple departments and annual budget responsibility of more than $75 million. I believe I can contribute to NCSBN advancement by continuing to showcase its programs through publications and presentations, mentoring of lesser experienced board members to engage with NCSBN activities and by continuing to link regulation with the practice environment.

Director-at-Large

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Joan Bainer, MN, RN, NE, BC

Board Staff, South Carolina, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

Joan K. Bainer, MN, RN, NE, BC, Executive Officer, South Carolina State Board of Nursing. Forty years of nursing practice in various roles to include the areas of general nursing, psychiatry, substance abuse, community health, education and management. Certified by the American Nurses Credentialing Center as a Nurse Executive 2000-present. Member of the Sigma Theta Tau, International Honor Society of Nursing, American Nurses Association and the South Carolina Nurses Association. State Level: South Carolina State Board of Nursing -Practice/ Advanced Practice Consultant 1994-2000, South Carolina State Board of Nursing -Executive Officer 2006-present. National Level: NCSBN Awards Committee, 2006-2008; NCSBN Chemical Dependency Committee, 2008-present; NCSBN Institute of Regulatory Excellence (IRE), 2007-present; NCSBN Information Technology Summit, Moderator, 2009; NCSBN Substance Use Disorder Conference, presenter, 2010; NCSBN conference calls, meetings and surveys, 1994-2000, 2006-2010. Committee Experience: Volunteered at the local child care center; Participated as a volunteer in the annual community Thanksgiving dinner for the homeless; Participated in sign language classes; Promoted nursing careers at a local middle school by participating in career day.

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

Nursing regulation has multifaceted challenges. As an Executive Officer, I envision the challenges for successful nursing regulation as increasing communication and education regarding regulation in a collaborative spirit with our licensees and the healthcare community and gathering and disseminating research to support regulation. One strategy is to increase the communication of the evidenced based research to the constituents thus supporting positive outcomes. Another strategy is to survey state boards of nursing as to the types of research that would be beneficial to them regarding the trends leading to future regulation and communicate the needs to each board of nursing and to the NCSBN Institute of Regulatory Excellence (IRE) committee for potential research proposals.

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

Spearheaded the effort to continue the development of a disciplinary sanctions guidelines chart. The chart was developed to guide and ensure consistent and fair disciplinary actions. The chart is utilized by the Board of Nursing, the Office of General Counsel (OGC), the Office of Investigations and Enforcement (OIE) and the Office of Licensure and Compliance (OLC). Also, the chart has been adapted by other agency multidisciplinary boards and shared with other boards of nursing. Continue to collaborate and explore ways with appropriate agency departments to increase the effectiveness and timeliness of our disciplinary processes. Regularly attend and participate in legislative meetings affecting the nursing community. Also, educated lawmakers to facilitate the passage of the Criminal Background Check bill for nursing licensure. Collaborating with the Office of Licensure and Compliance (OLC) to ensure the accuracy of our state's NURSYS database. Communicate with our licensees and community in an ongoing manner through the quarterly Palmetto Nurse magazine publication and the Labor, Licensing and Regulation agency electronic ledger. Encourage Board member and board staff participation in NCSBN activities in order to continue to advance the organization.

Date of expiration of term:
March 31, 2013

Eligible for reappointment:
Yes

Director-at-Large

Marguerite Herman, MAT, MMC

Board Member, Wyoming, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

First I will discuss my experience with the seven-member Wyoming State Board of Nursing. I am beginning my second three-year term, in the seat for public representation. I have been board secretary for three years and continue in that office. I designed the logo for WSBN. I also have served for three years on the WSBN's Education Committee, along with another board member and the board's education consultant. I participate in review of nursing education programs at the University of Wyoming and the state's seven community colleges. I have worked since my appointment on rules revision. I have a Bachelor of Arts (English major) from the Colorado College, Master of Art in Teaching from the University of Chicago and a master's in Mass Communications from the University of South Carolina. My work experience includes teaching secondary school, journalism, layout and design, resale business owner, columnist and lobbyist. I developed a working relationship with nurses (mostly in public health) through my work with La Leche League. I admire nurses greatly and enjoy working with. I have lobbied for the League of Women Voters, the Wyoming and National PTA, US Breastfeeding Committee, Laramie County Breastfeeding Taskforce, Wyoming Psychological Association, American Cancer Society and C-WISH (a health insurance consumer advocacy group). I serve on several boards as chairman or other officer. They are: Wyoming State Board of Nursing, secretary and consumer representative Wyoming State PTA, Legislative Chair League of Women Voters of Wyoming, director and lobbyist Wyoming Breastfeeding Coalition, chairman COMEA Inc., chairman (homeless shelter in Cheyenne) Children's Land Alliance Supporting Schools, Board of Governors secretary/treasurer St. Mary's Cathedral Guild, Cheyenne, WY, legislative commission chair I have education, skills and experience with public presentation, communication, promotion, advocacy, education, writing, design and the policy and management responsibilities of board work.

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 challenges to nursing regulation are thorough and quick disposition of applications and of complaints against licensees, to carry out regulatory agencies' duty to ensure the safe and competent practice of nursing. I am familiar with the news stories about the delays in completing investigations and restricting or revoking licenses of nurses who violate practice acts and regulations. In Wyoming, the board is acutely aware of the potential danger to the public when it takes us months or years to complete an investigation and report disciplinary action to national registers. Fortunately, our board convinced the 2010 Wyoming Legislature to change our practice act to clarify our subpoena powers and give us continuing jurisdiction over lapsed licenses. Along the same line, the WSBN is dealing with the problem of putting a rigorous, reliable system into place to monitor addicted nurses who have conditional licenses. The other top challenge relates to initial licensure, assuring the competence and integrity of applicants. The Wyoming board completes a thorough criminal background check on applicants at great cost. We are reluctant to join the nurse licensure compact when we must offer licensing reciprocity to nurses from states that don't do rigorous background checks on their applicants, although the board is criticized by some legislators and our governor for failing to take a step they view as saving time and money and making it easier for nurses to work in Wyoming. The WSBN continues to struggle with a small staff to act on license applications quickly but with diligence.

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

I have served many years on many different kinds of boards, elected and appointed, and I understand the role of boards to implement policy and make important management decisions for organizations. What I contribute to the NCSBN Board is a strong, articulate voice for the consumer of healthcare. I will work diligently to understand issues that nursing boards put to NCSBN and to implement the policies set by the Delegate Assembly. I will bring the public (non-nursing) perspective to the decisions we are called on to make. I also will bring forward consumer-related issues that I think NCSBN should address. I am hard-working, creative, collaborative, resourceful, articulate, responsible and goal-oriented. I have strong communication skills, among board members and with the general public. I understand the importance of public education and support for controversial decisions, and I can take a leadership role in communication with the public and advocacy for NCSBN Board actions. As the collective voice of nursing regulation in the United States and territories, NCSBN is an important source of research, policies and other support for member boards—especially boards that are trying to operate more efficiency or that are under political pressure to ease regulations. I am eager to help to this effort.

Date of expiration of term: November 7, 2011

Eligible for reappointment: Yes

Director-at-Large

Julio Santiago, MSN, RN, CCRN

Board Member, Illinois, Area II

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

Illinois Board of Nursing member since 2005 and chairperson for the last 18 months. NCSBN Board of director since September 2009. Twenty years of varied experience in nursing from behavioral health, management to critical care. Educational back ground includes a master's in nursing education and CCRN certification.

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 top challenges for nursing regulators are having the needed resources to do the work of the boards and the perception of the public that nurses are not being disciplined on a timely basis. Strategies to deal with the lack of resources would be to continue to work with boards of nursing to see how the work is being done at individual boards and what things they are implementing to do the work more efficiently. It was a great idea to have the California Board of Nursing present at midyear meeting and share with the delegates some of the changes they are making to improve the work of the board. Having sessions at the midyear meeting and yearly meeting for EO and board presidents allows our members to interact and learn from each other. Continue to provide opportunities to member boards to apply for waivers and grants to help support their work and the work of the NCSBN. Education of the public is an important part of the boards of nursing and the NCSBN. The work that NCSBN is doing with consumer groups allows the delegates to learn more about the issues related to the consumers and helps the consumer groups learn more about the work of the boards. More transparency through the use of the Nur*sys*® system will allow the public to have access to the boards of nursing discipline records. Continue to share best practices during midyear meeting, yearly meeting and NCSBN website with member boards and the public. Making change happen at the level of individual boards is always a little easier when it can be supported with data from the states that have implemented the changes and have had success.

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

Leadership competencies that I bring to the NCSBN include a year of experience under the current board of directors where I have been able to work collaborative with the current board to provide leadership to the organization. I'm an active listener and can provide productive feedback to further the cause and goals of the organization. My nursing experience allows me to be thoughtful about the work of the organization and respectful of how I communicate the important work of the organization. This past year has helped me to look at the role of the board of directors for the NCSBN and how I can help direct the work of NCSBN. Examples include but not limited: Providing support to member boards when resources are needed, whether it is monetarily, technological or educational, working on important issues related to transition to practice, nursing competencies and supporting the research of the organization. I'm able to contribute with creative problem solving ideas in order to help brain storm about ideas that drive the organization. My nursing work experience allows me to have a well rounded perspective of the nursing profession and nursing regulation. Actively working in a critical care unit keeps me in touch with current nursing trends, nursing care issues and nursing regulation.

Director-at-Large

Date of expiration of term: Oct. 1, 2013

Eligible for reappointment: Yes

Kathy Scott, RN, PhD, FACHE

Board Member, Arizona, Area I

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

I have served as the senior nurse executive and CNO of a large healthcare system as well as on numerous boards including the Arizona Organization of Nurse Executives (President for one term), currently on the Arizona State Board of Nursing, on numerous community boards including Global Hope Resources, Streetlight, Inc., Banner surgery centers, and Advisory Board for several universities including Michigan State University, Northwest Nazarene University and Boise State University. I also have served as adjunct faculty at Michigan State University and Arizona State University. From a regulatory perspective, I have served as a consultant and member to the TERCAP committee and most recently the Continuing Competency Committee in addition to Board Member of the Arizona State Board. I am an expert in complex systems, high reliability and innovative clinical delivery models. In January 2010 I started my own firm and serve as President and CEO of Kathy A Scott & Associates. www.kathyascott.com.

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

1) Demonstration of Continuing Competence. Strategies include partnering with other organizations to implement pilots related to continuing competency; working collaboratively with ANA, NLN and AONE to develop strategies to test/pilot. The second top challenge is moving from a punitive mode to a "just" approach of managing practice breakdown through a standardized approach across the country.

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

I bring current knowledge of the practice setting of nursing as well as expertise in complex systems, high reliability and patient safety, the TERCAP® tool and process and simulation.

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Director-at-Large

Katherine Thomas, MN, RN

Board Staff, Texas, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

Katherine Thomas is the Executive Director for the Texas Board of Nursing (BON), a position she has held since November, 1995. Prior to her appointment to the ED position, she served the Board as Director of Nursing Practice, November 1994-1995, as Nursing Consultant for Advanced Practice from 1990-1994, and as Education Consultant from 1989-1990. Her educational preparation includes a BSN from the University of Virginia; a Pediatric Nurse Practitioner (PNP) Certificate, US Army, Fitzsimons Army Medical Center, Denver, CO and a Masters Degree in Nursing from the University of Kansas. Prior to joining the BON, Ms. Thomas taught nursing as an Instructor and Assistant Professor at the University of Texas at San Antonio, baccalaureate and graduate degree programs and practiced for 10 years as a Pediatric Nurse Practitioner. Ms. Thomas serves as a member of the Executive Committee of the Compact Administrators, the group responsible for implementation of the Nurse Licensure Compact. She served as the Vice-Chair of the Health Professions Council, a council of agencies who regulate health care professionals in Texas, 1999-2000, and has been the chair of this group since 2000. Ms. Thomas served on several Advanced Nursing Practice committees of the National Council of State Boards of Nursing, chairing the APRN Advisory Committee from 1995-2007. She has also served on the Practice, Regulation and Education Committee and the Awards Committee. She has been active in the NCSBN for the past 13 years and has received two awards from this organization: the R. Louise McManus Award (August 2002) and the Meritorious Service Award (August 1999).

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

1. Ensuring that the NCLEX examinations evolve with developing technologies while maintaining the reputation for being the premier licensure examinations they have historically been known for. Strategies to address: a. Test new interactive scenarios items; and b. Explore new technologies to improve measurement of competency. 2. Expand the Nursys® data base, ensuring it is contains accurate, complete, and current national licensure and disciplinary data upon which all boards of nursing can rely. Strategies to address: a. Continue efforts to explore all options to encourage and support states in submitting this data; and b. Continue efforts to ensure that data contained in Nursys is accurate and reliable.

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

I bring a strong commitment to the mission, vision and values of NCSBN. I am open and honest in expressing my opinions and ideas and listen to and value the ideas of others. I believe in a creative process to envision and plan for the future. I respect the opinions and perspectives of all of the Council's members and external stakeholders as we consider solutions for our current challenges. We must own our decisions but remain flexible and adapt as our environment changes and evolves.

Director-at-Large

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Emmaline Woodson, DNP, MS, RN, FRE

Board Staff, Maryland, Area IV

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

I am the Deputy Director with the Maryland Board of Nursing. I have been employed by the Maryland Board of Nursing since 1990. I was hired as the Director for Discipline and Rehabilitation and held that position until spring of 2001. In 2001, I became the Deputy Director and Director for Advanced Practice. I received my Doctor of Nursing Practice from the University of Maryland School of Nursing in 2010. I have been involved with the work of the NCSBN since 1994. Having served on various committees and task forces. I am a member of the APRN Committee appointed in 2008. I was elected for a two-year term with the Nomination Committee for Area IV in 2006, and served as Chairperson of this committee for the year 2007 – 2008. I participated in the Institute of Regulatory Excellence program and was inducted into the fellowship in August 2008. I have served on the following committees and task forces for NCSBN: Continued Competency, Discipline Advisory Panel, Commitment to Excellence Workshop, Multi-State Regulation Task Force, Chemically Impaired Nurses Task Force, Literature Review Focus, and casted in the video, "Breaking The Habit: When Your Colleague Is Chemically Dependent." My community involvements include the following: Maryland Nurses Association, Baltimore Tuskegee Alumni Association, American Red Cross Disaster Nurses group, The Wayland Baptist Church Sunday School Workers Education group, Delta Sigma Theta Sorority, and the community Liaison for the Diabetes Association's annual fund-raising drive.

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 major challenges is the economic down turn had having to work with fewer resources including scheduled furlough days. One of the strategies we are using is to streamline our processes. We have had paperless licenses since 2007. All but one of our frequently used forms are online and the online renewals are now at approximately 97 percent for RNs and LPNs. The certificate holders on line renewals are less than 90 percent, but increasing yearly. There should be a significant increase in online renewals for certificate holders after July 1, 2010 when the new law takes effect. The new statue change removes the requirement for a registered nurse to sign for a certificate holder's renewal. These automated changes have allowed our current staff to manage the renewal process. The new Health Care Reform Legislative should have a significant impact on the practice of APRN's especially on nurse practitioners. We have a most recent legislative change which removes joint regulation on nurse practitioners from the medical board and places the regulation within the nursing board. This will increase the independent practice of nurse practitioners and address access to care especially in the rural areas of the state. This change has a significant impact on the workload of staff within the advanced practice area.

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

I have over 40 years of nursing experience which include 20 years of regulatory nursing experience. I have had progressively responsible positions in my career. I posses a thorough knowledge of the regulatory process and a thorough knowledge of the legislative process which is the basis for our various statues and regulations by which Boards of Nursing operate. I fully support the mission, vision and core values of the NCSBN. I will bring the following abilities to the position of Director-at-Large:

- negotiating with stakeholders
- establishing and maintaining trusting relationships
- engaging and motivating others
- communicating clearly and concisely
- looking at things objectively

I believe these attributes along with my organization skills will serve this office well. I am very passionate about the work of the National Council of State Boards of Nursing and the Boards of Nursing's need to maintain its overarching goal which is public protection.

Leadership Succession Committee
Area II Member

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Lisa Emrich, MSN, RN

Board Staff, Ohio, Area II

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

Twenty-seven years of RN practice included critical care and critical care management, obtaining and maintaining my CCRN®, implementation of a hospital-based cardiac rehabilitation program, and assistant director of a surgical unit. As a critical care manager, I implemented a competency-based orientation for new staff within the critical care unit, and served on the hospital's critical care and quality assurance committees. Served five years with the State Medical Board as its Standards Review and Intervention Supervisor, responsible for implementation and coordination of its Quality Intervention Program, a confidential, non-disciplinary remediation program for physicians. Also reviewed information for evidence of a violation of the Medical Practice Act, explained evidence in relation to the expected standard, and contracted with physician experts as needed. Served 10 years with the Nursing Board with various responsibilities over time. I implemented its Practice Intervention and Improvement Program (PIIP) and have been responsible for areas including: the alternative program for chemical dependency, post-disciplinary monitoring, human resources, fiscal, the Board's responses to practice issues, nursing education and various other training programs. I have been actively involved with NCSBN since 2002, when I was appointed to the Practice Breakdown Committee that developed the TERCAP. Have served as chair of the TERCAP® Committee since 2007. Was contributing author to NCSBN's Nursing Pathways for Patient Safety published in 2009. My MSN is with a concentration in legal studies that included Health Care Law, Bioethics and the Law, and Medical Malpractice completed at the University's law school. Community involvement includes serving the past three years on the board of trustees (volunteer) for a nonprofit long-term care campus and elected to the office of Secretary. Additional responsibilities include chairing its Long Range Planning Committee, serving on its Executive Committee. In addition, I serve as director of the children's program at my church.

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 most significant challenges to nursing regulation are maintaining outstanding public protection with significantly decreasing resources, and maximizing its autonomous control over the resources that are available. With the current revenue shortfalls experienced by most states, and rising unemployment and reduced wages in the marketplace, the public is increasingly reliant on government resources and its protections, and is vocalizing its expectations in multiples ways. Boards need to focus on the basics of regulation. This includes drafting regulations that set clear expectations that must be met, unacceptable practices that will not be tolerated, and outcome measures that reflect that the licensee or nursing education program is practicing and operating for the public good. Regulations that were effective three or four years ago may not be effective in the current climate. The establishment of effective regulations and their enforcement is paramount. Boards should analyze and continuously reprioritize the areas in which it expends their resources, and improve the effectiveness and efficiency of its processes, while still positively responding to customers. This includes fostering effective relationships with other entities and agencies outside of the Board. While the increased use of technology and other human resource extenders respond to the majority of the public's informational needs, Boards have to be willing to identify and address the needs of the individual caller who expects to talk with a knowledgeable person. Boards should qualify and quantify their work and explain it to the public in a manner that is meaningful to the public, and demonstrates that Board decisions,

and utilization of resources, are prioritized based on the value to the public in a manner that promotes transparency in government.

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

I bring an understanding of nursing practice, nursing regulation and good stewardship. This is reflected in my professional, regulatory and community experiences. I bring the confidence of knowledge in the discussion and application of nursing and its regulation, and the self-assurance to ask clarifying and informative questions. I bring the ability to set and understand a vision, and the goals that are to be accomplished, and the skill to enjoin others in the path to reach the desired product. This involves establishing positive relationships, respecting differences of opinions, and linking common agendas. This is evident in my work for the Board in its development of Interpretive Guidelines for practice that required work and input of many shareholders. As a long-term care campus Trustee, I introduced the concept of just culture to other Trustees and administration, which is now being utilized as a risk management process. The work of the TERCAP Committee, which I have chaired, has resulted in a steady increase of instrument utilization and the Committee's work this year has focused on the manner in which practice breakdown data may be more readily provided to Member boards. As the Board's Fiscal Unit Manager I work with our Fiscal Officer to monitor the Board's budget and spending. Similarly, as a Trustee for a long-term care campus I am jointly responsible for its assets including investments and have been involved in the financing, planning and building of a campus community center scheduled to open in June 2010 that will serve campus residents and the surrounding community. I am accepting of opportunities to improve the manner in which I work and work with others. I welcome feedback and use it constructively. I have the confidence to seek change when it is warranted and work to communicate with those involved to increase productivity.

Leadership Succession Committee Area III Member

Date of expiration of term: Jan. 1, 2013

Eligible for reappointment: No

Richard Gibbs, LVN

Board Member, Texas, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

Board member Texas Board of Vocational Examiners 2002-2003; Board member Texas Board Nurse Examiners 2004-2007; Board member Texas Board of Nurses 2008-present; Served as Vice-President Texas Board of Nurse Examiners 2005-2006; Served two terms as committee member for Resolutions Committee; Currently serving as committee member for CORE committee; Served as Editor-in-Chief of LPN 2009; Serves on Eligibility and Disciplinary Committee for Texas Board of Nurses and also serves as Board Development Liaison for Texas Board of Nurses

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 feel that the nursing shortage and the shortage of nurse educators is a problem that needs to be addressed at the state and national level. With the present high median age of the nursing professional it is with utmost importance that we continue to find ways to educate recruit and retain our future nurses. I feel with the joint effort of NCSBN and the state boards of nursing we can continue to regulate, monitor, recruit and retain nurses for the present and future.

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

When elected I would continue to support and carry out the mission and vision of NCSBN and work collaboratively with NCSBN and other Member Boards. I bring my experience as a NCSBN committee member, state board member and 28 years of nursing experience to the table.

Date of expiration of term:
N/A

Eligible for reappointment:
N/A

Leadership Succession Committee
Area III Member

Brenda McDougal

Board Staff, North Carolina, Area III

DESCRIBE ALL RELEVANT PROFESSIONAL, REGULATORY AND COMMUNITY INVOLVEMENT, INCLUDING SERVICE ON NCSBN COMMITTEES:

I serve as the Associate Executive Director – Operations of the North Carolina Board of Nursing with oversight of the Licensure, Information Technology and Office Operations Departments, as well as other business infrastructure functions. I hold a BS in Business Administration and will resume my studies to complete an MBA at North Carolina State University – Fall 2010. I have 21 years of nursing regulation experience from a business results, continuous quality improvement and public protection framework. I've served NCSBN in the following capacities: Current Chair, Uniform Licensure Committee; Member, Disaster Preparedness Committee; Member, Operations Focus Workgroup; Presenter, IT Summit: "Innovations in Licensure"; Presenter, "Paperless Licensure System Webinar."

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 significant challenge facing nursing regulation today is the need to apply consistent and standardized licensing requirements in all jurisdictions which would facilitate ease of mobility among licensees while providing a greater degree of public protection and confidence in the skill, knowledge and abilities of the nation's nursing workforce.

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

My genuine support of the vision, mission and strategic plan of NCSBN coupled with my nursing regulation experience would provide my basis to assist in the development of strategies and tactics to accomplish the goals and objectives of the Leadership Succession Committee to insure highly skilled leadership candidates from member boards are recruited, developed and placed in leadership position to sustain this organization.

Attachment B

Leadership Development Plan

Advancing Potential – Discover the Leader Within

Success of an organization and its mission is inextricably tied to the strength of its leadership and leadership resources. Leaders of an organization must possess self-knowledge and governance leadership competencies to successfully guide and advance an organization.

NCSBN believes there is a deliberate path to identify and nurture individuals to secure a legacy of leadership at all levels to advance and sustain an organization. That path supports the ongoing performance and growth of NCSBN and includes a defined organizational strategy to leadership succession. It is essential that the organization creates and sustains a path to develop leaders.

Leadership succession is the deliberate, ongoing process of identifying and developing qualified leaders who:

- Serve the purpose, mission, vision and values of the organization;
- Advance and promote excellence in nursing regulation;
- Sustain and evolve continued success and viability of NCSBN; and
- Embrace and cultivate a culture of service and stewardship.

Candidates for NCSBN positions are individuals who possess knowledge of regulation, are committed to the mission, vision and values of NCSBN, and who demonstrate:

Self-knowledge

- Particularly in relation to honesty, integrity and courage;
- Ability to deal with ambiguity and complexity;
- Flexibility and adaptability;
- Cultural competence—the ability to work effectively cross culturally; and
- Interpersonal and communication effectiveness.

Governance Leadership

- Stewardship—selecting service to greater good over self-interest;
- Strategic and futuristic thinking;
- Fiduciary knowledge;
- Evidence-based decision making;
- Consensus building through strategic alliances, networks and partnerships;
- Effective change and risk management, including accountability and transparency;
- Diplomatic and politically savvy relationship building; and
- Creativity and innovation.

LEADERSHIP DEVELOPMENT

The purpose of leadership development is to cultivate and recognize leadership within the organization to ensure sustained, progressive viability of the organization. The overall goal of the leadership development plan is to build leadership within and throughout the organization. The ultimate focus is to have a pool of available, diverse and qualified candidates for election to the Leadership Succession Committee (LSC) and the NCSBN Board of Directors (BOD) to meet the challenges of the future.

NCSBN proposes leadership building through three objectives:

1. Early Connectivity: Members are engaged quickly with NCSBN to understand its purpose, function, products and services, and their role in relation to the organization.
2. Building Self-Knowledge – Self-Discovery: Members participate in opportunities for enhancing leadership knowledge, skills and ability.
3. Building Board and Organizational Governance Expertise: Members participate in opportunities to build governance expertise.

LEADERSHIP DEVELOPMENT ACTIVITIES

The purpose of this description is to aid interested individuals in building their leadership competence for their own interest, serving NCSBN on the BOD and/or the LSC through self-selection of relevant activities. These opportunities described below are not an all-inclusive list, nor do they imply mandatory participation; rather, these leadership development activities are offered based on an individual's own personal goals.

Early Connectivity

- Connect with NCSBN staff to:
  - Enter their member information immediately into a membership database;
  - Access resources and networks specific to their role;
  - Initiate opportunity for mentorship into respective member roles. (e.g., executive officer to executive officer, president to president, board member to board member, education consultant to education consultant); and
  - Establish an online account and sign into Web-based services.
- Complete NCSBN 101.
- Participate in a state-specific orientation unique to roles, such as board member, investigator, licensure specialist, manager, receptionist, consultant, consumer, etc.
- Identify specific leadership development activities to support personal goals.

Current NCSBN Resources	External Resources	NCSBN Resources Needed
▪ NCSBN 101 ▪ iMiS membership database ▪ NCSBN website ▪ President's Governance Role online course ▪ *Council Connector* ▪ NCSBN Guide to External Products and Services ▪ NCSBN Directory of Programs and Services ▪ Attendance at Midyear and Annual Meetings ▪ New Delegate Orientation online course ▪ Use of Resource Fund to attend BOD meeting ▪ Participate in BOD Member Board conference calls	▪ Parliamentary Procedure/ Robert's Rules of Order ▪ Individual state board of nursing (BON) website ▪ Board members and staff on NCSBN committees need to give regular reports to the BON ▪ Board members and staff participating on conference calls need to give regular reports on information ▪ Other BONs ▪ Other professional boards and national entities ▪ Internet search with key words such as nonprofit associations, administrative law, licensing boards, state-based regulation, orientation, mentorship, coaching, leadership, time management and work-life balance ▪ Annotated bibliography on leadership	▪ Easy and open access to NCSBN 101 ▪ New member welcome video ▪ LSC video ▪ Mentor checklist for mentors or toolkit and mentors orientation ▪ Materials to educate mentors on mentoring: ▪ Develop orientation programs for all BON roles, such as receptionist, licensure specialist, practice consultant, etc. ▪ Develop support program to assist members with putting their own leadership development plan together

Current NCSBN Resources	External Resources	NCSBN Resources Needed
▪ Resource Fund ▪ Executive Officer Mentor Program ▪ IRE Fellowship Program ▪ NCSBN *Journal of Nursing Regulation* ▪ Participate on NCSBN committees ▪ Participate in related state or national committees ▪ Participate in NCSBN special interest network conference calls as appropriate	▪ TalentSIM: online interactive leadership assessment module (two hours, $250) ▪ *Now Discover Your Strengths*–book with code for Web-based assessment that identifies five top strengths with fun, interesting explanation of results. Reading the book is recommended, but not required in order to take the assessment (45 mins., $18) ▪ STTI Mentored Leadership Development Program–a yearlong leadership, scholarship and evidence-based nursing program that requires individuals to identify and enroll a mentor for a specific research project (one year, travel costs) ▪ Suite 101: http://skill-assessment.suite101 (30-40 mins., free) ▪ Seek out a personal mentor ▪ Seek out a personal mentee	▪ Available and reliable leadership and cultural competence assessment tools identified ▪ Developed mentor or coaching program for other types of members (e.g., practice or education consultants, board members) ▪ Executive Officer Coaching made available to all executive officers ▪ Develop seminar on mentoring ▪ Develop candidate readiness program on how to know when to run for office; how to run/ campaign strategies. Could include taped interviews with former board members. Have checklist for readiness.

Building Self-knowledge – Self-Discovery

- Address the leadership competencies of self-knowledge, strategic vision, risk taking and creativity, interpersonal and communication effectiveness, and inspiring and leading change through completion of leadership self-assessments.
- Create, implement and evaluate a leadership development plan.
- Complete a cultural competence assessment.
- Participate in education offerings relevant to development plan.

Current NCSBN Resources	External Resources	NCSBN Resources Needed
▪ Access report on identification of regulatory trends and other evidence from research that impact public protection policy decisions ▪ President's Governance Role online course ▪ NCSBN Articles of Incorporation and Bylaws ▪ Current strategic initiatives and strategic objectives ▪ Review historical BOD decisions and Delegate Assembly resolutions ▪ Review NCSBN financial reports ▪ Review NCSBN Annual Report ▪ Review Tom Abram's handout on Legal Role & Responsibilities of NCSBN as a 501(c)(3) ▪ NCSBN Model Act & Rules ▪ Commitment to Ongoing Regulatory Excellence (CORE) program ▪ NCSBN research	▪ Formal and informal knowledge building and mentoring agreements between BONs ▪ Engage consumer groups to assess the BON and its organizational performance related to accountability and transparency ▪ Appraise strategic partnerships to advance the mission of the BON	▪ Develop various online governance education courses ▪ Develop organizational/ BON performance assessment review/survey process

Building Board and Organizational Governance Expertise

- Understand fundamental governance principles and practices of high-performance boards related to governance structure, philosophy, mission, vision, values, strategic planning, and legal and fiduciary responsibility of board members and staff.
- Understand the similarities and differences between the governance of a national nonprofit association and the governance of a state regulatory agency.

Draft: Nov. 11, 2009
Jan. 4, 2010
Jan. 5, 2010

Attachment C

Essential Competencies for Governance Leadership

Sept. 22, 2009

FRAMEWORK FOR GOVERNANCE LEADERSHIP POSITIONS

The success of an organization and its mission are inextricably tied to the strength of its leadership and leadership resources. Leaders of an organization must possess self-knowledge and governance leadership competencies to successfully guide and advance an organization.

NCSBN believes there is a deliberate path to identify and nurture individuals to secure a legacy of leadership at all levels to advance and sustain an organization. That path supports the ongoing performance and growth of NCSBN and includes a defined organizational strategy to leadership succession. It is essential that the organization creates and sustains a path to develop leaders.

Leadership succession is the deliberate, ongoing process of identifying and developing qualified leaders who:

- Serve the purpose, mission, vision and values of the organization;
- Advance and promote excellence in nursing regulation;
- Sustain and evolve continued success and viability of NCSBN; and
- Embrace and cultivate a culture of service and stewardship.

ESSENTIAL COMPETENCIES

Candidates for NCSBN positions are individuals who possess knowledge of regulation and commitment to the mission, vision and values of NCSBN, and who demonstrate:

Self-knowledge

- Particularly in relation to honesty, integrity and courage;
- Ability to deal with ambiguity and complexity;
- Flexibility and adaptability;
- Cultural competence—the ability to work effectively cross culturally; and
- Interpersonal and communication effectiveness.

Governance Leadership

- Stewardship— selecting service to greater good over self-interest;
- Strategic and futuristic thinking;
- Fiduciary knowledge;
- Evidence-based decision making;
- Consensus building through strategic alliances, networks and partnerships;
- Effective change and risk management, including accountability and transparency;
- Diplomatic and politically savvy relationship building; and
- Creativity and innovation.

Attachment D

Leadership Succession Committee Interview Questions

Revised Sept. 22, 2009

1. What are your previous leadership experiences? What leadership competencies that you have will you use to contribute to NCSBN's Board?
2. What motivated you to apply for this position? (Stewardship, Strategic and Futuristic Thinking)
3. What challenges do you see ahead for NCSBN? How do you see yourself contributing to managing these challenges? (Strategic and Futuristic Thinking)
4. Describe your knowledge and experience with enacting fiduciary responsibilities. (Fiduciary Knowledge)
    - Because of economic constraints, we all are cognizant of our money management. Provide an example of a financial decision amid financial constraint.
    - How do you get a job done with limited financial and personnel resources?
    - At the end of the fiscal year there are excess funds. What would you do with the funds?
5. Describe how you make important decisions.
    - Give an example of a difficult decision you had to make within the last two years. What was the outcome and would you have done anything differently?
6. How have you built consensus among diverse stakeholders with complex issues and what actions did you take? (Consensus Building, Relationship Building)
7. What partnership alliances will be important to NCSBN in the future? (Consensus Building)
    - How have you worked with a group that had polar opposite reactions to an issue and was that group able to come to consensus?
8. How do you know when you are communicating effectively and accurately? (Alternative question: If 70 percent of all communication is miscommunication, how do you know when you are communicating effectively and accurately?) Communication Effectiveness
9. Describe your response to change and risk, and the best way to manage these for NCSBN. (Effective Change and Risk Management, Accountability, Flexibility and Adaptability, Evidence-based Decision Making, Consensus Building)
    - Provide an example of implementing a change that had significant risk to your organization.
    - Tell us about a change you implemented in your work environment requiring significant risk. How did you manage the change? What did you do to adapt to the change and respond?
10. Describe your ability to deal with ambiguity. What leadership qualities did you use?
11. Describe your policy-setting experience. What characteristics do you use to be successful?
12. Describe a creative idea you had and its development into innovation. (Creativity and Innovation)
13. What does cultural competency and cultural sensitivity mean to you? (Cultural Competence)

14. Describe the role technology will play in the NCSBN's future. (Strategic and Futuristic Thinking)
15. How will you manage the time commitment? (Flexibility and Adaptability, Effective Change and Risk Management, Accountability, Transparency)
    - How do you manage multiple and competing priorities?
    - Do you understand the time commitment involved for this position?
    - Do you have the support of your board, staff and employer?
    - What measures will you take to meet your commitment of time and expertise for this position?

Committee Notes:

- Staff will distribute test pool interview questions to all nominees for self-reflection the day after the nomination deadline and schedule the interviews with breaks and points for deliberation.
- The same questions should be asked of all nominees in the category, but not necessarily all the same questions for all the nominees.
- Come prepared with the questions we feel are needed for each category: vice president, area directors and leadership succession.

Attachment E

Candidate Selection Assessment Worksheet

This tool is designed for Leadership Succession Committee (LSC) members to track their assessment of the nominees based on the data reviewed. The information identified on this worksheet will be data needed during deliberations and decision making. This worksheet will not be shared with other members of the committee or staff. It is for each member's personal use to help organize their assessment data of the nominees. This worksheet should be destroyed when the committee has completed its work in January.

Nominee Name/Credentials: _____

1. Which position(s) did the candidate apply for and validate at the interview?

2. The purpose of the assessment is to determine if the nominee has demonstrated sufficient evidence of the leadership competencies to warrant moving forward in the process. To make this determination, the committee will need to take a step back and consider the full pool of data that is available.

   On the left side of the chart that follows is a list of the required leadership competencies. Using the first column to the right of each competency and the rating scale above it, indicate how often the nominee demonstrates the required competencies. Use the Notes/Examples column to track the evidence you found to support the presence of the competency. There are various methods that you may choose to complete the Notes/Examples column, including, but not limited to:

   - Entering your complete notes on the nominee with examples.
   - Making brief notes along with copying and pasting sections from the nominee's application that support your notes.

Rating scale for how often the competencies were evident:

1	2	3	4	5
Never/Almost Never	Rarely	Occasionally	Frequently	Always/Almost Always

Essential Competencies	How often were the competencies evident?	Notes/Examples
SELF-KNOWLEDGE		
Particularly in relation to honesty, integrity and courage		
Ability to deal with ambiguity and complexity		
Flexible and adaptable		
Cultural competence—the ability to work effectively cross culturally		
Interpersonal and communication effectiveness		
GOVERNANCE LEADERSHIP		
Stewardship—selecting service to greater good over self-interest		
Strategic and futuristic thinking		
Fiduciary knowledge		
Evidence-based decision making		
Consensus building through strategic alliances, networks and partnerships		
Effective change and risk management, including accountability and transparency		
Diplomatic and politically savvy relationship building		
Creativity and innovation		

3. Were there any inconsistencies compared to the information the nominee presented about himself/herself? Were there any questions or concerns that arose during the interview or review of the nomination form (e.g., potential conflicts of interest)?

4. Additional comments:

5. Now, taking a step back and considering the nominee and your assessment of his/her competencies as a whole, has the nominee demonstrated the necessary leadership competencies to be eligible for the position(s) applied for?

YES NO

Draft: Nov. 12, 2009

Attachment F

Leadership Succession Committee Policy and Procedure

POLICY NUMBER	1.0
POLICY NAME	LEADERSHIP SUCCESSION COMMITTEE
DATE OF ORIGIN	December 2008
PURPOSE	▪ To define the role, function and procedures for the Leadership Succession Committee. ▪ To utilize core leadership competencies to determine nominees' readiness for candidacy for all elected positions consistent with the mission, vision and values of NCSBN. ▪ To establish a timeline of activity for engagement, preparation and presentation of a slate of candidates at Delegate Assembly. ▪ To implement a nomination, selection and campaign process that reflects the values of fairness, integrity and accountability.
1.0 POLICY	1.1 The Leadership Succession Committee recommends strategies for the ongoing sustainability and advancement of the organization through leadership succession planning. 1.2 The Leadership Succession Committee presents a slate of candidates through a determination of qualifications and geographic distribution for inclusion on the ballot for the election of the Board of Directors and the Leadership Succession Committee.
2.0 STANDARDS/CRITERIA	**2.1 Facilitate the operations of the committee.** 2.2 Determine candidate qualifications based on demonstration of identified core leadership competencies. 2.3 Ensure equitable, fair and consistent campaign procedures.
3.0 OPERATIONAL PROCEDURE	**3.1 Engagement Strategy** a. Review and evaluate prior engagement strategies including talking points for committee members. b. Review evaluations from the prior Delegate Assembly. c. Review, update and finalize committee materials used for preparation and presentation of the slate of candidates. d. Issue Call for Nominations through NCSBN communication channels, which may include: 1. NCSBN website; 2. *Council Connector;* and 3. Electronic distribution and direct mailing to Member Board Presidents, Executive Officers, Member Boards, all current NCSBN committee members and all member networks.

	3.2 Preparation of Slate and Interview Process a. Determine nominee's eligibility and qualifications based on demonstrable and measurable criteria and consistency with the organization's mission, vision and values. b. Validate the nominee's eligibility to serve a complete term with proper documentation. Board Members of Member Boards who are not eligible for reappointment and whose term would expire during the NCSBN term of office, if elected, are prohibited from running for election. c. Conduct interviews with nominees and identify core leadership competencies through interview questions and information provided by the nominee. 1. Contact nominees. 2. Explain process of the interview to the nominee. 3. Conduct interview and allow nominee to ask questions. 4. Conclude nominee interview. Members of the Leadership Succession Committee who have submitted a nomination form for a second term shall recuse themselves from the interview of nominees for that position. d. Potential nominees who wish to be nominated from the floor are strongly encouraged to arrange for an interview with the Leadership Succession Committee the day before adoption of the slate by the Delegate Assembly and shall submit a completed nomination form. Subsequent to the interview and prior to the start of Delegate Assembly, the potential nominee will be notified in writing of the committee's recommendation. e. Prepare slate of candidates for consideration by the Delegate Assembly. f. Notify each candidate in writing of acceptance or denial of candidacy.
	3.3 Presentation of the Slate a. Prepare the slate for the Business Book according to the date established by the Board of Directors. b. The slate of candidates is announced to the membership and the Board of Directors at the same time. c. The report of the Leadership Succession Committee is read at the first business meeting of the Delegate Assembly and nominations from the floor are accepted pursuant to NCSBN Bylaws Article 7, Section 1(f). d. Conduct Candidate Forum. e. Election

	3.4 Campaign Procedure a. General contact information for Member Boards including mailing list, phone list and e-mail address shall be furnished to candidates for the purpose of campaigning. The general Member Board e-mail group address will be provided. E-mail addresses of all Delegate Assembly registrants shall also be provided to candidates. b. Candidates may campaign through informal communication with the membership through letters, e-mails, flyers and telephone calls after public announcement of the slate and prior to Delegate Assembly. Campaigning via videotape shall not be permitted. c. PowerPoint presentations may be permitted during the Candidate Forum but must be submitted electronically to NCSBN three weeks prior to Delegate Assembly. d. Information provided on NCSBN candidate nomination form and the submitted photo will be published in the Delegate Assembly Business Book. e. A photo of the candidate submitted to NCSBN and a candidate ribbon provided by NCSBN shall be the only candidate identification during Delegate Assembly. f. The Leadership Succession Committee will monitor compliance with the campaigning guidelines and will be available to address concerns before and during the Delegate Assembly. Campaigning by display or distribution of materials is prohibited during Delegate Assembly. g. A candidate unable to attend the Delegate Assembly shall be granted the right to have his or her personal statement read during the candidate forum by a selected board of nursing representatives or by a member of the Leadership Succession Committee. Videotaped personal statements shall not be permitted. h. Integrity of the election process shall be demonstrated by the members of the Leadership Succession Committee and the Board of Directors. These members are prohibited from providing opinion, counsel or advice about candidates or campaign strategies. i. Candidates will be expected to act ethically and professionally at all times and in accordance with the organizational values. j. The Leadership Succession Committee is available to answer questions or provide information about the campaigning process.

	k. Candidate Forum: 1. Candidate Forum – Approximately two hours in duration 2. Candidate Speech Time – Limit five minutes for President candidates; four minutes for all other Board of Director positions; and two minutes for Leadership Succession Committee candidates. 3. Candidate Forum Order of Presentations: Even Numbered Years • President • Vice-President • Treasurer • Director-at-Large (two positions) • Area I, Leadership Succession Committee • Area II, Leadership Succession Committee • Area III, Leadership Succession Committee • Area IV, Leadership Succession Committee Odd Numbered Years • Area I Director • Area II Director • Area III Director • Area IV Director • Director-at-Large (two positions) • Designated Member Positions, Leadership Succession Committee
REVISED: JAN. 4, 2010	

2010 Report of the Board of Directors

Highlights of Business Activities Oct. 1, 2009 through May 31, 2010

NEW BEGINNINGS

The 2010 Board of Directors (BOD) began the year in a unique orientation session to ensure effective governance. The facilitated session held in September 2009 addressed how a diversity of leadership styles supports quality performance outcomes. The BOD addressed its year-long performance through implementation of a governance performance improvement action plan.

In October 2009, the BOD held a retreat in North Carolina to discuss the future direction of the organization. The retreat was facilitated by a consultant to assist the BOD in identifying important environmental factors that will influence the work of the organization as it moves into the future. As a result, the BOD began drafting a new mission statement, a new vision, new organizational values and new strategic initiatives. Environmental factors identified by the BOD included:

1. **Current and Future Economy**

   Based on the current economic impact on individual states, NCSBN should consider a variety of ways to support Member Boards.

2. **Patient Safety and Public Protection**

   NCSBN should continue to explore approaches that positively impact patient safety through products, services and public education.

3. **Globalization**

   NCSBN should continue to learn and lead in the global nursing regulatory community.

4. **Consumers**

   NCSBN should continue to collaborate with consumer groups as an essential collaboration in promoting public safety, as well as informing the public about the work of nursing regulators.

5. **Increased Leadership Development**

   NCSBN should continue its support for leadership development to sustain and grow the future of the organization.

6. **NCSBN–NLCA Relationship**

   NCSBN should continue the important discussion regarding the right relationship between NCSBN and the Nurse Licensure Compact Administrators (NLCA).

7. **The Future of NCLEX®**

   NCSBN should explore new technologies and continue to be a leader in the testing industry.

The BOD diligently supported the ongoing discussion regarding the relationship of NCSBN and the NLCA. This work has highlighted the need for identification of regulatory issues as a result of the interface between the single state and multistate licensure models, including the need for ongoing, structured conversation and education for the benefit of all members.

The BOD met its fiduciary responsibilities through the annual independent audit, approving a new auditing firm for the future and a review of risk management best practices, as reflected by the assessment of organizational assets and liabilities. The BOD continually monitored the fiscal year 2010 (FY10) budget with due regard for the wise use of organizational resources.

Members

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

Myra Broadway, JD, MS, RN
Vice President, Maine, Area IV

Randall Hudspeth, MS, APRN-CNS/NP, FRE, FAANP
Treasurer, Idaho, Area I

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

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

Julia George, MSN, RN
Area III Director, North Carolina

Pamela McCue, MS, RN
Area IV Director, Rhode Island

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

Debra Scott, MSN, RN, FRE
Director-at-Large, Nevada, Area I

Pamela Autrey, PhD, MBA, MSN, RN
Director-at-Large, Alabama, Area III

Julio Santiago, MSN, RN, CCRN
Director-at-Large, Illinois, Area II
(appointed September 2009)

Staff

Kathy Apple, MS, RN, CAE
CEO

Kate Jones
Manager, Executive Office

Board Meeting Dates

- Aug. 14, 2009 – Philadelphia
- Sept. 14-16, 2009 – Chicago
- Oct. 26-28, 2009 – Asheville, N.C.
- Dec. 9-11, 2009 – Chicago
- Dec. 21, 2009 – Teleconference
- Feb. 10, 2010 – Teleconference
- March 8, 2010 – Chicago
- May 3-5, 2010 – Chicago

Recommendations to the Delegate Assembly

1. ***Adopt the proposed revisions to the NCSBN Bylaws.***

   Rationale:
   The proposed revisions clarify election by acclamation when there is one candidate for an elected position. The proposed language is consistent with the concepts of Robert's Rules of Order. The proposed revision further clarifies the role of the Leadership Succession Committee (LSC) and nominations from the floor.

   Fiscal Impact:
   Incorporated into the fiscal year 2011 (FY11) budget.

2. ***Adopt the proposed revision to the NCSBN Mission Statement:***

   Through collaborative leadership, NCSBN provides education, service and research to promote regulatory excellence for patient safety and public protection.

   Rationale:
   The current mission statement has been in place since 2003. The standard practice for nonprofit associations is to review mission statements every five to seven years; the policy of NCSBN is to review the mission statement every six years. The BOD reviewed and discussed the purpose of a mission statement as a declaration of purpose that drives other elements of the organization and the current environmental drivers influencing the role and function of nursing regulation. The proposed draft mission statement has been presented to the membership for feedback during the fiscal year.

   Fiscal Impact:
   None.

3. ***Adopt the proposed 2011–2013 Strategic Initiatives.***

   - ***NCSBN promotes evidence-based regulation.***
   - ***NCSBN advances the engagement and leadership potential of all members through education, information and networking.***
   - ***NCSBN provides state-of -the-art competence assessments.***
   - ***NCSBN collaborates to advance the evolution of nursing regulation worldwide.***
   - ***NCSBN optimizes nursing regulation through efficient use of technology.***

   Rationale:
   The BOD developed the proposed 2011–2013 Strategic Initiatives through a facilitated strategic planning process and solicited feedback from the membership during the fiscal year. The proposed plan identifies critical strategic direction for the next three years for fulfillment of the NCSBN Mission and Vision.

   Fiscal Impact:

   The strategic initiatives will serve as a basis for allocating financial resources for the next three years. Annual operating budgets will be developed to fund strategic objectives and performance measures designed to carry out the strategic plan.

4. ***Approve the College of Licensed Practical Nurses of British Columbia as an Associate Member 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 application for Associate Membership meets the qualifications as stated in the NCSBN Bylaws.

Fiscal Impact:
Upon acceptance, the new associate member will pay a $1,500 annual fee.

5. ***Adopt the proposed revisions to Chapter III and Chapter XI of the NCSBN Model Practice Act and Administrative Rules.***

   Rationale:
   In 2008-2009, the Discipline Resources Committee published an updated booklet on sexual misconduct as a resource for the Member Boards. For that project, the committee members surveyed the Member Boards about their needs related to sexual misconduct cases. Many boards of nursing (BONs) felt they needed more specific statutory and rule language related to sexual misconduct and boundary violations. Therefore, the BOD charged the 2009-2010 Discipline Resources Committee with developing model rules on boundaries and sexual misconduct.

   Fiscal Impact:
   None.

6. ***Adopt the proposed Guiding Principles for Continued Competence.***

   Rationale:
   The Guiding Principles of Continued Competence lay the foundation for future work in continued competence and establishes a basis for a regulatory standard to assist Member Boards.

   Fiscal Impact:
   None.

FY10 Highlights and Accomplishments

COLLABORATION WITH EXTERNAL ORGANIZATIONS

Strategic Partnership Meeting Attendance by BOD and/or NCSBN Staff

- National League for Nursing (NLN) Annual Education Summit
- American National Standards Institute World Standards Week
- National Federation of Licensed Practical Nurses (NFLPN) Annual Convention
- American Association of Colleges of Nursing (AACN) Fall Meeting
- National Organization for Associate Degree Nursing (NOADN) Convention
- International Council of Nursing (ICN) Regulatory Forum
- ICN Observatory on Registration & Licensure
- ICN Credentialing Forum
- ICN Triad Meeting
- European Council of Nursing Regulators
- An Bord Altranais National Conference on Patient Safety
- Arizona State Board of Nursing
- Michigan/DCH/Bureau of Health Professions
- National Student Nurses Association (NSNA) Midyear Meeting
- AACN Baccalaureate Meeting
- Nursing Organizations Alliance (NOA) Fall Summit

- Council on Licensure, Enforcement and Regulation (CLEAR) Annual Meeting
- Licensure, Accreditation, Certification & Education (LACE) Meeting
- Nursing Certification and Competency Summit
- Delaware Board of Nursing
- Federation of Associations of Regulatory Boards (FARB) Annual Forum
- Health Resources and Services Administration (HRSA) Workforce Meeting
- World Health Professions Conference on Regulation
- New York State Board of Nursing
- AACN Spring Meeting
- NSNA Annual Convention
- American Organization of Nurse Executives (AONE) 43rd Annual Meeting and Exposition
- Federation of State Medical Boards (FSMB) Annual Meeting
- Alliance for Advanced Practice Registered Nurse (APRN) Credentialing Meeting
- Association of Standardized Patient Educators (ASPE) Status of Data Sources to Inform Health Workforce Policy & Supply Adequacy

FINANCE

- The BOD approved the budget proposal for the 12-month period beginning Oct. 1, 2009, and ending on Sept. 30, 2010 (FY10).
- The BOD accepted the quarterly financial statements for the periods ending Dec. 31, 2009, and March 31, 2010.
- The BOD accepted the audited financial statements and the independent accountant's report on applying other agreed-upon procedures.
- The BOD approved Blackman Kallick LLP to audit the NCSBN financial statements for fiscal years ending on Sept. 30, 2010, Sept. 30, 2011, and Sept. 30, 2012.
- The BOD approved the revision to Policy 8.8, NCSBN Travel Policy, as it facilitates compliance with the policy guideline for submitting expense reports for reimbursement by changing the timeline from within 15 days to within 30 days.
- The BOD approved the revision to Policy 8.2, Financial Planning, to ensure that the Finance Committee fulfills its responsibility to assess financial impact of new NCSBN business ventures and programs after initial consideration by the BOD.
- The BOD approved the 2009 IRS 990 form.

GOVERNANCE AND POLICY

- The BOD reviewed and discussed its legal and fiduciary responsibilities as members of the NCSBN BOD.
- The BOD reviewed and revised the eligibility criteria for participation in the Center for Regulatory Excellence Program.
- The BOD held a Member Board conference call at each BOD meeting to facilitate communication with the membership regarding the business of the BOD.
- The BOD conducted a scan of the environment for relevant issues regarding nursing regulation at each meeting of the BOD.
- The BOD appointed members to the Continued Competence and Bylaws Committees,

along with committee charges.

- The BOD reviewed and revised the draft-guiding principles developed by the FY09 Continued Competence Committee.
- The BOD appointed Barbara Morvant as the chair of the LSC.
- The BOD approved the FY10 Balanced Scorecard.
- The BOD appointed members to the NCLEX® Item Review Subcommittee.
- The BOD assigned board member liaisons to FY10 committees.
- The BOD finalized and implemented a BOD performance-improvement action plan for FY10.
- The BOD finalized assignments to the FY10 external meeting list.
- The BOD reviewed and discussed the evaluations from the 2009 Delegate Assembly, including the drafted minutes from the Area Meetings and the Knowledge Network sessions. Areas for improvement were identified and noted for next year.
- The BOD appointed Julio Santiago, chairperson, Illinois Board of Nursing, to fill the director-at-large vacancy until Delegate Assembly 2010.
- The BOD continued to approve funding per the Direct Assistance Policy related to the Data Integrity Project for 24 Member Boards totaling $2.4 million.
- The BOD engaged in a strategic and visionary conversation facilitated by consultant Tom Sappington. The BOD identified potential strategic initiatives for 2011-2013 and possible revisions to the mission, vision and values of the organization. The BOD engaged in a variety of opportunities with the membership for discussion and feedback.
- The BOD reviewed and revised the Guiding Principles for Continued Competence in Nursing, developed by the Continued Competence Committee.
- The BOD approved the appointment of members to the Bylaws Committee.
- The BOD approved revisions to Policy 5.12, Funding Members to Annual Midyear Meeting, to provide flexibility for the purposes of meetings management planning.
- The BOD approved revisions to Policy 8.8, NCSBN Travel Policy, to facilitate compliance with guidelines for submission of expense reports for reimbursement.
- The BOD discussed consideration of a standardized electronic nursing education program annual report and perhaps partnering with NLN and AACN for a common report as a future strategic objective.
- The BOD approved participation of NCSBN as a founding board member of the newly formed 501(c)(3) organization titled Alliance for Ethical International Recruitment Practices.
- The BOD reviewed and discussed the joint meeting with NCSBN and the Canadian Nurses Association on issues of mutual concern related to initial licensure, entry-level competence assessment examinations.
- The BOD routinely reviewed and discussed the monitoring of federal legislation with Prime Policy Group.
- The BOD approved changing the name of the NCSBN Special Award to the NCSBN Distinguished Achievement Award with the identified criteria.
- The BOD approved a funding donation to the Citizens Advocacy Center for its proposal on health care scope of practice.
- The BOD met with the chair and members of the LSC to review and discuss progress on the Leadership Development Plan.

- The BOD approved revisions to Policy 2.4, Member Board Resource Fund, to allow for funding of independent audits of Member Board functions.
- The BOD approved revisions to Policy 2.9, Direct Assistance to Member Boards, to ensure that funded changes would be sustainable over time.
- The BOD approved funding a two-day summit to explore solutions in moving toward uniformity in APRN regulation.
- The BOD supported a joint meeting with NCSBN, the NLCA Executive Committee and the ANA to discuss the current status of ANA's Seven Point Position on the Nurse Licensure Compact (NLC).
- The BOD discussed the business model of the Nur*sys*® Licensure Verification Program and options for access to certain functions for Member Boards not currently participating in the program. The BOD directed staff to present alternative business models to manage Nur*sys* for discussion and consideration.
- The BOD reviewed and approved revisions to the NCSBN Bylaws for consideration by the Delegate Assembly.
- The BOD approved revision to Policy 4.1, Committees, to clarify conflict of interest for committee members.
- The BOD met with NSNA CEO Diane Mancino to discuss current issues related to nursing education, student nurses and new graduates.
- The BOD discussed options for assisting the Canadian Nurses Association through consultation with information and practices related to computer-based testing.
- The BOD approved application as a Standards Development Organization through accreditation by the American National Standards Institute in support of licensure and practice standards as developed by the membership.
- The BOD approved funding executive coaching services for interested Member Board executive officers.
- The BOD reviewed the recommendations of the Carnegie Foundation study on nursing education.
- The BOD reviewed the Excelsior Nursing Education White Paper and Study report.
- The BOD approved a new vision and values for the organization. The BOD approved a new mission statement and strategic initiatives for FY11-13 for consideration by the Delegate Assembly.

TESTING

- The BOD approved the revised NCLEX-RN® passing standard of -0.16 logits. This passing standard will be effective from April 1, 2010, through March 31, 2013.
- The BOD reviewed the preliminary 2011 NCLEX-PN® Test Plan recommendations.
- The BOD met with representatives from Pearson VUE to discuss various aspects of NCLEX and National Nurse Aide Assessment Program (NNAAP™) administration.
- The BOD reviewed current NCLEX data trends.
- The BOD approved revisions to various NLCEX® policies.
- The BOD reviewed the outcomes of three research studies comparing nursing competencies with the European Union and nursing practice with Ontario and British Columbia.
- The BOD approved a passing standard for the Pearson Test of English (PTE) Academic.

NURSING REGULATION

- The BOD approved funding for two members from each jurisdiction for a two-day forum to present and discuss model guidelines for alternatives to discipline programs.
- The BOD moved to approve removal of the word "core" from Uniform Core Licensure Requirements and approved distribution of draft recommendations to Member Boards for their input.
- The BOD revised the committee charge to the Disciplinary Resources Committee regarding alternative programs for practice violations.
- The BOD approved the recommendation that the Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®) be used as a reporting database and the establishment of a minimum data set within the TERCAP instrument.
- The BOD approved new research for FY11 regarding continued competence.

INFORMATION TECHNOLOGY

- The BOD reviewed and discussed the 2009 IT Summit evaluations.
- The BOD discussed and decided not to move forward with the Comprehensive Licensure Data Management System.
- The BOD directed staff to proceed with requests to Member Board approval for granting primary source equivalency for information on Nur*sys*.
- The BOD approved the Nur*sys*® Committee recommendations of administrative and other revisions to various Nur*sys* policies and to display the original licensure date in Nursys.com QuickConfirm public verifications.
- The BOD reviewed the status of the new Emergency Response Organization, Nur*sys*® Bulk Access Service, prior to implementation.
- The BOD approved the Nur*sys*® Committee recommendation to push out disciplinary action alerts to all states.
- The BOD reviewed options for offering access to certain Nur*sys* reports to Member Boards that do not participate in the Nur*sys* licensure verification program.

RESEARCH

- The BOD routinely reviewed progress updates on all current research projects.
- The BOD reviewed the progress and challenges to the workforce data-collection project.

Attachment

A. Annual Progress Report, October 2009–May 2010

B. NCSBN Associate Member Application

Background

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

Attachment A

Annual Progress Report, October 2009–May 2010

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.

NCSBN staff identified, developed and evaluated discipline and remediation courses for Member Board constituents. A video on the disciplinary process titled "Board of Nursing Complaint Process: Investigation to Resolution" was produced in coordination with committee charges for the Discipline Resources Committee. Currently in the development stage is an ethics course. Based on the patient-safety data collected from the Professional Patient Issues (PPI) study, recommendations for practice, education and regulation were also developed. Discipline case studies were published in the *Journal of Nursing Regulation*. In addition, the NCSBN Board of Directors (BOD) explored the features and benefits of becoming an American National Standards Institute (ANSI) Standards Development Organization.

STRATEGIC OBJECTIVE 2

Develop regulatory models based on just culture principles.

A compendium of different models and strategies of just culture principles was formulated and reported with related recommendations.

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.

In its continued effort to provide education, information sharing and networking opportunities in support of its members, NCSBN offered a myriad of resources aimed at strengthening and developing its membership. Members were invited to participate in the Institute of Regulatory Excellence (IRE) Annual Conference; Executive Officers Seminar; Midyear Meeting Leadership Day for executive officers and Member Board presidents; Attorney/Investigator Symposium; IT Summit; NCLEX® Invitational; three NCLEX® Regional Workshops; and a Legislative and Leadership Seminar. Additionally, the following NCSBN Interactive courses were identified and developed: NCLEX® 101 and Disciplinary Investigations.

NCSBN unveiled the *Journal of Nursing Regulation*, a peer-reviewed, academic/professional publication, in 2010. More than 2,000 copies of the first issue were distributed to Member Boards, national nursing organizations, and select international regulatory agencies, hospitals and nursing programs. *Leader to Leader, Council Connector* and *Policy Perspectives* were

published as scheduled. The following consumer brochures were marketed and disseminated to their intended audience: *A Nurse's Guide to the Importance of Appropriate Professional Boundaries; State and Territorial Boards of Nursing: What Every Nurse Needs to Know; Your Nursing License is the Key to Your Career;* and *Your State Nursing Board Works for You: A Health Care Consumer's Guide.*

Member Boards were also encouraged to participate in numerous networking opportunities available to them, which included NCLEX webinars, the APRN Roundtable and networking sessions at the Midyear Meeting. Information sharing and networking were also made easy through conference calls in areas such as education, policy, discipline and practice. Conference calls for Advanced Practice Registered Nurse (APRN) consultants, executive officers, investigators and Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®) users were also held. The Continuous Quality Improvement (CQI) Survey was conducted, the results of which were analyzed for program and service improvements.

STRATEGIC OBJECTIVE 3

Maintain and protect a substantial internal financial reserve.

Financial statements were reviewed quarterly to ensure the availability of internal funds to support NCSBN activities in perpetuity. Investment, policy, strategy, asset allocation and returns on investments were also examined on a quarterly basis. Adequate internal controls and accurate financial statements were attested to by an independent, certified accountant upon review of the audit. NCSBN's investment manager and consultant performances were also evaluated. The Finance Committee, along with legal counsel, met with insurance brokers to certify NCSBN had adequate property and liability coverage for insurable losses. NCSBN's investments and the audit were reviewed, and the budget for fiscal year 2011 (FY11) was developed and presented to the BOD for final approval. An analysis of the long-range forecast was also completed.

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

STRATEGIC OBJECTIVE 1

Promote ongoing regulatory excellence.

The Commitment to Ongoing Regulatory Excellence (CORE) survey tool for 2011 data collection was reviewed and refined to meet the needs of Member Boards. Data from the 2010 survey were collected and analyzed, and top-performing boards of nursing (BONs) and the reasons for their excellence were identified. Strategies to increase knowledge and use of CORE performance measures were implemented. Measures to support participation in CORE were also identified. A comprehensive literature review analyzing the profiles of independent and umbrella board structures and outcomes was completed. In addition, the 2010 IRE Fellowship participants and mentors were selected, and the project proposals and final reports were approved. Staff was apprised on the content of the Annual IRE Conference, the annual induction ceremony and on issues related to the implementation of the IRE fellowship program.

STRATEGIC OBJECTIVE 2

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

BONs were given assistance with the implementation of the APRN Model Act and Rules, as well as the implementation of criminal background checks. A common core licensure application was developed with recommendations for its utilization. The 1999 Delegate Assembly Uniform Core Licensure Requirements (UCLRs), which included initial, renewal, endorsement and international requirements, were reviewed and revisions recommended. Actions regarding variances to core licensure requirements were also reviewed and recommended. Solutions were offered for

identified issues regarding the interface between the two licensure models. A strategic plan for assisting Member Boards, as well as uniform nursing approval regulations, was developed. A literature review on competency-based education was conducted.

Discipline and alternative programs were reviewed and regulatory practices for chemically dependent licensees were recommended for the purposes of public protection. Feedback regarding the Guiding Principles for Continued Competence was obtained from Member Boards. Questions for the development of a research study addressing continued competence were identified and presented to the BOD for review. Model rules on sexual misconduct, including boundaries, as well as content for a model course on professional ethics and conduct for use in remediation and discipline, were also developed. A video titled "Board of Nursing Complaint Process: Investigation to Resolution" was produced by the Discipline Resources Committee with the assistance of the NCSBN Interactive Services department. Implementation steps for building and launching alternative programs for practice violations were developed.

Strategies were developed for the ongoing sustainability and advancement of the organization through leadership succession. A slate of qualified candidates, geographically distributed, was presented and included on a ballot for the election of the BOD and Leadership Succession Committee (LSC). A plan to increase TERCAP data collection was developed and implemented. The TERCAP protocol was also evaluated.

The business plan for the Transition to Practice Pilot Study was drafted. Content was developed for new nurse transition to practice modules, as well as for preceptor training.

STRATEGIC OBJECTIVE 3

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

TERCAP aggregate data were periodically analyzed. The Center for Regulatory Excellence Program continued and the research conference was planned. Member Board Profiles were updated as scheduled. The NCLEX candidate projections and the licensure statistics research projects were completed. An employer survey on patient safety and new nurses was conducted. The APRN, simulation and medication aide research projects were designed and implemented, along with the Graduates of Programs with Faculty Precepted Clinical Training Study.

STRATEGIC OBJECTIVE 4

Support single state and multistate licensure initiatives.

A new relationship between NCSBN and Nurse Licensure Compact Administrators (NLCA) was defined and agreed upon by the membership.

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

STRATEGIC OBJECTIVE 1

Maintain a comprehensive national nurse licensure database.

NCSBN continues to support Member Boards reporting disciplinary actions to federal databanks and has been 100 percent compliant with federal reporting requirements. The requirements for primary source equivalency of Member Board data in Nursys® with the Joint Commission were finalized, and a request to make Nursys.com the primary source equivalent was sent to Member Boards. The Nursys® Committee reviewed the status of the Data Integrity Project, developed a model to display APRN information in Nursys and devised strategies to implement electronic discipline uploads to Nursys from a Member Board's database.

STRATEGIC OBJECTIVE 2

Maintain a national nurse workforce data repository.

Member Board participation in workforce data collection increased. Workforce data was collected through automated reports available online to participating jurisdictions.

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 NCLEX examinations were administered in accordance with security policies and procedures. Registered nurse (RN) and practical nurse (PN) practice analyses were conducted and an NCLEX-PN® test plan was recommended. Areas of innovations continued to be explored and reported to the BOD. Practice analysis studies of entry-level RNs in Ontario and British Columbia were conducted. U.S. nursing competencies were analyzed using nursing competency statements included in the European Union TUNING project. An official NCSBN-endorsed passing standard for the Pearson Test of English (PTE) Academic was recommended.

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.

Sufficient items and skills were built to populate the required number of test forms. The 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 advanced the visibility and mission of the organization through various presentations and participation at national and international meetings, as well as Member Board visits. Additionally, NCSBN has actively participated in the following meetings: Alliance for Ethical International Recruitment Practices; Nursing Alliance for Quality Care; Federal Nursing Services Council; Institute of Regulatory Excellence; American Association of Colleges of Nursing; Joint Commission Advisory Council; National League for Nursing (NLN) Education Summit; American National Standards Annual Meeting; National Federation of Licensed Practical Nurses; Council on Licensure, Enforcement & Regulation (CLEAR) Annual Meeting; International Council of Nurses (ICN) Regulatory Forum; ICN Credentialing Forum; ICN Observatory on Licensure and Registration; National Student Nurses Association (NSNA); Nursing Organization Alliance; Alliance for APRN Credentialing Meeting; Licensure, Accreditation, Certification & Education (LACE) Meeting; Nursing Certification and Competency Summit; National Organization for Associate Degree Nursing (NOADN); and Federation of State Medical Boards.

NCSBN continued to be an active associate member of the European Council of Nursing Regulators (FEPI). The organization also explored the possibility of collaborating with ICN on a joint regulatory conference on performance measures or regulatory bodies.

STRATEGIC OBJECTIVE 2

Formal structure to sell NCSBN products and services to international regulators explored.

A desirability of a business plan was explored.

Attachment B

NCSBN Associate Member Application

NCSBN
National Council of State Boards of Nursing

111 E. Wacker Drive, Suite 2900
Chicago, IL 60601 4277

312.525.3600
www.ncsbn.org

NCSBN Associate Member Application

Applicant Contact Information

Name		Title
John Mayr		Executive Director/Registrar
Phone	**Fax Number**	**E-mail**
Toll Free 1-877-373-2201 (Direct 778-373-3112)	778-373-3102	jmayr@clpnbc.org

Organization Information

Full Name			Chief Staff Person
College of Licensed Practical Nurses of BC			John Mayr
Mailing Address			
3480 Gilmore Way Suite 260			
City	State	Country	Postal Code
Burnaby	BC	Canada	V5G 4Y1
Street Address (if not the same)			
City	State	Country	Postal Code
Phone Number	Fax Number	E-mail	Web site
778-373-3100	778-373-3102	info@clpnbc.org	www.clpnbc.org

Organization Description

Please list all the professions your organization regulates:

Practical Nurses

Please list the number of person regulated (by profession):

8900

Please describe the authority under which your organization regulates:

Health Professions Act (RSBC 1996)

Please describe why your organization wants to be an Associate Member of NCSBN:

We are interested in increasing our international contacts and resources. Nursing is a dynamic field and advancements in labour mobility and foreign qualification recognition will play an increasingly important role for regulators. We are specifically interested in working with NCSBN in the areas of competency and licensure testing.

By signing this application the undersigned understands that, if approved for membership, applicants are required to abide by NCSBN bylaws and the NCSBN Board Policy Manual. Failure to pay annual associate membership fee may result in termination of status. Decisions of the NCSBN Delegate Assembly regarding membership are final.

Signature	Executive Director	August 7, 2009
	Title	Date

In addition to your original application, I have a request for additional information regarding your organization. At your earliest convenience can you respond to the following questions?

1. Is the College of Licensed Practical Nurses of British Columbia incorporated or not?
Yes, the College of Licensed Practical Nurses of British Columbia is a corporation under section 15(2) of the Health Professions Act. That section says:

A College established us a corporation consisting of (a) the members of the board elected under section 17(3) and (b) the persons who are registrants of the college.

2. Are you considered for profit or non-profit?
We are considered not for profit. We do not receive any funding from government. 99% of revenues are derived from registrant fees (exams, initial registration, and renewals) with the remainder being fines, penalties, advertising, and annual meeting.

3. Are you a membership organization?
Sort of. We do not have members, we have registrants. Member generally means that belonging to the organization is voluntary. Because we are a licensure organization, being registered is mandatory if a person wishes to practice as a LPN.

4. Can you send a copy your Bylaws and Mission Statement?
Bylaws are attached (also found here http://clpnbc.org/index.php?dbq=15#3915)

Here is the mission statement and mandate (also found here http://clpnbc.org/index.php?dbq=8#18)Mission/Mandate/Vision/Values)

Our Mission
The CLPNBC is responsible for regulating the profession of Licensed Practical Nurses (LPNs) in the public interest.

Our Mandate
It is the duty of the CLPNBC at all times to:

- serve and protect the public.
- establish, monitor, and enforce standards of practice.
- enhance the quality of practice and reduce incompetent, impaired, or unethical practice.
- establish and maintain a continuing competency program to promote high standards of practice.
- establish, monitor, and enforce standards of professional ethics among registrants.

Our Vision
The College of Licensed Practical Nurses of British Columbia is recognized provincially, nationally, and internationally as a leader in professional nursing regulation and is committed to protection of the public through safe, competent, and ethical practice of its registrants.

Our Values
We base our work on a commitment to the following Values:

- Accountability
- Responsibility
- Ethics
- Competence
- Adaptability
- Collaboration

Section II

2010 NCSBN Annual Meeting

SECTION II: COMMITTEE REPORTS

Reports with Recommendations

Informational Recommendations

Report of the Bylaws Committee

Recommendation to the Delegate Assembly

Approve the proposed bylaw revisions for adoption by the 2010 Delegate Assembly.

Rationale:
The proposed revisions clarify election by acclamation when there is one candidate for an elected position. The proposed language is consistent with the concepts of Robert's Rules of Order. The proposed revision further clarifies the role of the Leadership Succession Committee (LSC) and nominations from the floor.

Background

The Bylaws Committee, chaired by Nathan Goldman, legal counsel, Kentucky Board of Nursing, met on two occasions. The Bylaws Committee was created by the fiscal year 2010 (FY10) Board of Directors (BOD).

Current Bylaws Committee members were appointed by the BOD following the 2009 Delegate Assembly and have the following charge:

> Develop possible revisions to the NCSBN Bylaws for consideration at the 2010 Delegate Assembly, including revisions to address the relationship of NCSBN and the Nurse Licensure Compact Administrators (NLCA) to ensure a united organization.

Additionally, the committee discussed new language to accommodate election by acclamation when there is only one candidate for an elected position, and new language to clarify the role of the LSC and nominations from the floor.

Highlights of FY10 Activities

- Kathy Apple oriented the committee regarding NCSBN committee policies and procedures, the Confidentiality and Conflict of Interest Agreement, Emergency Contact Information and expense reports.
- The committee reviewed and discussed bylaw fundamentals utilizing the book, *The Nonprofit Board's Guide to Bylaws: Creating a Framework for Effective Governance*.
- Apple provided a brief history and background of the Bylaws Committee, including a discussion on the most recent revisions to the bylaws.
- The committee discussed their charge to develop possible revisions to the NCSBN Bylaws for consideration at the 2010 Delegate Assembly, including revisions to address the relationship of NCSBN and NLCA to ensure a united organization.
- The committee reviewed and revised the draft straw man article previously discussed by the NCSBN BOD and NLCA Executive Committee. The Bylaws Committee moved to accept the draft revision of this new article for submission to the BOD for review at the Feb. 10-12, 2010 BOD meeting.
- The committee discussed the historical background of voting by ballot versus acclamation. The committee drafted bylaw language to accommodate for acclamation. The committee moved to submit revisions to allow acclamation in the event there is only one candidate for an officer or director position on the BOD or the LSC. This revision is consistent with Robert's Rules of Order.
- The committee reviewed and revised the recommended bylaw revision submitted by the LSC regarding nominations from the floor. The committee moved to submit the proposed revision, allowing the LSC to determine qualifications and geographic distribution of nominations from the floor for recommendations to the Delegate Assembly.

Members

Nathan Goldman, JD
Kentucky, Area III, Chair

Patti Clapp, Texas, Area III

Cereese Lewis-Smith, MSN, RN
Virgin Islands, Area IV

Laura Poe, MS, RN
Utah, Area I

Patricia A. Seabrooks, DNSc, ARNP, BC
Florida, Area III

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

Staff

Kathy Apple, MS, RN, FAAN
CEO

Kate Jones, Manager, Executive Office

Meeting Dates

- Jan. 27-28, 2010
- Feb. 22, 2010 (Teleconference)

- The committee reviewed and approved the 2010 Delegate Assembly Standing Rules.
- The committee reported their progress to date at the Feb. 10-12, 2010, BOD meeting.
- Apple presented feedback from the Feb. 10-12, 2010, BOD meeting regarding the Bylaws Committee's proposed revisions. The BOD held the proposed Article 11 revision regarding the relationship between NCSBN and the NLCA until further discussions between and among the NCSBN BOD, the NLCA and the membership at large could occur.
- Goldman presented a proposed revision to the NCSBN Bylaws' Article VII Leadership Succession Committee. The Bylaws Committee moved to approve the revision as it demonstrates consistency pertaining to the previous revision made regarding election by acclamation. The revision was brought forth for approval by the BOD on March 8, 2010, before being presented to the membership at the 2010 Midyear Meeting.

Attachments

A. Current Bylaws

B. Proposed Bylaws Revisions, Redline Version

C. Proposed Bylaws, Clean Copy

Attachment A

Current Bylaws

NCSBN
Leading in Nursing Regulation

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. ***Definitions.***

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.

Attachment B

Proposed Bylaws Revisions, Redline Version

NCSBN
Leading in Nursing Regulation

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
Amended – 8/13/10

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. ***Definitions.***

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.

f) Notwithstanding any provision of this Section, in the event there is only one candidate for an officer or director position, election for that position shall be declared by acclamation. No ballot shall be necessary.

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. In the event there is only one candidate for a committee position, election for that position shall be declared by acclamation. No ballot shall be necessary. 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. The Leadership Succession Committee shall determine qualifications and geographic distribution of nominations from the floor for recommendations to the Delegate Assembly.

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.

Attachment C

Proposed Bylaws, Clean Copy

NCSBN
Leading in Nursing Regulation

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
Amended – 8/13/10

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. ***Definitions.***

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.
f) Notwithstanding any provision of this Section, in the event there is only one candidate for an officer or director position, election for that position shall be declared by acclamation. No ballot shall be necessary.

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. In the event there is only one candidate for a committee position, election for that position shall be declared by acclamation. No ballot shall be necessary. 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. The Leadership Succession Committee shall determine qualifications and geographic distribution of nominations from the floor for recommendations to the Delegate Assembly.

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.

Report of the Continued Competence Committee

Recommendation to the Delegate Assembly

Approve the Guiding Principles for Continued Competence.

Rationale:
The Guiding Principles of Continued Competence lay the foundation for future work in continued competence and establish basic principles all Member Boards can agree on.

Background

Fiscal Year 2010 (FY10) Charge: Identify research questions for the development of a research study addressing continued competence for review by the Board of Directors (BOD) at the February 2010 BOD meeting.

Among the recommendations of the 2009 Continued Competence Committee, a research project was proposed to test the regulatory model and collect data that would help substantiate the need for continued competence, as well as identify an evidence-based method(s). Using these suggestions as a springboard for future work, the BOD charged the 2010 Continued Competence Committee with developing potential research questions for the development of a study.

After an extensive review of the literature, history of continued competence and a discussion of all the issues related to continued competence, the committee developed five research questions for boards of nursing (BONs) to review. These questions are based on the assumption that continued competence of nurses improves the quality and safety of patient care. They are as follows:

1. What methods are other disciplines and high-risk industry regulators currently using to determine competency?
2. Which methods are most effective in determining nurse continued competency?
3. Which method(s) should nurse regulators use?
4. What are the demographics/descriptions of competent versus incompetent nurses in the core areas of continued competence?
5. What set of variables or combination of variables contributes to the measurement of competency?

For a list of definitions related to continued competence, as well as the core competencies identified in the *2006 RN Post-Entry Practice Analysis*, see Attachment A.

The committee also provided an additional set of questions that they felt were pertinent to continued competence, but not an immediate priority. They are as follows:

1. What is the role of the regulator in remediation?
2. How frequently should continued competence be assessed/measured?
3. What are the triggers for assessing competence?
4. Do the top five certification exams measure the core competencies identified in the *2006 RN Post-Entry Practice Analysis*?
5. Is there a relationship/correlation among the measures used by the individual nurse, regulators, employers and the profession to periodically evaluate continued competence?
6. What is the relationship between the eight TERCAP® (Taxonomy of Error, Root Cause

Members

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

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

Linda Burhans, PhD, NEA-BC, CPHQ, RN
North Carolina, Area III

Sean Gorman, JD
Indiana, Area II

Margaret Hourigan, EdD, CNAA, BC, RN
Maine, Area IV

Terry Karfonta, PhD, MSN, RN
Florida, Area III

Melinda Rush, DSN, FNP/ANP
Mississippi, Area III

Kathy Scott, PhD, MPA, RN
Arizona, Area I

Francene Weatherby, PhD, CNE, RN
Oklahoma, Area III

Wendy Winslow, MSN, RN, FCCHSE
British Columbia, Associate Member

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

Staff
Maryann Alexander, PhD, RN
Chief Officer, Nursing Regulation

Meeting Dates

- Jan. 11-12, 2010

Relationship to Strategic Plan

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

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

Analysis and Practice-responsibility) categories and the core competencies?

7. How do the expectations for competency change throughout one's career?
8. How can we support the use of common language regarding core competencies identified by the Institute of Medicine?

During the February 2010 BOD meeting, the BOD acknowledged the importance of all the recommended questions and suggested further expert consultation. The BOD also suggested that the questions be reviewed by the research staff at NCSBN. The staff felt the questions were excellent; however, they recommended that these pertinent and well-structured questions be used by the researchers (should the study move forward) as a catalyst for discussion in designing the study. The researchers should be allowed the flexibility to structure the questions according to the specific needs of the study design. The BOD was in agreement and requested the staff move forward in developing a research proposal.

FY10 Charge: Obtain feedback from the membership regarding the Guiding Principles for Continued Competence.

The Guiding Principles for Continued Competence were developed by the 2008-2009 Continued Competence Committee. These were submitted to the BOD, which made some revisions and requested that they be distributed to the membership for comment. In fall 2009, the Guiding Principles of Continued Competence were distributed to NCSBN executive officers for feedback. They were also discussed at the 2010 Midyear Meeting, where further opportunity for feedback was provided. All comments and suggestions were presented to the BOD at its May meeting and minor revisions were made based on suggestions made by the membership. The BOD voted to bring the Guiding Principles of Continued Competence to the Delegate Assembly for a vote at the Annual Meeting.

Highlights of FY10 Activities

- Development of research questions for continued competence.
- Development of the Guiding Principles of Continued Competence.
- Conducted a half-day presentation on continued competence at the Midyear Meeting, which provided an opportunity for all members to comment and provide feedback on the research questions, guiding principles and continued competence in general.

Future Activities

- Present Guiding Principles of Continued Competence for adoption by the Delegate Assembly.
- Continue to move forward and develop research to study continued competence.

Attachments

A. Definitions and Core Competencies of Continued Competence

B. Guiding Principles of Continued Competence

Attachment A

Definitions and Core Competencies of Continued Competence

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 abilities 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 registered nurses (RNs) or licensed practical/vocational nurses (LPN/VNs), regardless of practice setting, specialty practice area and/or years of experience.

Culture of Nursing 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.

Institute of Medicine (IOM) Competencies: Practitioners must provide patient-centered care (PCC), work in interdisciplinary teams (ITs), employ evidence-based practice (EBP), apply quality improvement (QI) techniques and utilize informatics.

LPN/VN Competencies: Provision of care, legal/ethical responsibilities, communication, inter-/intradisciplinary collaboration and safety.

LPN/VN Core Competencies: Competencies identified through a practice analysis that are universal to LPN/VNs, regardless of practice setting or geographic location.

Nursing Practice: The application of the art and science of nursing.

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.

QSEN (Quality and Safety Education for Nurses) Competencies: Patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety and informatics.

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

RN Competencies: Clinical judgment and provision of care, professional responsibilities, communication, inter-/intradisciplinary collaboration, supervision/management and safety.

RN Core Competencies: Competencies identified through a practice analysis that are universal to RNs, regardless of specialty, practice setting or geographic location.

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

TERCAP® Categories: Medication administration, documentation, attentiveness, clinical reasoning, prevention, intervention, professional responsibility and patient advocacy.

Attachment B

Guiding Principles of Continued Competence

- The individual nurse, in collaboration with the state board of nursing, nursing educators, employers and the nursing profession, has the responsibility to demonstrate continued competence through:
  - Acquisition of new knowledge and skills; and
  - Appropriate, safe application of knowledge and skills.
- A culture of continued competence is based on the premise that the competence of any nurse should be periodically evaluated.
- Requirements for continued competence should support nurse accountability for lifelong learning and foster improved nursing practice and patient safety.
- The state boards of nursing have the regulatory authority for establishing continued competence requirements.

Report of the Disciplinary Resources Committee

Recommendation to the Delegate Assembly

Recommend adoption of the proposed revisions to Chapter III and Chapter XI of the NCSBN Model Practice Act and Administrative Rules.

Rationale:
In 2008-09, the Disciplinary Resources Committee (DRC) published an updated booklet on sexual misconduct for Member Boards. For that project, committee members surveyed Member Boards about their needs related to sexual misconduct cases. Many boards of nursing (BONs) felt that they needed more specific language related to sexual misconduct and boundary violations. Therefore, the Board of Directors (BOD) charged the 2009-10 DRC with developing model rules on sexual misconduct, including boundaries.

Background

The fiscal year 2009-2010 (FY09-10) charges to the DRC included the following:

1. Develop model rules on sexual misconduct including boundaries;
2. Develop content for a model course on professional ethics and conduct for use in remediation and discipline;
3. Develop a video on the disciplinary process for nurses; and
4. Extend the work on alternative programs for practice violations by exploring how states can implement successful programs.

MODEL RULES ON SEXUAL MISCONDUCT, INCLUDING BOUNDARIES

Member Boards were surveyed on their needs for language related to sexual misconduct and boundary violations. Current model language from BONs and boards of other health care disciplines was reviewed. Related literature was reviewed and model language was developed for sexual misconduct and boundary violations. Feedback was obtained from Member Boards on draft model language and comments were reviewed toward creating the final draft. The proposed revisions were approved by the BOD for presentation to the Delegate Assembly (see Attachment A).

MODEL COURSE ON PROFESSIONAL ETHICS AND CONDUCT FOR USE IN REMEDIATION AND DISCIPLINE

Nursing and other health care ethics courses were reviewed for content and it was found that these course offerings do not have objectives related to remediation and discipline. A literature review was conducted on nursing and health care ethics related to practice. Meetings with NCSBN Interactive Services provided information about the interactive capabilities of the program, postproduction. The committee developed content for an ethics course, which includes concepts on ethical values and professional conduct, an ethics decision-making process, and assessments and reflective exercises. All exercises would need to be reviewed and completed to pass the exam and successfully complete the course. The committee completed the course content; it will be reviewed by an ethics expert for ethics theory input. After the review has been completed, the assessment and testing segments of the course will be finalized. The final course production will be posted on the NCSBN's Interactive Services website.

VIDEO ON THE DISCIPLINARY PROCESS FOR NURSES

This video was developed for BONs to use as a resource for nurses who are the subject of a complaint, students or those interested in learning about the complaint and disciplinary processes. It also includes the BON's role in handling complaints and protecting the public, the complaint investigation and resolution process, and actions that can be taken against a nurse's license. The

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Meeting Dates

- Aug. 25, 2009 (Teleconference)
- Oct. 13-15, 2009
- Dec. 1-2, 2009
- Jan. 11, 2010 (Teleconference)
- Feb. 2-3, 2010
- Feb. 26, 2010 (Teleconference)
- March 16-17, 2010
- March 29, 2010 (Teleconference)

Relationship to Strategic Plan

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

Strategic Objective 1
Promote ongoing regulatory excellence.

video script was developed by the DRC; NCSBN's Interactive Services and the Chicago-based production company SolidLine Media helped the committee develop the storyboard. The video shoot took place on March 18-19, 2010; production was completed in April 2010. Each BON received a copy of the video, titled "The Board of Nursing Complaint Process: Investigation to Resolution." Additionally, the film will be posted on the NCSBN Interactive Services website and YouTube.

ALTERNATIVE PROGRAMS FOR PRACTICE VIOLATIONS

Member Board survey information was reviewed to identify common elements in currently existing predisciplinary alternative programs for substandard practice. It was discovered that alternative programs for nursing practice violations are either nonexistent in the states or are too newly implemented to identify and assess outcomes at this point. It was concluded at the Dec. 1-2, 2009, DRC meeting that more programs like these are needed, as well as formal data collection, before a model can be identified for best practices. On Feb. 10, 2010, the BOD approved the DRC's suggestion that the committee develop guidelines for BONs wishing to implement a predisciplinary alternative program for substandard practice. The guidelines include information on building and launching these programs and will be published in the *Journal of Nursing Regulation.*

Highlights of FY10 Activities

- Completion of revisions to Chapter III and Chapter XI of the NCSBN Model Practice Act and Administrative Rules on sexual misconduct, including boundaries.
- Development of content for a professional ethics course for use by BONs.
- Completion of the video, "The Board of Nursing Complaint Process: Investigation to Resolution."
- Development of predisciplinary alternative program for substandard practice guidelines.
- Participation on Discipline Networking Conference Calls.

Future Activities

- Develop guidelines to protect patient privacy on social and electronic media.

Attachment

A. Model Rules for Sexual Misconduct, Including Boundaries

Attachment A

Model Rules for Sexual Misconduct, Including Boundaries

DEFINITIONS (ARTICLE III OF NCSBN MODEL PRACTICE ACT AND ADMINISTRATIVE RULES)

Dual Relationship: When a nurse is involved in any relationship with a patient, in addition to the therapeutic nurse-patient relationship.

Electronic Media: Online forms of publication, including, but not limited to, websites, blogs and social networking sites.

Key Party: Immediate family members and others who would be reasonably expected to play a significant role in health care decisions of the patient. This includes, but is not limited to, a spouse, domestic partner, sibling, parent, child, guardian and person authorized to make health care decisions for the patient.

Professional-boundary Crossing: A deviation from an appropriate boundary for a specific therapeutic purpose with a return to established limits of the professional relationship.

Professional-boundary Violation: Failure of a nurse to maintain appropriate boundaries with a patient and key parties.

Sexual Misconduct: Conduct of a sexual nature that constitutes grounds for discipline, as defined by the board of nursing (BON).

Sexualized Body Part: A part of the body not conventionally viewed as sexual in nature that evokes arousal.

ARTICLE XI. DISCIPLINE AND PROCEEDINGS (SECTION 2, H, 3): FAILURE TO MAINTAIN PROFESSIONAL BOUNDARIES WITH PATIENTS, AS DEFINED BY THE BON.

Administrative Rules: 11.2.1. Principles of Professional Boundaries

The following principles shall delineate the responsibilities of the nurse regarding the establishment and maintenance of appropriate professional boundaries with a current or former patient and key party. Patient consent to, or initiation of a personal relationship, is not a defense. The nurse shall:

a. Establish, maintain and communicate professional boundaries with the patient;

b. Avoid relationships with patients that could impair the nurse's professional judgment;

c. Not exploit in any manner the professional relationship with a patient for the nurse's emotional, financial, sexual, or personal advantage or benefit;

d. Avoid dual relationships to the extent possible, making alternate arrangements for care when necessary, if a nurse's ability to provide appropriate care would be impaired due to the nature of the additional relationship with the patient (always avoid dual relationships in mental health nursing);

e. Not engage in self-disclosure to a patient unless it is limited in terms of amount, nature and duration, and does not adversely impact the patient's care and well-being;

f. Recognize the potential for negative patient outcomes of professional-boundary crossings;

g. Not use any confidence of a patient to the patient's disadvantage or for the advantage of the nurse;

h. Recognize the importance of clear understandings with the patient regarding financial matters. For nurses practicing independently, arrangements for reimbursement must be made at the initiation of the nurse-patient relationship. A nurse shall not engage in loans to or from a patient and shall not barter with a patient;

i. Only accept gifts of minimal value from a patient or key party;

j. Avoid statements or disclosures that create a risk of compromising a patient's privacy, confidentiality and dignity. This includes, but is not limited to, statements or disclosures via electronic media; and

k. Avoid suggestions or discussions of the possibility of dating or a sexual or romantic relationship after the professional relationship ends.

ARTICLE XI. DISCIPLINE AND PROCEEDINGS ACT (SECTION 2, H, 4): ENGAGING IN SEXUAL MISCONDUCT, AS DEFINED BY THE BON, WITH A CURRENT OR FORMER PATIENT OR KEY PARTY, INSIDE OR OUTSIDE OF THE HEALTH CARE SETTING.

11.2.2. Sexual Misconduct

Sexual misconduct includes, but is not limited to, the following behavior with a current or former patient or key party. Patient consent to, or the initiation of a sexual or romantic relationship, is not a defense:

a. Sexual intercourse;

b. Touching of the breasts, genitals, anus or any sexualized body part initiated by the nurse or patient, except as consistent with accepted standards of nursing practice;

c. Rubbing against current or former patient or key party, initiated by the nurse, current or former patient, or key party, for sexual gratification;

d. Hugging, kissing or caressing of a romantic or sexual nature;

e. Failure to provide adequate patient privacy to dress or undress, except as may be medically necessary or required for patient safety;

f. Failure to provide the patient with an appropriate gown or draping, except as may be medically necessary or required for patient safety;

g. Dressing or undressing in the presence of the patient;

h. Encouraging masturbation or other sex acts in the presence of the nurse;

i. Masturbation or other sex acts performed by the nurse in the presence of the current or former patient or key party;

j. Discussing sexual history, behaviors or fantasies of the nurse;

k. Behavior, gestures, statements or expressions that may reasonably be interpreted as romantic or sexual;

l. Making inappropriate statements to current or former patients or key parties regarding their body parts, appearance, sexual history or sexual orientation;

m. Sexually demeaning behavior, which may be reasonably interpreted as humiliating, embarrassing, threatening, or harmful to current or former patients or key parties;

n. Showing a current or former patient or key party sexually explicit materials, other than for health care purposes;

o. Posing, photographing or recording the body or any body part of a current or former patient or key party, other than for health care purposes with consent;

p. Transmitting information via electronic media that can be reasonably interpreted as sexual or sexually demeaning by the current or former patient or key party; and

q. Sexual or romantic conduct with a key party when that person is being manipulated into such a relationship by the nurse.

11.2.3. Former Patient

A nurse may not engage or attempt to engage in sexual or romantic conduct with a former patient if doing so creates a risk that the relationship could cause harm to or exploitation of the former patient.

a. Factors which the BON may consider in determining risk of harm or exploitation include, but are not limited to:
    1. The length of time the nurse-patient relationship existed;
    2. The circumstances of the cessation or termination of the nurse-patient relationship;
    3. The amount of time that has passed since nursing services were terminated;
    4. The nature of the patient's health status and the extent of care received;
    5. The degree of the patient's dependence and vulnerability;
    6. The extent to which there exists an ongoing nurse-patient relationship following the termination of services, and whether the patient is reasonably anticipated to become a patient of the nurse in the future; and
    7. Any statements or actions made by the nurse during the course of treatment suggesting or inviting the possibility of sexual or romantic conduct.
b. Due to the unique vulnerability of mental health patients, including patients with substance use or dependency disorders, nurses are prohibited from engaging in or attempting to engage in sexual or romantic conduct with such former patients or key parties for a period of at least two years after termination of nursing services.

11.2.4. These Rules Do Not Prohibit:

a. Providing health care services to a person with whom the nurse has a preexisting, established personal relationship where there is no evidence of, or potential for, exploiting the patient; and
b. Contact that is necessary for a health care purpose that meets the standards of the profession.

Report of the NCLEX® Examination Committee

Recommendation to the Delegate Assembly

Adopt the proposed 2011 NCLEX-PN® Test Plan.

Rationale:
The NCLEX® Examination Committee (NEC) reviewed and accepted the *Report of Findings from the 2009 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (NCSBN, 2010) as the basis for recommending revisions to the *2008 NCLEX-PN® 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 2011 NCLEX-PN® 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, 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 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 the chair of the subcommittee on a rotating basis. Highlights of the activities of the NEC and NIRSC activities follow.

Highlights of FY10 Activities

2010 NCLEX-RN® Test Plan

At the October 2009 meeting, the NEC reviewed the results of the *Report of Findings from the 2009 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice*. Empirical data from the 2009 LPN/VN Practice Analysis was used to evaluate the *2008 NCLEX-PN® Test Plan* to determine if changes were needed. After indepth discussion and careful deliberation, the committee decided to retain the client needs framework and minor revisions were made throughout the document to provide clarity. Using the data from the practice analysis and psychometric considerations, the NEC determined changes to the percentage of test items allocated to each category and subcategory.

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Meeting Dates

- Oct. 27-29, 2009 (NEC Business Meeting)
- Dec. 1-4, 2009 (NIRSC Meeting)
- Jan. 11-14, 2010 (NIRSC Meeting)
- Jan. 25-26, 2010 (NEC Business Meeting)
- March 1-4, 2010 (NIRSC Meeting)
- March 29-31, 2010 (NIRSC Meeting)
- April 12-13, 2010 (NEC Business Meeting)
- May 17-20, 2010 (NIRSC Meeting)
- June 21-24, 2010 (NIRSC Meeting)

	Percentage of Items from Each Category/Subcategory	
Client Needs	2008	2011
Safe and Effective Care Environment		
· Coordinated Care	12-18%	13-19%
· Safety and Infection Control	8-14%	11-17%
Health Promotion and Maintenance	7-13%	7-13%
Psychosocial Integrity	8-14%	7-13%
Physiological Integrity		
· Basic Care and Comfort	11-17%	9-15%
· Pharmacological Therapies	9-15%	11-17%
· Reduction of Risk Potential	10-16%	9-15%
· Physiological Adaptation	11-17%	9-15%

A draft of the proposed 2011 NCLEX-PN® Test Plan was sent to all Member Boards in November 2009 for feedback on these changes. During its April 2010 business meeting, the committee discussed all comments from the Member Boards and approved a final draft of the proposed 2011 NCLEX-PN® Test Plan as noted in Attachments A and B, as well as approved the timeline for implementation (Attachment C).

Joint Research Committee (JRC)

The JRC is a small group comprised of NCSBN and Pearson VUE psychometric 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 examinations, as well as to investigate possible future enhancements to the examination program.

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; effects of sample size on the properties of the separate calibration t-test in the detection of differential item functioning; an examination of decision rules; alternate item scoring methodology; enemy items identifying algorithm; establishing pretest statistical criteria specific for alternate item types; and optimal item pool design.

The JRC has also approved research to be conducted on the feasibility of various approaches to situated tasks as a format for new item types; an investigation of hybrid item selection procedures; and an analysis of how candidates interact with alternate item types.

TUNING Survey

One of the NEC's performance measures was to "compare U.S. nursing education competencies using an international nursing survey." In order to accomplish this, NCLEX staff conducted what is being identified as the TUNING Survey. Higher education institutions in the European Union (E.U.) have been transforming their education systems to bring about a greater degree of convergence. This process is known as TUNING and was undertaken in response to the Bologna Declaration, in which the education ministers of 29 countries first agreed to bring down the education borders of the countries. A survey was conducted in participating universities to determine the core nursing education competencies throughout Europe and other select countries.

Following the methodology used in the original E.U. study, NCLEX staff conducted a study to determine how U.S. nursing programs compare to those in Europe in regard to 47 core nursing education competencies identified in the E.U. TUNING Project. To ensure comparability, staff replicated the methodology and sampling processes as much as possible.

In summer 2009, NCSBN surveyed recent NCLEX registrants, nurses that passed the NCLEX within the past year, nursing educators and nursing supervisors. A five-stage mailing process was used to engage participants in the study. Adjusted return rates among the four participant groups ranged from 25.4 percent to 50.2 percent. A total of 5,021 nursing professionals took part in the survey.

Results of the study indicated that the demographic characteristics among U.S. survey participants were very similar to those of the E.U. survey respondents with respect to age, gender and ethnicity. In terms of education background, it should be noted that a baccalaureate degree is a prerequisite for entry into the nursing profession in the E.U. A direct comparison of education backgrounds between E.U. and U.S. nurses may not be appropriate due to the differences in educational requirements.

Participants in the present study were asked to provide importance ratings on 47 core nursing education competencies along a four-point scale, with 0 being not important and 4 being vital. U.S. and E.U. samples rated the 47 education competency statements very similarly with no statement discrepancy over half a scale point. Results of this study provide evidence that U.S. and European nurses view nursing education competency statements in much the same way. The complete report can be found on www.ncsbn.org.

Canadian Surveys in Ontario and British Columbia

The NEC was charged with conducting surveys for registered nurses (RNs) in Ontario and British Columbia, Canada, using job tasks derived from the *2008 U.S. RN Practice Analysis: Linking the NCLEX-RN® Examination Practice* in absence of Canadian incumbent job analyses data.

Ontario Survey

NCLEX staff partnered with the College of Nurses of Ontario (CNO) to conduct a practice analysis study using job activity statements for RNs in Ontario, Canada, derived from the 2008 RN Practice Analysis. A five-stage mailing process was used to engage participants. All candidates who successfully passed the Canadian Registered Nurse Examination (CRNE®) during its June 2009 administration were invited to take part in the present study. Of the 1,697 candidates identified, 540 completed surveys were gathered. This represents an adjusted response rate of 32.0 percent.

Participants were asked to provide frequency and importance ratings on 142 entry-level nursing job tasks. The frequency scale required respondents to indicate the number of times a particular task was performed on the last day of work. The scale ranged from 0 to 5 or more times, with an option to indicate never performed in work setting. In terms of task importance, respondents used a five-point scale ranging from not important to critically important. In all, results of the present survey indicated that job task importance and frequency ratings are very similar among entry-level nurses in Ontario and those in the U.S. The complete report can be found at www.ncsbn.org.

British Columbia Survey

A second survey study was conducted in collaboration with the College of Registered Nurses of British Columbia (CRNBC) to further the initiative on international RN practice analyses. Similar to the Ontario study described in the previous section, entry-level nursing job activity statements used in the *2008 RN Practice Analysis: Linking the NCLEX RN® Examination Practice* were sent to entry-level nurses in British Columbia (B.C.), Canada, to ascertain whether practice characteristics are similar between the two cohorts. A five-stage mailing process similar to the one utilized in the Ontario study was used to engage participants. All candidates who successfully passed the CRNE licensure examination during its June 2009 administration were invited to take part in the study. Of the 669 surveys sent, 219 were received for an adjusted return rate of 31.4 percent.

Similar to the Ontario study, B.C. participants were asked to provide frequency and importance ratings on 142 entry-level job tasks. The frequency and importance rating scales used in the current study were identical to those used in the Ontario survey. In all, results of the present study indicated that frequency and importance of job tasks were rated very similarly between B.C. and U.S. entry-level nurses. The complete report can be found on www.ncsbn.org.

- July 20, 2010 (NEC Conference Call)
- Sept. 27-30, 2010 (NIRSC 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.

Item Pool Rotation Plan

NCSBN has been working to reduce the amount of time 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. In 2009, the JRC conducted a series of studies to develop optimal NCLEX quarterly item pool design. The guiding principle for these studies is that the NCLEX examinations generated from quarterly pools will be comparable to the semiannual pools and will not show significant adverse impacts in terms of measurement precision, decision consistency, content validity or overall item exposure rates. Rigorous planning and research have been conducted to permit the transition from semiannual to quarterly pool rotation. As of April 1, 2010, the NCLEX operational item pools are to be deployed quarterly.

Setting Performance Benchmarks for Pearson Test of English Academic (PTE Academic)

PTE Academic is a computer-based academic English language test. The test delivers real-life measures of test takers' language ability to universities, higher education institutions, government departments and other organizations requiring academic-level English. Pearson developed PTE Academic in response to feedback from institutions and organizations that needed a test to measure the English communication skills of nonnative English speaking students in an academic environment. PTE Academic was launched in October 2009. Pearson plans to make the test available in 35 countries and more than 200 locations by the end of 2010. Anticipating widespread use of PTE Academic, NCSBN conducted a standard-setting study using this test to provide Member Boards with an additional option by which to evaluate English language proficiency of licensure applicants.

On Nov. 4-6, 2009, a panel of 19 subject matter experts (SMEs) met in Chicago to participate in a criterion-referenced standard setting exercise for PTE Academic. Pearson staff members facilitated the panel. Using actual PTE Academic 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 and the NCSBN BOD for consideration.

After reviewing the standard-setting process and recommendations from the standard-setting panel, historical data from the previous NCSBN English proficiency passing standard and other available evidence, such as comparability and impact data, NCSBN policy groups recommended that a total score of 55, with no individual section score below 50, was necessary on the PTE Academic 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 PTE Academic scores to be portable across jurisdictions. However, the final decision of whether to adopt the recommended passing standard rests on each individual board of nursing (BON). Each BON should carefully consider the applicability of the recommended standard to circumstances unique to their jurisdiction. This recommendation regarding the PTE Academic passing standard will be communicated to Member Boards, as well as other stakeholders. Additional information regarding the PTE Academic standard setting is available on the NCSBN website.

NCLEX® Alternate Item Types

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

NCLEX® Administration Enhancements

In October 2009, two new options became available to Member Boards via the NCLEX® Candidate Administration website: (1) a monthly report that provides end-of-examination survey information for candidates from the selected jurisdiction; and (2) a real-time seat-availability search for Pearson Professional Centers (PPCs).

Pearson VUE has begun to phase in palm vein technology at PPCs. This technology is very accurate and allows NCSBN to more precisely 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. The palm vein device serves as a second level of security; it does not replace fingerprinting.

Pearson VUE will be opening four new PPCs and expanding seating capacity at 17 other centers in 2010. 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 BOD examination-related policies and procedures, as well as NEC policies and procedures.

MONITORED 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 NEC continue to chair NIRSC meetings. The NEC and NIRSC reviewed RN and PN operational and pretest items; provided direction regarding RN and PN multiple-choice and alternate format items; and made decisions addressing revisions to content coding, operational definitions for client needs, cognitive codes, integrated processes and the NCLEX® Style Manual. In addition, the NIRSC and NCSBN staff currently evaluate 25 percent of all validations for pretest items and 25 percent of all validations of master pool items scheduled for review.

Assistance from the NIRSC continues to reduce the NEC'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 NIRSC is 19, with representation from all four NCSBN geographic areas. Orientation to the NIRSC 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, who's 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 website.

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
April 09 – March 10	6	66	1931	14	7948

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
April 09 – March 10	2	24	869	5	1578

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

Monitored Item Sensitivity Review

NCLEX® Pretest 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, NCSBN NCLEX® Examinations staff monitor the panels when needed. Overall, panelists and committee representatives in attendance have rated item development sessions favorably.

Monitored 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 examinations 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 the performance of the NCLEX through these and other psychometric reports and analyses.

Member Board Review of Items

BONs are provided opportunities to conduct reviews of NCLEX pretest and operational items twice a year. Based on these reviews, BONs may refer items to the NEC for review and comment for one of the following reasons: not entry-level practice, not consistent with the nurse practice act or for other reasons. In October 2009, the NEC reviewed the items referred from the April 2009 Member Board Review. In April 2010, the NEC reviewed the items referred from the October 2009 Member Board Review. The NEC provided direction on the resolution of each Member Board item and staff gave Member Boards feedback on the NEC's decisions on all referred items. The NEC encourages each Member Board to take advantage of the semiannual 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 investigate each incident and reports their findings to the NEC for decisions related to retention of the item.

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 semiannual basis, Pearson VUE conducts a check for duplicate candidate records on all candidates who have tested within the last six months.

Monitored 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 websites and Internet forums that might attempt to trade in NCLEX items. Also, NCSBN staff continue to visit many domestic PPCs and several international PPCs to review the physical and procedural security measures that are in place. NCSBN staff, Pearson VUE staff and the NEC continue to be vigilant regarding the administration and security of the NCLEX in domestic and international PPCs.

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, 2009, to Dec. 31, 2009, all candidates were able to be tested in compliance. A dedicated department at Pearson VUE continues to analyze PPC utilization levels in order to project future testing volumes and meet the testing needs of all testing clients. As an early indicator of PPC usage, Pearson VUE reports to NCSBN staff on a weekly basis when sites exceed 80.0 percent capacity levels.

Responded to Member Board Inquiries Regarding NCLEX® Examination Administration

As part of its activities, the NEC and the NCSBN NCLEX® Examinations department responded to Member Boards' questions and concerns regarding administration of the NCLEX exams.

More specific information regarding the performance of Pearson VUE can be found in the Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX®), available in Attachment D of this report.

ADMINISTER NCLEX® AT INTERNATIONAL SITES

The international PPCs meet the same security specifications and follow the same administration procedures as the PPCs located in Member Board jurisdictions. Please see Attachment D of this report for the 2009 candidate volumes and pass rates for international PPCs.

EDUCATE STAKEHOLDERS

NCLEX® Research Presentations

At the 2009 American Educational Research Association (AERA) Annual Meeting, two papers, "Innovative Items Memorability and Cognitive Processing: A Pilot Study" and "Developing Item Variants: An Empirical Study" were presented. In collaboration with test service, a paper titled "Evaluating Parameter Drift of Innovative Items in a Computerized Adaptive Test" was selected for presentation at the 2009 National Council of Measurement in Education (NCME) Annual Meeting. AERA and NCME are internationally recognized professional organizations with the primary goal of advancing educational research and its practical application.

NCSBN and test service staff also participated in the 7th Conference of the International Test Commission (ITC) in Hong Kong. There were two papers, "Setting Minimal English Proficiency Standard for Entry-level Healthcare Professionals: A Comparison of Standard Setting Methods" and "Developing Effective Statistical Screening Criteria for Pretest Items on a Computerized Adaptive Test," as well as a poster presentation, "Comparing Item Performance Between Domestic and International Examinees on a High Stakes Licensure Computerized Adaptive Test," that were selected by the conference. The ITC is an association of national psychological associations, test commissions, publishers and other testing organizations that provides a venue where researchers and practitioners come together to improve practice, and advance the field of testing and measurement. 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 staff conducted numerous NCLEX informational presentations, webinars and workshops, including:

- "Nursing Mobility and the NCLEX Examinations" at the Philippine Nurses Association International Conference in Cebu, Philippines;
- "International Learnings, Challenges, and Opportunities: Best Practices for Partnering or Delivering Directly," "International Growth" and an Americans with Disabilities Act poster presentation at the 2009 National Organization for Competency Assurance (NOCA) Annual Educational Conference in Phoenix, Ariz.;
- "Developing Item Variants: An Empirical Study" and "Innovative Items Memorability and Cognitive Processing: A Pilot Study" at the 2010 American Educational Research Association (AERA) Annual Meeting in Denver, Colo.; and
- "Evaluating Parameter Drift of Innovative Items in a Computerized Adaptive Test" at the 2010 National Council on Measurement in Education (NCME) Annual Meeting in Denver, Colo.

In order to ensure NCSBN membership was kept current on the NCLEX program, the NCLEX® Examinations department hosted four informational webinars for Member Boards. Additionally, as part of the department's outreach activities, content staff conducted three 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 California-RN, Illinois and Wisconsin. These opportunities assist the NCSBN NCLEX® Examinations department with educating stakeholders about the examination, as well as recruit for NCSBN item development panels.

The committee continues to oversee development of various publications that accurately reflect the NCLEX examination process. This year the *2009 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* and the *2009 Knowledge of Newly Licensed Practical/ Vocational Nurses Survey* were published, distributed to Member Boards and made available to the public at no charge on the NCSBN website.

Other articles were written and accepted for publication by NCSBN and Pearson VUE staff:

- "Keeping the NCLEX-RN® current," *Nurse Educator,* 35(1);
- "Developing models that impact item development," *CLEAR Exam Review*, 20(2); and
- "Setting a passing standard for English proficiency on the Internet-Based Test of English as a Foreign Language," *JONA: Healthcare Law, Ethics, and Regulation*, 11(3).

NCLEX® Member Board Manual

NCSBN updates the *NCLEX® Member Board Manual* on a quarterly basis. Changes included updates on the NCLEX® Candidate Rules, palm vein recognition, NCLEX candidates from U.S. sanctioned (embargoed) countries, correspondence received by candidates, item development volunteer process and information on Member Board reviews.

NCLEX® Invitational

Historically, NCLEX® Examinations staff has coordinated and hosted the NCLEX® Invitational in order to provide Member Boards, educators and other stakeholders an opportunity to learn about the NCLEX program. The 2009 NCLEX® Invitational was held in Chicago on Sept. 21, 2009, with 317 participants. The 2010 NCLEX® Invitational is scheduled for Sept. 13, 2010, at the Hyatt Regency in Atlanta.

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 and staff 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—the faculty and staff who 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 the BONs directly) 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 2009, 146,147 candidates utilized this service.

Future Activities

- Complete the continuous online LPN/VN practice analysis.
- 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 the RN practice analysis.

Attachments

A. Proposed 2011 NCLEX-PN® Test Plan-Strikethrough Copy

B. Proposed 2011 NCLEX-PN® Test Plan-Clean Copy

C. Timeline for Implementation of the 2011 NCLEX-PN® Test Plan

D. Annual Report of Pearson VUE for the NCLEX®

Attachment A

Proposed 2011 NCLEX-PN® Test Plan-Strikethrough Copy

Comparison of 2008 to the proposed 2011 NCLEX-PN® Test Plan

(Track Changes: Strikethroughs represent deletions; underscore represents additions)

NCLEX-PN® Test Plan2011

National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-PN® 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 meet set requirements that include passing an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level practical/vocational nurse. NCSBN develops a licensure examination, the National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-PN® Examination), which is used by member board jurisdictions to assist in making licensure decisions.

Several steps occur in the development of the *NCLEX-PN® Test Plan.* The first step is conducting a practice analysis that is used to collect data on the current practice of entry-level practical/vocational nurses (*Report of Findings from the 2009 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* [NCSBN, 2009]). Newly licensed practical/vocational nurses are asked about the frequency and priority of performing 150 nursing care activities. Nursing care activities are then 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 that are fundamental to the practice of nursing. The next step is the development of the *NCLEX-PN® Test Plan*, which guides the selection of content and behaviors to be tested. Variations in jurisdiction laws and regulations are considered in the development of the test plan.

The *NCLEX-PN® 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 examination assesses the knowledge, skills and abilities that are essential for the entry-level practical/vocational 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-PN® Test Plan.*

Beliefs

Beliefs about people and nursing influence the *NCLEX-PN® Test Plan.* People are finite beings with varying capacities to function in society. They are unique individuals who have defined systems of daily living that reflect their values, cultures, motives and lifestyles. Additionally, people have the right to make decisions regarding their health care needs and to participate in meeting those needs. The profession of nursing makes a unique contribution in helping clients (individuals, families and significant others) achieve an optimal level of health in a variety of settings.

Nursing is both an art and a science, founded on a professional body of knowledge that integrates 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 is preventing illness; promoting comfort; protecting, promoting, and restoring health; and promoting dignity in dying.
The practical/vocational nurse uses "specialized knowledge and skills which meet the health needs of people in a variety of settings under the direction of qualified health professionals" (NFLPN, 2003). The practical/vocational nurse uses a clinical problem-solving process (the nursing process) to collect and organize relevant health care data, assist in the identification of the health needs/problems throughout the client's life span and contribute to the interdisciplinary team in a variety of settings. The entry-level practical/vocational nurse demonstrates the essential competencies needed to care for clients with commonly

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occurring health problems that have predictable outcomes. "Professional behaviors, within the scope of nursing practice for a practical/vocational nurse, are characterized by adherence to standards of care, accountability of one's own actions and behaviors, and use of legal and ethical principles in nursing practice" (NAPNES, 2007).

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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). The practice of practical/vocational nursing requires application of knowledge, skills and abilities, therefore the majority of items are written at the application or higher levels of cognitive ability.

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Test Plan Structure

The framework of Client Needs was selected because it provides a universal structure for defining nursing actions and competencies for a variety of clients across all settings and is congruent with state laws/ rules.

Client Needs

The content of the *NCLEX-PN® 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
- Coordinated Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

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

Integrated Processes

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

- *Clinical Problem-Solving Process (Nursing Process)* – a scientific approach to client care that includes data collection, planning, implementation and evaluation.

- *Caring* – interaction of the practical/vocational nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the practical/vocational nurse provides support and compassion to help achieve desired therapeutic outcomes.

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- *Communication and Documentation* –verbal and nonverbal interactions between the practical/vocational nurse and the client as well as 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.

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- *Teaching and Learning* – facilitation of the acquisition of knowledge, skills and attitudes to assist in promoting a change in behavior.

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Distribution of Content

The percentage of test items assigned to each Client Needs category and subcategory in the *NCLEX-PN® Test Plan* is based on the results of the study entitled *Report of Findings from the 2009 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (NCSBN, 2009), and expert judgment provided by members of the NCLEX® Examination Committee.

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Client Needs	Percentage of Items from each Category/Subcategory
Safe and Effective Care Environment	
▪ Coordinated Care	13-19%
▪ Safety and Infection Control	11-17%
Health Promotion and Maintenance	7-13%
Psychosocial Integrity	7-13%
Physiological Integrity	
▪ Basic Care and Comfort	9-15%
▪ Pharmacological Therapies	11-17%
▪ Reduction of Risk Potential	9-15%
▪ Physiological Adaptation	9-15%

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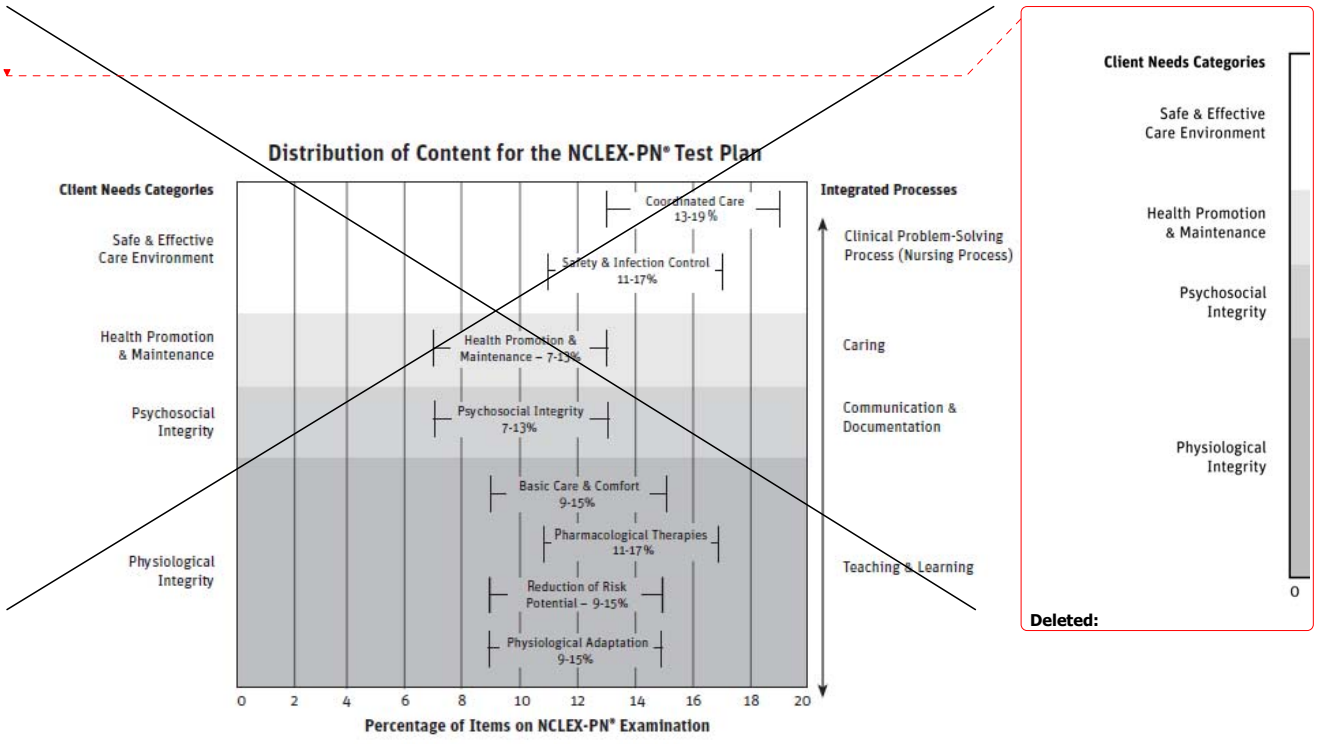

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Overview of Content

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

Safe and Effective Care Environment

The practical/vocational nurse provides nursing care that contributes to the enhancement of the health care delivery setting and protects clients* and health care personnel.

- *Coordinated Care* – The practical/vocational nurse collaborates with health care team members to facilitate effective client care

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

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

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- *Safety and Infection Control* – The practical/vocational nurse contributes to the protection of clients and health care personnel from health and environmental hazards.

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

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

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Health Promotion and Maintenance

The practical/vocational nurse provides nursing care for clients that incorporates the knowledge of expected stages of growth and development and prevention and/or early detection of health problems.

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

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Data Collection Techniques
- Developmental Stages and Transitions
- Health Promotion/Disease Prevention
- High Risk Behaviors
- Lifestyle Choices
- Self-Care

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Psychosocial Integrity

The practical/vocational nurse provides care that assists with promotion and support of the emotional, mental and social well-being of clients.

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

- Abuse or Neglect
- Behavioral Management
- Chemical and other dependencies
- Coping Mechanisms
- Crisis Intervention
- Cultural Awareness
- End of Life Concepts
- 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 practical/vocational nurse assists in the promotion of physical health and well-being by providing care and comfort, reducing risk potential for clients and assisting them with the management of health alterations.

- *Basic Care and Comfort* – The practical/vocational nurse provides comfort to clients and assistance in the performance of their 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

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- *Pharmacological Therapies* – The practical/vocational nurse provides care related to the administration of medications and monitors clients who are receiving parenteral therapies.

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

- Adverse Effects/Contraindications/Side Effects/Interactions
- Dosage Calculations
- Expected Actions/Outcomes
- Medication Administration
- Pharmacological Pain Management

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- *Reduction of Risk Potential*– The practical/vocational nurse reduces the potential for clients to develop complications or health problems related to treatments, procedures or existing conditions.

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
- Therapeutic Procedures

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- *Physiological Adaptation* – The practical/vocational nurse participates in 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
  - Basic Pathophysiology
  - Fluid and Electrolyte Imbalances
  - Medical Emergencies
  - Radiation Therapy
  - Unexpected Response to Therapies

Administration of the NCLEX-PN® Examination

The *NCLEX-PN® Examination* is administered to candidates by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory.

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 administered is chosen to measure the candidate's ability 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-PN® Test Plan* requirements. The examination continues with items selected and administered in this way until a pass or fail decision is made.

All practical/vocational nurse candidates must answer a minimum of 85 items. The maximum number of items that a practical/vocational nurse candidate may answer is 205 during the allotted five-hour time period. The maximum five-hour time limit to complete the examination includes the tutorial, sample questions and all breaks. Candidates may be administered multiple choice items as well as items written in alternate formats. These formats may include but are not limited to multiple response, fill-in-the-blank calculation, ordered response, and/or hot spots. All item types may include multimedia such as charts, tables, graphics, sound and video. All items go through an extensive review process before being used as items on the examination.

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.

Examination Security and Confidentiality

Any candidate that violates test center regulations or rules, or engages in irregular behavior, misconduct and/or does not follow a test center administrator's warning to discontinue inappropriate behavior may be dismissed from the test center. Additionally, exam results may be withheld or cancelled and the licensing board may take other disciplinary action such as denial of a license and/or disqualifying the candidate from future registrations for licensure. Refer to the current candidate bulletin for more information.

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. Disclosure of examination materials includes but is not limited to discussing examination items with faculty, friends, family, or others.

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Bibliography

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.

Bloom, B. S., Engelhart, M. D., Furst, E. J., Hill, W. H., & Krathwohl, D. R. (1956). *Taxonomy of educational objectives: the classification of educational goals. Handbook I. Cognitive Domain.* New York: David McKay.

National Association for Practical Nurse Educators and Service (NAPNES). (2007). *Standards of practice and Educational Competencies of Graduates of Practical/Vocational Nursing Programs.* Silver Spring, MD: Author.

National Council of State Boards of Nursing (2010). *Report of the findings from the 2009 LPN/VN practice analysis: linking the NCLEX-PN examination to practice.* Chicago, Author.

National Council of State Boards of Nursing. (2006). *Model nursing administrative rules.* Chicago: Author.

National Council of State Boards of Nursing. (2006). *Model nursing practice act.* Chicago: Author.

National Federation of Licensed Practical Nurses, Inc. (NFLPN). (2003). *Nursing practice standards for the licensed practical/vocational nurse.* Raleigh, NC: Author.

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Attachment B

Proposed 2011 NCLEX-PN® Test Plan-Clean Copy

NCLEX-PN® Test Plan 2011

National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-PN® 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 meet set requirements that include passing an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level practical/vocational nurse. NCSBN develops a licensure examination, the National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-PN® Examination), which is used by member board jurisdictions to assist in making licensure decisions.

Several steps occur in the development of the *NCLEX-PN® Test Plan*. The first step is conducting a practice analysis that is used to collect data on the current practice of entry-level practical/vocational nurses (*Report of Findings from the 2009 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* [NCSBN, 2009]). Newly licensed practical/vocational nurses are asked about the frequency and priority of performing 150 nursing care activities. Nursing care activities are then 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 that are fundamental to the practice of nursing. The next step is the development of the *NCLEX-PN® Test Plan*, which guides the selection of content and behaviors to be tested. Variations in jurisdiction laws and regulations are considered in the development of the test plan.

The *NCLEX-PN® 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 examination assesses the knowledge, skills and abilities that are essential for the entry-level practical/vocational 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-PN® Test Plan*.

Beliefs

Beliefs about people and nursing influence the *NCLEX-PN® Test Plan*. People are finite beings with varying capacities to function in society. They are unique individuals who have defined systems of daily living that reflect their values, cultures, motives and lifestyles. Additionally, people have the right to make decisions regarding their health care needs and to participate in meeting those needs. The profession of nursing makes a unique contribution in helping clients (individuals, families and significant others) achieve an optimal level of health in a variety of settings.

Nursing is both an art and a science, founded on a professional body of knowledge that integrates 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 is preventing illness; promoting comfort; protecting, promoting, and restoring health; and promoting dignity in dying.

The practical/vocational nurse uses "specialized knowledge and skills which meet the health needs of people in a variety of settings under the direction of qualified health professionals" (NFLPN, 2003). The practical/vocational nurse uses a clinical problem-solving process (the nursing process) to collect and organize relevant health care data, assist in the identification of the health needs/problems throughout the client's life span and contribute to the interdisciplinary team in a variety of settings. The entry-level practical/vocational nurse demonstrates the essential competencies needed to care for clients with commonly occurring health problems that have predictable outcomes. "Professional behaviors, within the scope of nursing practice for a practical/vocational nurse, are characterized by adherence to standards of care, accountability of one's own actions and behaviors, and use of legal and ethical principles in nursing practice" (NAPNES, 2007).

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). The practice of practical/vocational nursing requires application of knowledge, skills and abilities; therefore, the majority of items are written at the application or higher levels of cognitive ability.

Test Plan Structure

The framework of Client Needs was selected because it provides a universal structure for defining nursing actions and competencies for a variety of clients across all settings and is congruent with state laws/ rules.

Client Needs

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

Safe and Effective Care Environment
- Coordinated Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

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

Integrated Processes

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

- *Clinical Problem-Solving Process (Nursing Process)* – a scientific approach to client care that includes data collection, planning, implementation and evaluation.

- *Caring* – interaction of the practical/vocational nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the practical/vocational nurse provides support and compassion to help achieve desired therapeutic outcomes.

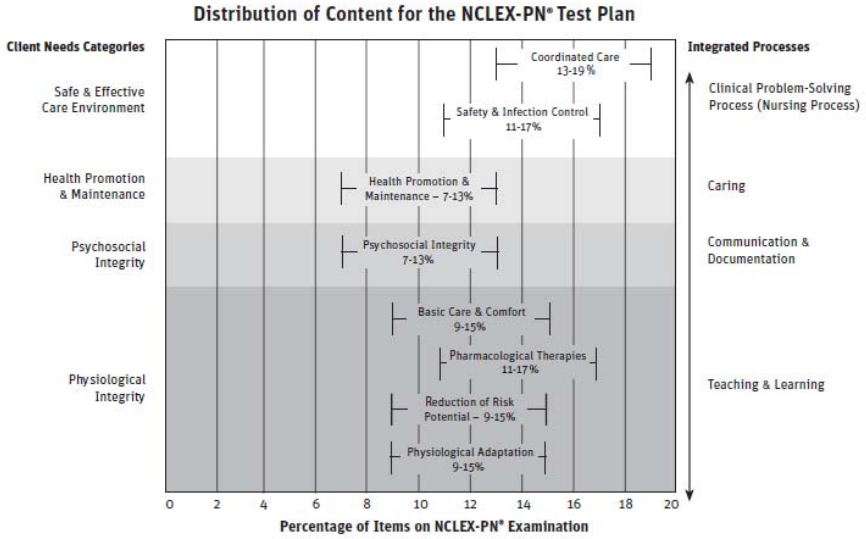
- *Communication and Documentation* –verbal and nonverbal interactions between the practical/vocational nurse and the client, as well as other members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.

- *Teaching and Learning* – facilitation of the acquisition of knowledge, skills and attitudes to assist in promoting a change in behavior.

Distribution of Content

The percentage of test items assigned to each Client Needs category and subcategory in the *NCLEX-PN® Test Plan* is based on the results of the study entitled *Report of Findings from the 2009 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice* (NCSBN, 2009), and expert judgment provided by members of the NCLEX® Examination Committee.

Client Needs	Percentage of Items from each Category/Subcategory
Safe and Effective Care Environment	
▪ Coordinated Care	13-19%
▪ Safety and Infection Control	11-17%
Health Promotion and Maintenance	7-13%
Psychosocial Integrity	7-13%
Physiological Integrity	
▪ Basic Care and Comfort	9-15%
▪ Pharmacological Therapies	11-17%
▪ Reduction of Risk Potential	9-15%
▪ Physiological Adaptation	9-15%



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 practical/vocational nurse provides nursing care that contributes to the enhancement of the health care delivery setting and protects clients* and health care personnel.

- *Coordinated Care* – The practical/vocational nurse collaborates with health care team members to facilitate effective client care

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

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

- *Safety and Infection Control* – The practical/vocational nurse contributes to the protection of clients and health care personnel from health and environmental hazards.

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

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

Health Promotion and Maintenance

The practical/vocational nurse provides nursing care for clients that incorporates the knowledge of expected stages of growth and development and prevention and/or early detection of health problems.

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

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Data Collection Techniques
- Developmental Stages and Transitions
- Health Promotion/Disease Prevention
- High Risk Behaviors
- Lifestyle Choices
- Self-Care

Psychosocial Integrity

The practical/vocational nurse provides care that assists with promotion and support of the emotional, mental and social well-being of clients.

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

- Abuse or Neglect
- Behavioral Management
- Chemical and other dependencies
- Coping Mechanisms
- Crisis Intervention
- Cultural Awareness
- End of Life Concepts
- Grief and Loss
- Mental Health Concepts
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Stress Management
- Support Systems
- Therapeutic Communication
- Therapeutic Environment

Physiological Integrity

The practical/vocational nurse assists in the promotion of physical health and well-being by providing care and comfort, reducing risk potential for clients and assisting them with the management of health alterations.

- *Basic Care and Comfort* – The practical/vocational nurse provides comfort to clients and assistance in the performance of their 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 Therapies* – The practical/vocational nurse provides care related to the administration of medications and monitors clients who are receiving parenteral therapies.

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

  - Adverse Effects/Contraindications/Side Effects/Interactions
  - Dosage Calculations
  - Expected Actions/Outcomes
  - Medication Administration
  - Pharmacological Pain Management

- *Reduction of Risk Potential*– The practical/vocational nurse reduces the potential for clients to develop complications or health problems related to treatments, procedures or existing conditions.

  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
  - Therapeutic Procedures

- *Physiological Adaptation* – The practical/vocational nurse participates in 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
  - Basic Pathophysiology
  - Fluid and Electrolyte Imbalances
  - Medical Emergencies
  - Radiation Therapy
  - Unexpected Response to Therapies

Administration of the NCLEX-PN® Examination

The *NCLEX-PN® Examination* is administered to candidates by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. 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 administered is chosen to measure the candidate's ability 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-PN® Test Plan* requirements. The examination continues with items selected and administered in this way until a pass or fail decision is made.

All practical/vocational nurse candidates must answer a minimum of 85 items. The maximum number of items that a practical/vocational nurse candidate may answer is 205 during the allotted five-hour time period. The maximum five-hour time limit to complete the examination includes the tutorial, sample questions and all breaks. Candidates may be administered multiple choice items as well as items written in alternate formats. These formats may include but are not limited to multiple response, fill-in-the-blank calculation, ordered response, and/or hot spots. All item types may include multimedia such as charts, tables, graphics, sound and video. All items go through an extensive review process before being used as items on the examination.

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.

Examination Security and Confidentiality

Any candidate that violates test center regulations or rules, or engages in irregular behavior, misconduct and/or does not follow a test center administrator's warning to discontinue inappropriate behavior may be dismissed from the test center. Additionally, exam results may be withheld or cancelled and the licensing board may take other disciplinary action such as denial of a license and/or disqualifying the candidate from future registrations for licensure. Refer to the current candidate bulletin for more information.

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. Disclosure of examination materials includes but is not limited to discussing examination items with faculty, friends, family, or others.

Bibliography

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.

Bloom, B. S., Engelhart, M. D., Furst, E. J., Hill, W. H., & Krathwohl, D. R. (1956). *Taxonomy of educational objectives: the classification of educational goals. Handbook I. Cognitive Domain.* New York: David McKay.

National Association for Practical Nurse Educators and Service (NAPNES). (2007). *Standards of practice and Educational Competencies of Graduates of Practical/Vocational Nursing Programs.* Silver Spring, MD: Author.

National Council of State Boards of Nursing (2010). *Report of the findings from the 2009 LPN/VN practice analysis: linking the NCLEX-PN examination to practice.* Chicago, Author.

National Council of State Boards of Nursing. (2006). *Model nursing administrative rules.* Chicago: Author.

National Council of State Boards of Nursing. (2006). *Model nursing practice act.* Chicago: Author.

National Federation of Licensed Practical Nurses, Inc. (NFLPN). (2003). *Nursing practice standards for the licensed practical/vocational nurse.* Raleigh, NC: Author.

Attachment C

Timeline for Implementation of the 2011 NCLEX-PN® Test Plan

October 2009	NCLEX® Examination Committee reviews PN practice analysis results and makes recommendations to the test plan.
November 2009	Proposed test plan is sent to Member Boards for feedback.
March 2010	NCLEX® Examination Committee presents the proposed test plan at the NCSBN Midyear Meeting.
April 2010	NCLEX® Examination Committee reviews feedback on the test plan and submits recommendations to the Delegate Assembly.
August 2010	Delegate Assembly action is provided.
September 2010	PN test plan is published and placed on the NCSBN website.
September 2010	Panel of Judges meets to recommend the passing standard.
December 2010	NCSBN Board of Directors evaluates the passing standard.
April 2011	Implementation of 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 seventh full year of providing test delivery services for the National Council Licensure Examination (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

The following senior content developers joined the Pearson VUE NCLEX® Test Development team in 2009: Paula Tedin-Moschovas (January), Candy Gordon (March), Megan McCatty (April), Latrice Johnson (May), Andrea Krzysko (July), Patty Gunning (August) and Wendy Quinn (December). Marie Lindsay was hired in November 2009 as content developer I.

Linda Conheady joined the Pearson VUE NCLEX team as test and report editor in August 2009.

In November 2009, Jason Schwartz accepted the position of director of content development, NCLEX, and agreed to a start date of Jan. 19, 2010. Jason's core areas of expertise are content development and online assessment. He was most recently the director of publishing systems for Pacific Metrics in Monterey, Calif.

Test Development

Psychometric and statistical analyses of the NCLEX data continue to be conducted and documented as required. Pearson VUE is continuing to develop multiple-choice items as well as items in alternate formats, such as multiple-response, drag-and-drop (ordered response), audio items and chart/exhibit items. Pearson VUE continues to focus on producing both the traditional and alternate format items at targeted difficulty levels and in sufficient quantities to meet our contractual obligations.

NCLEX® Examinations Operations

In addition to Pearson VUE delivering the NCLEX examination in the U.S., NCSBN has approved Pearson VUE to deliver the NCLEX examination at 18 international Pearson Professional Centers in 11 countries. The NCLEX is currently being administered in Australia, Canada, Germany, Hong Kong, India, Japan, Mexico, the Philippines, Puerto Rico, Taiwan and the United Kingdom. These additions raise the number of Pearson Professional Centers delivering the NCLEX examination to a current total of 235 locations globally.

Pearson VUE visits to NCSBN

- Jan. 20-22, 2009, NCLEX® Examination Committee Business Meeting
- Jan. 22, 2009, Pearson VUE Business Review Meeting
- March 2-4, 2009, Midyear Meeting
- April 15-17, 2009, NCLEX® Examination Committee Business Meeting
- April 18, 2009, NCLEX® Development Group Meeting
- April 27, 2009, Alternate Item Group Meeting
- May 7, 2009, Medical Illustrator Vendor Meeting/Presentation
- May 21, 2009, Audio Vendor Meeting/Presentation
- June 11, 2009, Production Schedule Meeting
- July 13, 2009, Test Content Contract Evaluation Meeting
- July 14, 2009, NCLEX® Development Group Meeting
- July 20, 2009, Animation Vendor Meeting/Presentation

- Aug. 11-14, 2009, Delegate Assembly
- Aug. 26, 2009, General NCLEX Meeting
- Sept. 18, 2009, NCLEX® Development Group Meeting
- Oct. 27-29, 2009, NCLEX® Examination Committee Business Meeting
- Oct. 30, 2009, Contract Evaluation Meeting
- Dec. 17, 2009, NCLEX® Development Meeting

Monthly Meetings/Conference Calls:

- Monthly conference calls are held with NCSBN, Test Development and Operations, and scheduled more frequently as needed.
- Conference calls with Pearson VUE and NCSBN content staff are held periodically, as needed.
- Other visits and conference calls are conducted on an as-needed basis.

Summary of NCLEX® Examination Results for the 2009 Calendar Year[1]

Longitudinal summary statistics are provided in Tables 1-8. Results can be compared to data from the previous testing year to identify trends in candidate performance and item characteristics over time.

Compared to 2008, the overall candidate volumes were lower for the NCLEX-RN® (about -3.7 percent), but higher for the NCLEX-PN® (about +3.9 percent). The RN passing rate for the overall group was 3.4 percentage points higher for 2009 than for 2008, and the passing rate for the reference group was 1.7 percentage points higher for this period compared to 2008. The PN overall passing rate was lower by 0.3 percentage point from 2008, and the PN reference group passing rate was 0.1 percentage point higher than in 2008. These passing rates are consistent with expected variations in passing rates and are heavily influenced by demographic characteristics of the candidate populations and by changes in testing patterns from year to year.

The following points are candidate highlights of the 2009 testing year for the NCLEX-RN® Examination:

- Overall, 202,029 NCLEX-RN Examination candidates tested during 2009, as compared to 209,769 during the 2008 testing year. This represents a decrease of approximately 3.7 percent.
- The candidate population reflected 134,725 first-time, U.S.-educated candidates who tested during 2009, as compared to 129,121 for the 2008 testing year, representing a 4.3 percent increase.
- The overall passing rate was 73.2 percent in 2009, compared to 69.8 percent in 2008. The passing rate for the reference group was 88.4 percent in 2009 and 86.7 percent in 2008.
- Approximately 51.7 percent of the total group and 55.4 percent of the reference group ended their tests after a minimum of 75 items were administered. This is slightly higher than in the 2008 testing year, in which 50.6 percent of the total group and 54.1 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 12.5 percent for the reference group. This is similar to last year's figures (14.3 percent for the total group and 12.8 percent for the reference group).
- The average time needed to take the NCLEX-RN Examination during the 2009 testing period was 2.5 hours for the overall group and 2.2 hours for the reference group (close to last year's average times of 2.6 hours and 2.3 hours, respectively).

[1]Data for October to December 2009 are preliminary pending updated data from stat extract files.

- A total of 56.0 percent of the candidates chose to take a break during their examinations (compared to 59.4 percent last year).
- Overall, 2.2 percent of the total group and 1.0 percent of the reference group ran out of time before completing the test. These percentages of candidates timing out were approximately the same as the corresponding percentages for candidates during the 2008 testing year (2.2 percent and 1.1 percent, respectively).
- In general, the NCLEX-RN Examination summary statistics for the 2009 testing period indicated patterns that were similar to those observed for the 2008 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, 80,854 PN candidates tested in 2009, as compared to 77,835 PN candidates tested during 2008. This represents an increase of approximately 3.9 percent.
- The candidate population reflected 63,534 first-time, U.S.-educated candidates who tested in 2009, as compared to 61,773 for the 2008 testing year (an increase of approximately 2.9 percent).
- The overall passing rate was 75.9 percent in 2009 compared to 76.2 percent in 2008, and the reference group passing rate was 85.7 percent in 2009 compared to 85.6 percent in 2008.
- There were 55.1 percent of the total group and 59.6 percent of the reference group who ended their tests after a minimum of 85 items were administered. These figures are slightly higher than those from the 2008 testing year, in which 54.4 percent of the total group and 58.8 percent of the reference group took minimum-length exams.
- The percentage of maximum-length test takers was 16.5 percent for the total group and 14.1 percent for the reference group. These figures are slightly lower than last year's percentages (17.3 percent for the total group and 14.9 percent for the reference group).
- The average time needed to take the NCLEX-PN Examination during the 2009 testing period was 2.3 hours for the overall group and 2.1 hours for the reference group (very similar to last year's times of 2.2 and 2.1 hours, respectively).
- Overall, 2.0 percent of the total group and 1.0 percent of the reference group ran out of time before completing the test (slightly higher than last year's figures of 1.8 percent and 0.9 percent, respectively).
- In general, the NCLEX-PN Examination summary statistics for the 2009 testing period indicated patterns that were similar to those observed for the 2008 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 2009 Testing Year										
	Jan 09 - Mar 09		Apr 09 - Jun 09		Jul 09 - Sep 09		Oct 09 - Dec 09		Cumulative 2009	
	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	46,891	31,060	52,565	35,468	73,790	56,440	28,783	11,757	202,029	134,725
Percent Passing	71.8	88.1	74.8	90.8	77.9	88.2	60.3	83.3	73.2	88.4
Ave. # Items Taken	120.8	115.2	118.4	110.9	120.8	116.4	127.7	120.5	121.2	115.1
% Taking Min # Items	52.1	55.9	54.0	58.5	51.9	54.4	46.2	49.4	51.7	55.4
% Taking Max # Items	14.1	12.3	13.4	11.2	14.5	13.1	16.1	13.6	14.3	12.5
Ave. Test Time	2.5	2.2	2.4	2.1	2.4	2.2	2.8	2.4	2.5	2.2
% Taking Break	56.3	48.8	53.4	43.0	54.3	48.3	64.6	53.2	56.0	47.5
% Timing Out	2.0	1.0	2.1	0.7	1.9	1.1	3.3	1.5	2.2	1.0

Table 2: 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
% 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	2.6	2.4	2.5	2.2	2.5	2.3	2.8	2.4	2.6	2.3
% 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 3: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2009 Testing Year*										
Operational Item Statistics										
	Jan 09 - Mar 09		Apr 09 - Jun 09		Jul 09 - Sep 09		Oct 09 - Dec 09		Cumulative 2009	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Point-Biserial	0.20	0.08	0.21	0.09	0.21	0.09	0.20	0.08	NA	NA
Ave. Item Time (secs)	71.8	17.4	73.9	36.5	72.8	35.9	76.6	36.4	NA	NA
Pretest Item Statistics										
# of Items	826		305		657		316		2,104	
Ave. Sample Size	532		1,542		586		513		692	
Mean Point-Biserial	0.08		0.07		0.07		0.08		0.08	
Mean P+	0.52		0.50		0.52		0.50		0.51	
Mean B-Value	0.17		0.34		0.15		0.25		0.20	
SD B-Value	1.79		1.76		1.62		1.35		1.67	
Total Number Flagged	368		154		315		116		953	
% Items Flagged	44.6		50.5		47.9		36.7		45.3	
*Data does not include research and retest items.										

Table 4: 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	
*Data do not include research and retest items.										

Table 5: Longitudinal Technical Summary for the NCLEX-PN® Group Statistics for 2009 Testing Year										
	Jan 09 - Mar 09		**Apr 09 - Jun 09**		**Jul 09 - Sep 09**		**Oct 09 - Dec 09**		**Cumulative 2009**	
	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	18,684	14,683	16,873	12,302	26,849	22,572	18,448	13,977	80,854	63,534
% Passing	74.1	84.0	72.2	84.2	80.4	88.0	74.5	85.1	75.9	85.7
Ave. # Items Taken	116.6	113.1	117.1	111.5	112.7	109.2	117.4	112.6	115.6	111.3
% Taking Min # Items	53.7	57.5	53.9	59.7	58.6	62.4	52.3	56.9	55.1	59.6
% Taking Max # Items	16.9	15.0	17.6	14.5	15.0	13.0	17.3	14.5	16.5	14.1
Ave. Test Time	2.2	2.1	2.3	2.1	2.1	2.0	2.4	2.2	2.3	2.1
% Taking Break	53.7	47.1	57.4	48.9	50.8	45.2	61.2	54.3	55.2	48.3
% Timing Out	1.8	1.0	2.4	1.2	1.7	0.9	2.1	1.1	2.0	1.0

Table 6: 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	2.2	2.0	2.3	2.1	2.1	2.0	2.3	2.1	2.2	2.1
% 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 7: Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2009 Testing Year*										
Operational Item Statistics										
	Jan 09 - Mar 09		**Apr 09 - Jun 09**		**Jul 09 - Sep 09**		**Oct 09 - Dec 09**		**Cumulative 2009**	
	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	0.21	0.08	0.21	0.08	NA	NA
Ave. Item Time (secs)	65.8	16.5	69.2	27.5	66.0	25.8	69.2	23.2	NA	NA
Pretest Item Statistics										
# of Items	303		572		866		356		2,097	
Ave. Sample Size	1,157		489		651		493		653	
Mean Point-Biserial	0.11		0.11		0.09		0.09		0.10	
Mean P+	0.51		0.47		0.41		0.42		0.44	
Mean B-Value	0.05		0.35		0.70		0.55		0.49	
SD B-Value	1.63		1.69		1.56		1.46		1.61	
Total Number Flagged	102		218		387		149		856	
% Items Flagged	33.7		38.1		44.7		41.9		40.8	
*Data do not include research and retest items.										

Table 8: 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	
*Data do not include research and retest items.										

International Testing Update

Pearson VUE has a total of 217 Pearson Professional Centers (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 235 test centers globally.

Represented in the tables below is international volume by Member Board, country of education, test center and pass/fail rate, respectively.

Table 9: NCLEX® International Test Center Volume by Member Board* Jan. 1–Dec. 31, 2009

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	3	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Alaska	4	0	0	0	1	0	0	0	0	1	0	0	0	0	0	1	0	0	1
Arizona	41	1	5	0	0	0	2	1	2	4	0	1	1	0	1	18	0	0	5
Arkansas	63	1	0	1	0	1	1	0	0	0	0	0	0	0	0	58	0	0	1
California - RN	9731	36	64	17	87	28	316	21	26	124	2	29	26	3	2	8354	3	154	439
California - VN	9	0	0	0	0	1	0	0	0	3	0	0	0	0	0	5	0	0	0
Colorado	9	1	2	0	0	1	1	0	0	1	0	0	0	0	0	3	0	0	0
Connecticut	20	0	0	0	0	2	0	1	0	0	0	0	0	0	0	15	0	0	2
Delaware	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
District of Columbia	4	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0	0	1
Florida	124	0	4	0	4	2	3	5	3	0	2	4	1	0	0	76	2	1	17
Georgia - RN	13	3	0	0	2	2	0	0	0	0	0	0	0	0	0	2	0	0	4
Hawaii	28	0	3	0	2	0	1	0	0	0	0	0	0	1	0	17	1	0	3
Idaho	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Illinois	439	0	1	0	5	1	6	6	1	0	0	0	0	0	0	405	0	0	14
Indiana	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	0	0
Iowa	2	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Kentucky	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Louisiana - PN	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Louisiana - RN	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Maryland	62	3	1	1	6	5	0	1	0	0	0	1	0	0	0	33	0	0	11
Massachusetts	28	1	1	1	3	0	0	1	0	0	0	0	0	0	0	17	0	0	4
Michigan	83	1	2	0	12	6	1	3	2	2	1	4	0	0	0	45	0	0	4
Minnesota	207	1	44	13	98	1	0	2	0	0	0	0	0	0	0	47	0	0	1

Table 9: NCLEX® International Test Center Volume by Member Board* Jan. 1–Dec. 31, 2009

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
Missouri	14	1	0	0	1	2	0	0	0	0	0	0	0	0	0	10	0	0	0
Montana	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Nebraska	2	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Nevada	74	2	1	1	0	1	2	1	1	0	0	0	0	0	0	64	0	0	1
New Jersey	53	1	0	0	2	0	3	0	0	0	0	0	0	0	0	44	0	0	3
New Mexico	407	2	2	0	0	2	29	2	5	2	0	2	1	1	0	334	1	0	24
New York	1879	25	11	7	34	10	388	20	16	9	1	7	602	9	0	505	6	183	46
North Carolina	49	0	2	0	1	0	0	3	9	0	0	1	0	1	0	24	1	0	7
Northern Mariana Islands	294	2	0	0	1	0	5	1	0	1	0	0	0	0	0	283	0	0	1
Ohio	22	0	0	1	1	0	0	0	0	0	0	1	0	0	0	18	0	0	1
Oregon	14	1	3	0	0	0	0	0	0	0	0	0	0	0	0	9	0	0	1
Pennsylvania	25	0	0	2	2	0	0	1	0	0	0	0	0	0	0	16	2	0	2
South Carolina	6	0	0	0	0	1	0	0	0	0	0	0	0	0	0	4	0	0	1
Tennessee	18	0	1	0	1	1	0	0	0	0	0	0	0	0	0	15	0	0	0
Texas	226	3	0	0	6	3	3	13	5	1	0	1	1	1	0	171	1	0	17
Utah	2	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Vermont	2971	10	3	2	10	3	50	155	131	181	20	74	1	0	2	2163	0	1	165
Virginia	26	0	0	0	0	1	0	8	4	2	2	1	1	0	0	3	1	0	3
Washington	10	0	6	0	2	0	0	0	0	0	0	0	0	0	0	2	0	0	0
West Virginia - PN	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	27	0	0	0
Wisconsin	44	0	0	0	0	0	1	0	0	0	0	0	0	0	0	15	27	0	1
Wyoming	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Total	17047	95	159	46	285	78	813	245	205	331	28	126	634	16	5	12810	51	339	781

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

Table 10: NCLEX® International Test Center Volume by Country of Education Jan. 1–Dec. 31, 2009

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
Armenia	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Australia	17	17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Austria	2	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Bahamas	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Bahrain	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Bangladesh	1	0	0	0	0	0	0	0	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
Belgium	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Bosnia and Herzegovina	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Cameroon	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Canada	250	1	62	27	158	0	0	0	0	0	0	0	0	0	0	0	0	0	2
China	89	1	4	0	4	0	73	0	0	0	0	0	0	0	0	2	0	0	5
Colombia	3	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Croatia	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Czech Republic	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Dominica	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Ethiopia	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Finland	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
France	2	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Gambia	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Germany	11	1	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	2
Ghana	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Guyana	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Hong Kong	4	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0
Hungary	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
India	934	4	5	0	10	6	0	227	193	289	27	88	0	0	0	0	0	0	85
Indonesia	3	0	0	0	0	0	1	0	0	0	0	0	0	0	0	2	0	0	0
Iran	8	0	0	0	1	3	0	0	0	2	0	1	0	0	0	0	0	0	1

Table 10: NCLEX® International Test Center Volume by Country of Education Jan. 1–Dec. 31, 2009

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
Ireland	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Israel	24	0	0	0	1	9	0	0	0	0	0	0	0	0	0	0	0	0	14
Italy	2	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Jamaica	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Japan	27	1	0	0	0	0	0	0	0	0	0	0	23	3	0	0	0	0	0
Jordan	3	0	0	0	1	0	0	0	0	1	0	1	0	0	0	0	0	0	0
Kenya	22	0	0	0	0	1	0	0	0	2	0	17	0	0	0	0	0	0	2
Korea, North	2	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0
Korea, South	1213	13	8	0	5	1	374	0	0	0	0	0	598	8	0	52	0	151	3
Lebanon	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Malaysia	4	1	0	0	0	0	1	0	1	0	0	0	0	0	0	1	0	0	0
Malta	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Moldova	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Nepal	12	0	0	0	0	0	0	5	0	4	0	0	0	0	0	0	0	0	3
Netherlands	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
New Zealand	16	14	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Nigeria	49	1	0	0	6	2	0	0	0	1	0	4	0	0	4	0	1	0	30
Oman	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Pakistan	16	0	0	0	1	0	0	0	0	10	0	2	0	0	0	0	0	0	3
Philippines	13768	34	66	16	82	13	282	8	7	16	1	10	8	2	0	12736	0	4	483
Puerto Rico	49	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	48	0	0
Romania	3	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1
Russian Federation	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Saint Kitts and Nevis	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Saudi Arabia	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sierra Leone	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Singapore	7	0	1	0	0	0	2	0	1	0	0	0	0	0	0	2	0	1	0
Slovakia	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2

Table 10: NCLEX® International Test Center Volume by Country of Education Jan. 1–Dec. 31, 2009

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
South Africa	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Sri Lanka	4	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	0	0	1
Swaziland	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Sweden	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Taiwan	182	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	180	0
Thailand	68	0	0	0	0	0	68	0	0	0	0	0	0	0	0	0	0	0	0
Trinidad and Tobago	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Turkey	3	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	0	0	0
Ukraine	9	0	0	0	1	6	0	0	2	0	0	0	0	0	0	0	0	0	0
United Arab Emirates	4	0	0	0	0	0	0	0	0	2	0	1	0	0	0	1	0	0	0
United Kingdom	89	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	85
United States	83	3	8	3	11	16	5	1	0	3	0	0	4	3	1	13	1	2	9
Viet Nam	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Zambia	5	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Zimbabwe	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	17047	95	159	46	285	78	813	245	205	331	28	126	634	16	5	12810	51	339	781

Table 11: NCLEX® International Volume by Testing Center Jan. 1–Dec. 31, 2009

Site ID	City	Country	Total	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
50482	Sydney	Australia	95	10	10	11	3	12	9	8	5	5	6	9	7
50486	Burnaby	Canada	159	10	9	17	14	12	14	17	14	18	10	12	12
50485	Montreal	Canada	46	2	0	9	5	2	4	6	3	5	5	1	4
50484	Toronto	Canada	285	18	11	32	22	25	29	32	19	23	23	24	27
50491	Frankfurt	Germany	78	3	6	7	4	7	10	6	8	4	7	6	10
50493	Hong Kong	Hong Kong	813	61	78	85	87	75	65	72	66	51	47	45	81
50497	Bangalore	India	245	29	21	33	18	19	17	11	26	15	21	18	17
50498	Chennai	India	205	36	18	20	25	8	16	18	15	15	18	8	8
50495	Delhi	India	331	18	40	37	34	15	29	33	24	40	17	24	20
50496	Hyderabad	India	28	4	3	3	2	4	1	1	3	2	2	3	0
50494	Mumbai	India	126	18	15	16	10	8	10	12	6	7	8	7	9
50500	Chiyoda-ku	Japan	634	54	67	65	63	42	39	44	47	53	49	62	49
50501	Yokohama City	Japan	16	0	2	1	0	0	4	1	3	0	5	0	0
50503	Mexico City	Mexico	5	0	1	2	1	0	0	0	0	0	0	1	0
54555	Manila	Philippines	12810	1313	1022	1168	1340	1125	1011	994	915	1012	1008	716	1186
47108	San Juan	Puerto Rico	51	3	3	1	4	2	2	4	9	3	7	4	9
50506	Taipei	Taiwan	339	20	34	48	25	33	27	25	29	28	19	22	29
50140	London	United Kingdom	781	72	64	102	82	67	58	62	65	47	64	62	36
		Total	17047	1671	1404	1657	1739	1456	1345	1346	1257	1328	1316	1024	1504

Table 12: NCLEX® International Testing Volume Pass Rate by Month: Jan. 1–Dec. 31, 2009

Raw data represents the total number of examinations delivered/total number of examinations posed.

Parenthetical data represents the passing rate for the month indicated.

Site ID	City	Country	Total Taken	Total Passed	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
50482	Sydney	Australia	95	43	10/4 (40.00%)	10/6 (60.00%)	11/5 (45.45%)	3/2 (66.67%)	12/6 (50.00%)	9/3 (33.33%)	8/3 (37.50%)	5/2 (40.00%)	5/3 (60.00%)	6/2 (33.33%)	9/5 (55.56%)	7/2 (28.57%)
50486	Burnaby	Canada	159	76	10/2 (20.00%)	9/6 (66.67%)	17/11 (64.71%)	14/5 (35.71%)	12/5 (41.67%)	14/8 (57.14%)	17/10 (58.82%)	14/5 (35.71%)	18/10 (55.56%)	10/4 (40.00%)	12/6 (50.00%)	12/4 (33.33%)
50485	Montreal	Canada	46	17	2/0 (0.00%)	0/0 (0.00%)	9/3 (33.33%)	5/0 (0.00%)	2/1 (50.00%)	4/2 (50.00%)	6/2 (33.33%)	3/2 (66.67%)	5/3 (60.00%)	5/1 (20.00%)	1/0 (0.00%)	4/3 (75.00%)
50484	Toronto	Canada	285	119	18/3 (16.67%)	11/4 (36.36%)	32/10 (31.25%)	22/10 (45.45%)	25/12 (48.00%)	29/14 (48.28%)	32/16 (50.00%)	19/7 (36.84%)	23/10 (43.48%)	23/7 (30.43%)	24/14 (58.33%)	27/12 (44.44%)
50491	Frankfurt	Germany	78	44	3/3 (100.00%)	6/3 (50.00%)	7/4 (57.14%)	4/2 (50.00%)	7/5 (71.43%)	10/7 (70.00%)	6/3 (50.00%)	8/4 (50.00%)	4/3 (75.00%)	7/4 (57.14%)	6/1 (16.67%)	10/5 (50.00%)
50493	Hong Kong	Hong Kong	813	388	61/33 (54.10%)	78/36 (46.15%)	85/44 (51.76%)	87/32 (36.78%)	75/32 (42.67%)	65/27 (41.54%)	72/38 (52.78%)	66/26 (39.39%)	51/30 (58.82%)	47/23 (48.94%)	45/28 (62.22%)	81/39 (48.15%)
50497	Bangalore	India	245	121	29/11 (37.93%)	21/16 (76.19%)	33/19 (57.58%)	18/7 (38.89%)	19/11 (57.89%)	17/8 (47.06%)	11/8 (72.73%)	26/6 (23.08%)	15/7 (46.67%)	21/7 (33.33%)	18/12 (66.67%)	17/9 (52.94%)
50498	Chennai	India	205	107	36/18 (50.00%)	18/10 (55.56%)	20/14 (70.00%)	25/12 (48.00%)	8/6 (75.00%)	16/6 (37.50%)	18/7 (38.89%)	15/9 (60.00%)	15/9 (60.00%)	18/10 (55.56%)	8/5 (62.50%)	8/1 (12.50%)
50495	Delhi	India	331	107	18/7 (38.89%)	40/9 (22.50%)	37/6 (16.22%)	34/12 (35.29%)	15/6 (40.00%)	29/12 (41.38%)	33/11 (33.33%)	24/5 (20.83%)	40/17 (42.50%)	17/8 (47.06%)	24/9 (37.50%)	20/5 (25.00%)
50496	Hyderabad	India	28	8	4/2 (50.00%)	3/1 (33.33%)	3/1 (33.33%)	2/0 (0.00%)	4/1 (25.00%)	1/0 (0.00%)	1/0 (0.00%)	3/0 (0.00%)	2/1 (50.00%)	2/0 (0.00%)	3/2 (66.67%)	0/0 (0.00%)
50494	Mumbai	India	126	76	18/14 (77.78%)	15/8 (53.33%)	16/11 (68.75%)	10/3 (30.00%)	8/5 (62.50%)	10/8 (80.00%)	12/7 (58.33%)	6/1 (16.67%)	7/5 (71.43%)	8/5 (62.50%)	7/4 (57.14%)	9/5 (55.56%)
50500	Chiyoda-ku	Japan	634	367	54/32 (59.26)	67/53 (79.10%)	65/38 (58.46%)	63/34 (53.97%)	42/25 (59.52%)	39/24 (61.54%)	44/24 (54.55%)	47/26 (55.32%)	53/32 (60.38%)	49/22 (44.90%)	62/28 (45.16%)	49/29 (59.18%)
50501	Yokohama City	Japan	16	8	0/0 (0.00%)	2/1 (50.00%)	1/1 (100.00%)	0/0 (0.00%)	0/0 (0.00%)	4/2 (50.00%)	1/1 (100.00%)	3/2 (66.67%)	0/0 (0.00%)	0/0 (0.00%)	0/0 (0.00%)	0/0 (0.00%)
50503	Mexico City	Mexico	5	3	0/0 (0.00%)	1/0 (0.00%)	2/1 (50.00%)	1/1 (100.00%)	0/0 (0.00%)	0/0 (0.00%)	0/0 (0.00%)	0/0 (0.00%)	0/0 (0.00%)	5/1 (20.00%)	1/1 (100.00%)	0/0 (0.00%)
54555	Manila	Philippines	12810	5954	1313/605 (46.08%	1022/478 (46.77%)	1168/530 (45.38%)	1340/650 (48.51%)	1125/512 (45.51%)	1011/493 (48.76%)	994/447 (44.97%)	915/415 (45.36%)	1012/436 (43.08%)	1008/477 (47.32%)	716/340 (47.49%)	1186/571 (48.15%)
47108	San Juan	Puerto Rico	51	10	3/0 (0.00%)	3/0 (0.00%)	1/0 (0.00%)	4/2 (50.00%)	2/0 (0.00%)	2/0 (0.00%)	4/0 (0.00%)	9/3 (33.33%)	3/0 (0.00%)	7/0 (0.00%)	4/2 (50.00%)	9/3 (33.33%)
50506	Taipei	Taiwan	339	143	20/10 (50.00%)	34/21 (61.76%)	48/16 (33.33%)	25/9 (36.00%)	33/11 (33.33%)	27/7 (25.93%)	25/15 (60.00%)	29/15 (51.72%)	28/15 (53.57%)	19/6 (31.58%)	22/8 (36.36%)	29/10 (34.48%)

Table 12: NCLEX® International Testing Volume Pass Rate by Month: Jan. 1–Dec. 31, 2009

Raw data represents the total number of examinations delivered/total number of examinations posed.

Parenthetical data represents the passing rate for the month indicated.

Site ID	City	Country	Total Taken	Total Passed	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
50140	London	United Kingdom	781	240	72/21 (29.17%)	64/17 (26.56%)	102/36 (35.29%)	82/24 (29.27%)	67/21 (31.34%)	58/21 (36.21%)	62/17 (27.42%)	65/20 (30.77%)	47/12 (25.53%)	64/20 (31.25%)	62/20 (32.26%)	36/11 (30.56%)
Total			17047	7831	1671/765 (45.78%)	1404/669 (47.65%)	1657/750 (45.26%)	1739/805 (46.29%)	1456/659 (45.26%)	1345/642 (47.73)	1346/609 (45.24%)	1257/548 (43.59%)	1328/593 (44.65%)	1316/597 (45.36%)	1024/485 (47.36%)	1504/709 (47.14%)

Report of the APRN Committee

Background

During the development of the Consensus Model for APRN Regulation, the APRN Committee worked closely with the APRN Consensus Group. 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.

Facilitated the APRN Roundtable

The APRN Roundtable was held on May 19, 2010, in Chicago. An invitation was extended to boards of nursing (BONs), as well as other APRN stakeholders, including APRN educators, accreditors and certifiers. The program included the presentations, "APRN Scope of Practice" by Joanne Pohl, PhD, ARP-BC, FAAN, and "Challenges and Successes of Passing Legislation" by Todd Herzog, BSNA, CRNA. An update on Licensure, Accreditation, Certification and Education (LACE) was provided using a panel discussion method, with each entity of LACE being given an opportunity to discuss how it is implementing the Consensus Model for APRN Regulation. Time was provided for attendee discussion.

Develop and Implement Strategies for the New Consensus Model for APRN Regulation

The APRN Committee worked on writing articles about the Consensus Model for APRN Regulation and updated the legislative fact sheet. It also developed a plan for a two-day APRN Summit, which includes inviting three representatives from each BON to explore solutions in moving toward uniformity in APRN regulation through the implementation of the APRN legislative language. Strategies to work with educators and state professional organizations in achieving uniformity will also be discussed. Educators and professional organizations will be invited to the second day to meet with the representatives of the BONs. Preliminary plans for the summit were made.

The APRN Committee has continued to provide feedback regarding issues that have arisen with the initial implementation of the Consensus Model for APRN Regulation. LACE, the communication mechanism of the Consensus Model for APRN Regulation representing licensure, accreditation, certification and education, was formed this year and had three meetings. The feedback provided included:

1. Consideration as to whether the three p's (pharmacology, pathophysiology and physical assessment) are stand-alone courses spread across the lifespan and have a clinical component;
2. A need for a definition of core, lifespan and primary care; and
3. Development of an FAQ document, which will be located on LACE's website when completed.

The committee concluded that position papers are needed to explain some issues, such as the difference between acute and primary care, the need for a gerontology course for many of the population foci and the need to clarify that the Doctorate of Nursing Practice is separate from the Consensus Model of Nursing Regulation.

The committee met with representatives of the Convenient Care Association and the American Association of Retired Persons (AARP) to discuss possible methods of collaboration.

Highlights of FY10 Activities

- Held the APRN Roundtable in Chicago on May 19, 2010.
- Continued developing articles on how each APRN role will be affected by the Consensus Model of APRN Regulation and NCSBN Model Legislative Language.
- Revised the Legislative APRN Fact Sheet.
- Presented a plan for an APRN Summit in FY11.

Members

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

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

Matthew Bishop, MS, CRNA
Hawaii, Area I

Kathryn Busby, JD, BSFS
Arizona, Area I

Darlene Byrd, MNSc, APN
Arkansas, Area III

Faith Fields, MSN, RN
Arkansas, Area III

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

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

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

Emmaline Woodson, MS, RN
Maryland, Area IV

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

Charlene Hanson, EdD, FNP-BC, FAAN
Consultant

Randall Hudspeth, MS, APRN-CNS/NP, FRE, FAANP
Idaho, Area I, Board Liaison

Staff

Nancy Chornick, PhD, RN, CAE
Director, Nursing Regulation

Esther White, MS
Coordinator, Outreach Services

Meeting Dates

- Sept. 10, 2009 (Teleconference)
- Dec. 16-17, 2009
- Feb. 15-16, 2010
- May 18-19, 2010

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 evidence-based nursing regulation and regulatory solutions for public protection.

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

- Provided feedback to LACE on the FAQ document and other issues related to the Consensus Model of APRN Regulation.
- Developed draft definitions of terms.
- Met with representatives of the Convenient Care Association and AARP to discuss possible methods for collaboration.

Future Activities

- Continue to meet quarterly with LACE.
- Hold an APRN Summit in 2011.
- Maintain and enhance communication among APRN stakeholders, Member Boards and NCSBN.
- Continue to assist BONs with the implementation of the NCSBN Model Legislative Language.
- Develop a position paper on issues regarding the implementation of the Consensus Model of APRN Regulation.

Attachments

None

Report of the Awards Committee

Background

The Awards Committee is charged with the selection of award recipients that are honored annually at the awards program in August. The selection process consists of a blind review by the Awards Committee to ensure that the nominee has met the awards criteria.

Honorees were selected in the following award categories: Meritorious Service, Exceptional Leadership, Exceptional Contribution and Regulatory Achievement. The awards program is planned as an evening dinner during the Annual Meeting in Portland, Ore.

The Distinguished Achievement Award is a new award approved by the Board of Directors (BOD). A description of the award with defined criteria can be found in the awards brochure (Attachment A).

The Awards Committee continues to review and refine the program to ensure consistency and fairness, and celebrate the contributions and accomplishments of the membership.

Highlights of FY10 Activities

- Reviewed the 2009 Awards Program and recommended the awards program be held as a dinner event in 2010.
- Recommended that membership be allowed to bring guests to the awards dinner.
- Reported the 2010 awards recipients as selected by the Awards Committee to the BOD.
- Conducted a blind review of the award nominations.
- Recommended the description and criteria for a new award, the Distinguished Achievement Award, to the BOD.
- Identified boards of nursing celebrating their centennial in 2010.
- Identified executive officers who are eligible for the Executive Officer Recognition Award for 5, 10, 15 and 25 years of service.
- Reviewed the award symbols for each award category. No changes were recommended.
- Sent official notification to award nominees and their nominators, confirming their selection by the Awards Committee as 2010 award recipients.
- Awards Committee members confirmed that they plan to read award recipient biographies at the awards dinner.

2010 AWARD RECIPIENTS:

Meritorious Service Award

Ann L. O'Sullivan, PhD, MSN, CRNP, CPNP, FAAN, board president, Pennsylvania State Board of Nursing

Regulatory Achievement Award

Texas Board of Nursing

Exceptional Leadership Award

Cathy Giessel, MS, RN, ANP, FAANP, recent past board chair, Alaska Board of Nursing

Exceptional Contribution Award

Valerie Smith, MS, RN, FRE, board staff, Arizona State Board of Nursing
Sue Tedford, MNSc, RN, board staff, Arkansas State Board of Nursing

Members

Judy Bontrager, MN, RN
Arizona, Area I

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

Nancy Sanders, PhD, RN
Alaska, Area I

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

Staff

Alicia Byrd, RN
Director, Member Relations

Meeting Dates

- Sept. 30, 2009 (Teleconference)
- March 30, 2010

Relationship to Strategic Plan

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

Strategic Objective 1
Recognize Member Board excellence.

Executive Officer Recognition Awards

5 YEARS

- Charlotte Beason, EdD, RN, NEA, executive director, Kentucky Board of Nursing
- Rula Harb, MS, RN, executive director, Massachusetts Board of Registration in Nursing
- Betsy Houchen, JD, MS, RN, executive director, Ohio Board of Nursing
- Toaga Seumalo, MS, RN, executive secretary, American Samoa Health Services

10 YEARS

- Claire Doody Glaviano, MN, RN, executive director, Louisiana State Board of Practical Nurse Examiners
- Barbara Zittel, PhD, RN, executive secretary, New York State Board of Nursing

15 YEARS

- Laura Skidmore Rhodes, MSN, RN, executive director, West Virginia Board of Examiners for Registered Professional Nurses
- Joey Ridenour, MN, RN, FAAN, executive director, Arizona State Board of Nursing
- Kathy Thomas, MN, RN, executive director, Texas Board of Nursing

25 YEARS

- Elizabeth Lund, MSN, RN, executive director, Tennessee State Board of Nursing

MEMBER BOARDS CELEBRATING 100 YEARS OF NURSING REGULATION

- Massachusetts Board of Registration in Nursing
- South Carolina State Board of Nursing

Future Activities

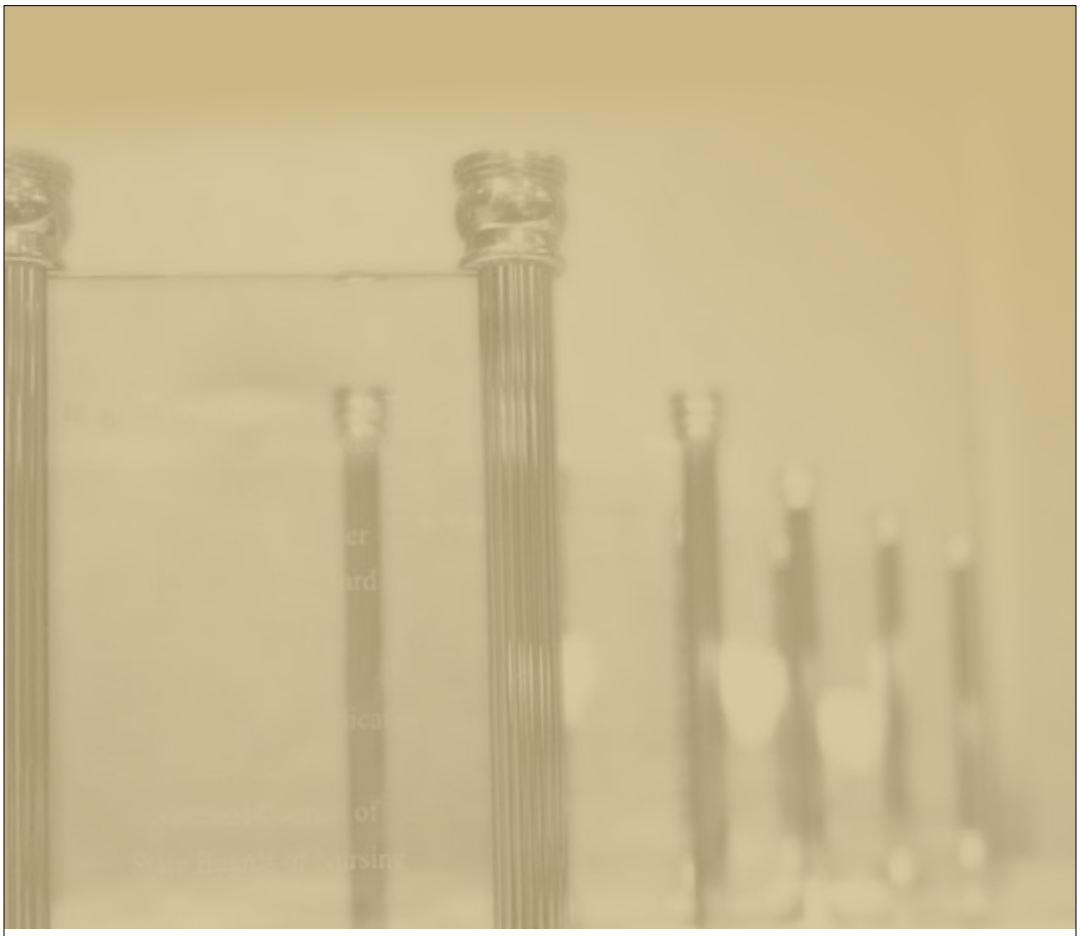
- Select the 2011 awards recipients.

Attachment

A. Awards Brochure

Attachment A

Awards Brochure



The NCSBN awards will be announced at the 2010 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. 12, 2010, 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 award template. Narratives should be no more than 500 words.
- 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 from the award for which he/she was originally nominated. 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.

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 board of nursing

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 or staff member of a Member Board 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 on a board of nursing (not a board president) or staff member of a board of nursing (not an executive officer)

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

DESCRIPTION OF AWARD
The Regulatory Achievement Award recognizes the Member Board 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

DISTINGUISHED ACHIEVEMENT AWARD

ELIGIBILITY
Individual, organization or group. Award can be given posthumously

CRITERIA FOR SELECTION
- No other award captures the significance of this contribution
- Could be given to an individual/organization/group who is not necessarily a board member or staff member of a member board
- Accomplishment/achievement is supportive to NCSBN's mission and goals
- Could be long and lasting contribution or one major accomplishment that impacts the NCSBN mission and goals

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
Unlimited

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 president and who has made significant contributions to NCSBN.

CRITERIA FOR SELECTION
- Demonstrated leadership as the Member Board president
- Served as a Member Board 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

Past NCSBN Award Recipients

R. LOUISE MCMANUS AWARD

2009 – Faith Fields
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

2009 – Sheila Exstrom
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

2009 – Ohio Board of Nursing
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

2009 – Nancy Murphy
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

Report of the Chemical Dependency Committee

Background

There are currently 41 jurisdictions that 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, and provide 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 nonpunitive process.

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

Highlights of FY10 Activities

- Disciplinary programs for nurses whose competency may be impaired because of the use of drugs and/or alcohol were surveyed. The information was used to provide a comparison with the alternative to discipline programs surveyed in 2009, and identify the differences and similarities in how the two approaches address nurses with substance use disorders.
- A set of model guidelines was developed. The purpose of these guidelines is to provide practical and evidence-based guidelines for evaluating, treating, monitoring and managing health care professionals with substance use disorders. The guidelines are based on a review of the most current research and knowledge synthesized from the literature and from the field.
- These guidelines were developed and written with the primary focus on alternative programs. These programs are known as alternative or diversion programs because nurses are diverted to treatment rather than to disciplinary action. These programs rest on the rationale that they can provide a path to recovery for nurses with substance use disorders, can help to retain them in the workforce and with proper monitoring, help avert harm to the public while the licensee receives help. The guidelines' underlying principles, however, are applicable to traditional discipline monitoring programs as well.
- Implementing these guidelines presents a number of opportunities, including best practices, so programs can focus on developing better services. Guidelines also set benchmarks for performance and quality; however, in order to adopt these guidelines it may be necessary to make changes in state laws, regulations and policies.
- The Substance Use Disorders Guidelines Forum was held in April 2010 to:
  - Review discipline and alternative programs;
  - Provide recommended regulatory practices for licensees with substance use disorders; and
  - Discuss the in-development guidelines based on the most current research and evidence that will provide recommendations on best practices for detection, prevention and intervention of substance use disorders cases.
- The forum was aimed at increasing the acceptance and implementation of the guidelines by boards of nursing (BONs), alternative to discipline programs and other relevant stakeholders.

Members

Nancy Darbro, PhD, RN, CNS
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Joan Bainer, MN, RN, NE, BC
South Carolina, Area III

Tom Dilling, JD
Ohio, Area II

Karl A. Hoehn, JD
Washington, Area I

Anjeanette Lindle, JD
Montana, Area I

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

Carol Stanford
California-RN, Area I

Kate Driscoll Malliarakis, MSM, CNP, NCADC II
External Member

Michael Van Doren, MSN, CARN
External Member

Kathy Thomas, MN, RN
Area III, Board Liaison

Staff

Kevin Kenward, PhD, MS
Director, Research

Lindsey Gross
Administrative Assistant, Research

Meeting Dates

- Oct. 26, 2009 (Teleconference)
- Dec. 16-17, 2009
- Jan. 8, 2010 (Teleconference)
- Feb. 4, 2010 (Teleconference)
- Feb. 26, 2010 (Teleconference)
- March 18, 2010 (Teleconference)
- March 24, 2010 (Teleconference)
- April 6, 2010 (Teleconference)
- April 27-29, 2010
- May 25-26, 2010

Relationship to Strategic Plan

Strategic Initiative B
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.

- 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 evidence-based models and best practices so that BONs and alternative to discipline programs can improve and better evaluate their own programs.

Future Activities

None

Attachments

None

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

Background

CORE was approved by the fiscal year 2002 (FY02) Board of Directors (BOD) 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: 2000, 2006, 2008 and 2010. BONs are surveyed regarding five BON functions: (1) discipline; (2) practice; (3) education program approval; (4) licensure; and (5) governance. There were three groups of stakeholders directly affected by BON actions that were also surveyed: (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 FY10 Activities

- NCSBN conducted a focus group with representatives from 10 BONs (Attachment A). The purpose of the focus group was to discover best practices that were common among BONs with consistently high ratings on the CORE survey in the area of discipline.

  The focus group identified a number of key features and strategies that BONs employ, to varying degrees, to fulfill their required functions, including:

  - Giving autonomy to staff through BON delegation;
  - Using a priority system for cases, including initial triage to identify high- and low-risk cases;
  - Keeping the investigator's caseload to 100 cases or less;
  - Hiring nurses as investigators;
  - Providing administrative support to the investigators;
  - Auditing of processes to evaluate performance, identify bottlenecks, and continuously develop and perpetuate improvements;
  - Using standardized forms and agreements;
  - Using a tracking system to monitor where a case is in the process and how long it has been there;
  - Providing BONs with authority to direct and control investigators and attorneys;
  - Conducting criminal background checks, and searching sex offender and child abuser databases;
  - Using a preponderance of evidence as the degree of proof required to determine whether or not disciplinary action should be taken (as opposed to beyond a reasonable doubt, clear and convincing evidence or reasonable doubt);
  - Collecting information up-front and in writing, when investigating a complaint; and
  - Issuing summary suspensions for noncompliance or nonresponse.

- The CORE Committee asked two performance-measurement experts to evaluate the program. The independent review will help determine the extent to which specified goals and objectives are being met, identify where corrections need to be made, and gain general and theoretical insights, which will apply to future efforts.

Members

Margaret Walker, EdD, RN, FRE
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Minnesota, Area II

Jessie Colin, PhD
Florida, Area III

Richard Gibbs, LVN
Texas, Area III

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Meeting Dates

- Oct. 27-28, 2009
- Dec. 7-8, 2009
- Feb. 22-24, 2010
- April 19-20, 2010

Relationship to Strategic Plan

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

Strategic Objective 1
Promote ongoing regulatory excellence.

One of the experts has completed her review (Attachment A). Her recommendations include the following:

- Define measurement terms.
- Clarify relationship between the survey questions and performance-measurement categories.
- Establish validity and reliability of the data.
- Establish performance measures for the CORE project.
- Include CORE project performance measures on balanced scorecard.
  - Identify measures that reflect CORE's performance in delivering its key products and services.
- Validate best practices.
- Establish a consortium of BONs to demonstrate leadership in transparency and use of data for continuous improvement.
- Review the exact purpose of the surveys and specific questions from a performance measurement perspective.
- Determine why some states do not use CORE.
- Simplify reports.
- Train respondents on performance measures.
- Provide respondents means to interact and pose questions.
- Provide training or other support that demonstrates how to effectively use the survey results.
- Administer a CORE customer survey.
- Compile and report trend data.
- Train BONs on best practices.
- Promote best practices.
- Train respondents on best practices.
- Conduct external search for best practices.

The second consultant's report will be completed by September 2010. After the committee's review, both reports will be synthesized, and findings and recommendations will be released in a detailed report.

- The committee developed definitions of terms used in the questionnaires. Standard definitions were developed for easy reference to minimize confusion and misunderstanding of questions. This will improve the validity and reliability of the survey instrument.
- The four CORE surveys were reviewed and revised.
- Surveys were pilot tested. The purpose of the pretest was to gather information prior to the larger study in order to improve the latter's quality and efficiency. A pretest revealed deficiencies in the design of the proposed study and procedures, which were then addressed before time and resources were expended on the larger scale study.
- To ensure that BONs receive as much information as possible completing the CORE survey, NCSBN and the CORE Committee prepared a webinar to inform respondents about the survey; 27 BONs participated in the webinar, which:
  - Briefly described CORE project and its importance for boards of nursing;

- Explained how to correctly complete the CORE Survey Tool;
- Described the data elements;
- Explained the definitions of the data elements;
- Provided the rationale and purpose of the survey questions;
- Described where to find available resources for successful completion of the CORE survey; and
- Answered questions about the survey.

Future Activities

- Develop CORE Survey Tool for data collection in 2012.
- Identify promising practices and reasons for excellence performance.
- Validate identified promising practices.
- Implement strategies to increase knowledge and use of CORE performance measures.

Attachments

A. Focus Group Report

Attachment A

Focus Group Report

PURPOSE

In September 2009 NCSBN conducted a focus group with representatives from 10 boards of nursing (BONs). These 10 BONs were selected for the focus group because they had the highest ratings based on the following questions from the 2007 Commitment to Regulatory Excellence (CORE) Board of Nursing Survey that measured performance in processing complaints and disciplining nurses:

1. Average number of days to resolve a case;
2. Percent of investigations completed in the last fiscal year; and
3. Nurses perception of the effectiveness of the BON's discipline process.

The purpose of the focus group was to identify practices common to these BONs for processing complaints.

FOCUS GROUP PARTICIPANTS

Focus group participants consisted of the following:

Gender:	Nine women and one man
Size of BON:	Four BONs with less than 20,000 licensees; two BONs with between 20,000 to 49,999 licensees; one BON with between 50,000 to 99,999 licensees; two BONs with between 100,000 to 199,999 licensees; and one BON with 200,000 or more licensees
Area:	Three BONs from Area I, three BONs from Area II and four BONs from Area III
BON Structure:	Two umbrella BONs and eight independent BONs
Position:	Three executive officers and seven board staff members (one attorney)

Methodology

The focus group followed a format whereby the participants responded to a series of questions related to their experiences, needs and perceptions regarding the BONs' disciplinary policies and procedures. The participants brought a rich variety of backgrounds to the discussions, and represented a range of BONs in terms of structure, number of licensees and geographical location.

The discussions revealed many similar experiences and perceptions among the BONs, although, at times, an issue applied to only one BON. In the text below, all references to individuals and BONs have been deleted in order to protect the identity of the participants.

BEST PRACTICES FOR DISCIPLINE

BONs play an important role in safeguarding public safety in health care. These licensing agencies are the only entities with the authority to establish criteria for licensure and determine when a license should be conditioned or revoked if the licensee is unsafe or practicing outside an expected level of competence. By statute and stated mission, the public expects BONs to provide assurance that nurses are competent and ethical. To do so, BONs must have budgeted resources sufficient to resolve complaints. What matters to success (or failure) in this key function is finding and appropriately sanctioning incompetent and unauthorized nurses. This in turn requires efficient and effective processes for the intake of complaints, well-targeted processing of complaints and effective BON review of allegations. Success results when a BON can move cases quickly and efficiently through multiple stages, from complaint intake to discipline and follow-up; failure is visible in large backlogs of cases and inability to prioritize so as to address those with the most serious implications for safe patient care. The following were identified

by the focus group participants as the ways and means to effectively and efficiently process complaints and discipline nurses.

Staff Autonomy

Several BONs tend to streamline their processing of complaints by delegating significant decision making to the executive director and staff when the investigative cases are routine/predictable, and the discipline outcome has been established by BON policy. These decisions do not substitute for BON decision making, but allow the BON to maintain accountability. BONs that streamline processes by delegating authority to staff seem more able to act quickly and bring complaints to a speedy conclusion without a formal hearing. Professional disciplinary staff are able to close categories and prioritize cases, make probable cause determinations and issue letters of concern.

Some BONs have a second level of review for staff-recommended disciplinary outcomes. These recommendations are reviewed by a committee or panel before being sent to the full BON. Whether initiated by individual staff or committee, consent agreements are generally approved by the BON under a consent agenda, rather than on a case-by-case basis.

Other BONs may have a subcommittee of BON members that review complaints before the BON conducts a hearing.

Prioritization and Intake Triage of Complaints

Policy-driven prioritization of complaints was frequently cited as an effective practice. Prioritization facilitates achieving a goal of resolving cases within an acceptable timeframe. Most states created ways to not pursue low-priority cases, fast-track high-priority cases and use standard investigation for those with a mid-priority level. Focus group participants perceived it as being especially important to identify cases that were serious and resource intensive.

Generally, staff enter complaints into an electronic or hard-copy log as they are received. Once logged, cases are screened to determine whether the BON has jurisdiction; that is, whether the BON could legally take action if the complaint is substantiated. Intake triage is a screening process that avoids expensive investigation of every complaint or communication received. A main reason for closure without investigation is that a complaint is nonjurisdictional. It may be misdirected to the BON and need to be referred to a different agency that has responsibility, such as a board of pharmacy; or it may not be a violation of the law. Case closure may also be an outcome when a complaint alleges unprofessional conduct, but it is determined not to constitute an offense requiring discipline. Another reason for closure is that the conduct, while potentially actionable, was deemed too low a risk to warrant action, sometimes referred to as below threshold cases.

Most states attempt to handle some complaints by immediate cease and desist orders or citations. All the states participating in the focus group had some mechanism for fast-tracking certain complaints, which all see as important to public protection in obviously high-profile cases with potential for immediate and ongoing harm to the public.

Staffing

One contributor to a backlog of cases is the shear volume of cases each investigator has been assigned. Caseloads can be a problem, especially when the volume of complaints jumps or the number of investigators falls. There was little agreement about a staffing methodology, appropriate levels of staffing or caseloads, and standards that do not currently exist. The average number of cases per investigator ranged from 25 to 100 cases at any one time for each investigator.

Some BONs are able to utilize and contract for investigators from other government agencies (e.g., board of pharmacy) or hire private investigators to complete tasks normally assigned to staff. This helps to keep the case per investigator ratio at acceptable levels and resolve complaints in a more timely manner.

Investigator Background

There was general consensus that lack of formal training as a nurse investigator may impede investigations. They often noted that investigations of nurses required different skills than for other licensees. The knowledge of medical conditions and understanding of history, procedures, treatments and pharmacology are major contributing factors in determining the direction of an investigation. The nurse's ability to analyze and assimilate health histories, the importance of writing reports and summaries in an objective format, making relevant observations and communications in a nonjudgmental way, and use of interpersonal and interrelation skills can enhance sometimes difficult interviews.

Train and Mentor Investigative Staff in a Systematic and Consistent Manner

The highest performing BONs in the area of discipline provide training for investigators that may or may not include a certification, such as what is offered by the Council on Licensure, Enforcement and Regulation (CLEAR). Training materials, such as a training manual, are provided to novice investigators, who then are supervised and/or mentored for a period of time as they develop the skills they need.

Administrative Support

Investigators at top-performing BONs have appropriate clerical/administrative support. Administrative support duties may include arranging and coordinating meetings, keeping track of materials and data, responding to written correspondence, establishing files and records, answering the telephone, filling out forms, word-processing project progress reports and other investigation-related activities.

Audits

It was recommended that BONs should conduct routine audits and in-depth evaluations of the discipline program. Audits may be conducted by outside auditors to ensure good business performance and compliance with laws, regulations and BON policies.

Standardization

Using standardized forms and agreements can provide for more complete data collection and analysis, thus saving time and fiscal resources. The objective is to develop standards to facilitate the development of accurate identification, tracking and reporting of information. It assures cases are handled uniformly and that all nurses are treated in the same manner. Furthermore, data collected from standardized forms can be stored in a structured database, allowing for retrospective data analysis. Standardization can also overcome the problems of not asking the right questions, collecting too much or too little information or collecting redundant information.

Tracking Systems

Data-tracking systems are powerful tools for collecting and analyzing discipline information. The top-performing BONs all have established centralized information systems to monitor and track the status of disciplinary cases. Tracking is also used for spotting and managing problem cases and meeting higher standards of accountability. Tracking systems inform managers how long a case is taking to investigate or how long a case has been in the attorney general's office.

Most of the focus group participants stated their BON set a maximum of 120 days as the goal to close a case. Tracking systems can be used to identify cases taking more than 120 days. These cases can then be reviewed to determine the steps that need to be taken to bring the case to resolution or identify bottlenecks in the system.

Management Timelines and Other Protocols

High performing BONs have formal management timelines by which BONs can measure the progress of cases through the disciplinary process. For example, the goal may be 10 days for intake and screening or 100 days to complete a routine investigation. The management timelines are somewhat artificial, but still useful markers for internal management and external accountability.

Coordination Across Stages of Discipline

In order to avoid fragmentation and a large number of handoffs as a case moves through the stages of the disciplinary process, it was recommended that BONs maintain authority over all disciplinary activities, including investigative, legal and compliance work. In other words, BONs need to be able to manage and control the caseload of investigators and attorneys. This approach facilitates achieving consistent results and allows BONs to set more measurable performance objectives. Participants assert teamwork is more difficult to achieve across the line of demarcation between BONs and offices of the attorney general, even though individual assistant attorneys general are often assigned in whole or in part to the BON.

Address Lookup Services

Throughout the complaint review process, the licensee's due process rights must be assured. That means that the nurse is informed of any allegations regarding the nurse's practice and the nurse has an opportunity to answer the allegations. The BON is, therefore, obligated to contact the nurse and inform them about the complaint and any action taken against their license. BONs often have difficulty in contacting nurses because the nurse has changed jobs or has not informed the BON of any address changes. Focus group participants identified services (such as Accurint) that are available to assist in providing current addresses. It was also noted that sending notifications by first class mail seemed to be just as effective in reaching the nurse as certified mail.

Automated Notification of Criminal Behavior

One best practice with regard to the discipline process is to search electronic databases of registered sex offenders and child abusers for anyone who applies for licensure as a nurse. This is not done automatically as part of the FBI criminal background checks.

Additional Effective Practices for Improving Discipline

Letters of Concern for Not Revealing Criminal Background—In some cases, nurses will indicate they have no criminal history when in fact they do. This is often because they have been told that they didn't have to report the incident if the charge was reduced or expunged. They do not realize that health care workers are still required to report these incidents. Rather than discipline nurses who fail to report criminal behavior under these circumstances, they should be subject to a letter of concern.

Halt Investigation—Once a nurse has confessed to a practice error or crime related to diversion, there is no reason to keep investigating the case. At that point, there is no reason to expend additional resources to gather more evidence.

Contract Stipulations—Some nurses attempt to delay having to be assessed for a chemical dependency problem by either not making an appointment for or postponing getting a chemical dependency assessment. An effective solution is to stipulate in the nurse's agreement that they have to be assessed within 30 days.

Preponderance of the Evidence—Preponderance of the evidence was recommended as the standard for burden of proof. That is, BONs need to show that the fact sought to be proved is more probable than not. The preponderance rule means that a case must be proved by a majority of evidence (which is often defined as meaning more likely than not or 51 percent of the evidence). Other standards or degrees of certainty for burdens of proof include: beyond a reasonable doubt (required to convict a defendant in a criminal action); clear and convincing (used for some issues in civil actions); and reasonable doubt.

The BON should not hesitate to take action based on the preponderance of the evidence, regardless of which side it favors. In doing so, fairness is promoted, a controversy is brought to an end, and time, costs and labor are saved, benefiting the nurse who was the subject of a complaint, the BON and the public.

Collect Data Upfront—Focus group participants advised that the investigation process should begin promptly. Investigators should request needed information upfront and collect it

aggressively. The participants recommend compiling readily available background information first to obtain a quick read of the situation and to have information available before the nurse is interviewed. Participants further recommend interviewing the nurse for whom a complaint has been filed and informing the nurse of the procedures for the investigation. They felt that it is important to get the nurse's side of the story in order to establish facts.

Summary Suspension for Noncompliance or Nonresponse

Some states have the authority to impose a summary suspension of a nurse's license when continuation of practice is thought to put patients or the public in imminent harm's way, often referenced as an immediate threat to public safety. Focus group participants also recommended using summary suspension when the licensee fails to comply with one or more of the BON's administrative requirements.

When a person signs an agreement with the BON, there is generally a statement that provides that if they do not comply with the agreement then they have violated the agreement, which then results in a suspension of the license. The licensee can request a hearing, however. The summary suspension is generally issued when someone has no current action against their license and no contract with the BON, yet their practice is dangerous to the public. For example, if the nurse is ordered to get an evaluation for chemical dependency within 30 days and fails to comply, his/her license can be automatically suspended.

RECOMMENDED CHANGES TO THE CORE SURVEY

Participants recommended dropping the reference to the year in the question: "On average, in FY09, how many days (please estimate if data not readily available) does it take for a case to be resolved from the date the complaint was received to the date of final resolution?" A number of BONs apparently interpreted the question to mean only the cases opened and closed in 2009, rather than including in the calculation all cases that were still open, regardless of what year they were opened, as intended by the CORE Committee.

Participants advised there are different interpretations of what a case is. One BON considered every complaint that was filed as a case. Other BONs excluded nonactionable (nonjurisdictional, anonymous complaints, etc.) filings as cases. Several BONs did not include the number of complaint applications that are reviewed for potential discipline related information. These are tracked separately from complaints filed.

Counting the number of full-time equivalent (FTE), investigators will have to consider the following: (a) investigators who work directly for the board of nursing; (b) how much of an FTE is an investigator who works for the BON if they share their time with multiple boards; (c) investigators who normally work for another board (e.g., pharmacy), but contract with the BON to perform investigations; and (d) investigators who are independent contractors.

SUMMARY

The focus group identified a number of key features and strategies that BONs employ, to varying degrees, to fulfill their required functions, including:

- Giving autonomy to staff through BON delegation;
- Using a priority system for cases, including initial triage to identify high- and low-risk cases;
- Keeping the investigator's caseload to 100 cases or less;
- Hiring nurses as investigators;
- Providing administrative support to the investigators;
- Auditing of processes to evaluate performance, identify bottlenecks, and continuously develop and perpetuate improvements;

- Using standardized forms and agreements;
- Using a tracking system to monitor where a case is in the process and how long it has been there;
- Providing BONs with authority to direct and control investigators and attorneys;
- Conducting criminal background checks and searching sex offender and child abuser databases;
- Using a preponderance of evidence as the degree of proof required to determine whether or not disciplinary action should be taken or not (as opposed to beyond a reasonable doubt, clear and convincing evidence or reasonable doubt);
- Collecting information up-front and in writing, when investigating a complaint; and
- Issuing summary suspensions for noncompliance or nonresponse.

Implications

This focus group documented many aspects of the structure and operations of BONs. It also identified practices considered to make discipline more efficient or effective. The extent of variation observed across BONs in terms of such factors as rates of sanctions, timeliness of case closure, investigatory staffing ratios, budgetary support, and many other outputs and inputs suggests that BONs can be a significant resource to learn from one another. Such learning is possible based on interest of the representatives from these BONs.

The success of BONs to improve nursing discipline will finally depend on, of course, the funding, staffing and authority of the BONs. In order to command additional resources in an era of constraint BONs must better document their performance needs and achievements. BON budgets in the past have been boosted mainly in response to failure, a highly publicized case detailing backlogged complaints or a clearly errant nurse whom the BON had neglected to discipline. Better analysis and documenting performance achievements and needs can also encourage increased budgetary and other forms of support from the rest of state government.

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. The committee reviews and recommends a budget to the BOD. The committee monitors income, expenditures and program activities against projections, and presents quarterly financial statements 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 auditors and the annual independent audit of NCSBN financial statements. The committee recommends to the BOD the appointment of a firm to serve as 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 FY10 Activities

- Reviewed and discussed the organization's audited financial statements for the fiscal year ended Sept. 30, 2009, with management and the organization's independent accountant. With and without management present, the committee discussed and reviewed the results of the independent accountant's examination of internal controls and financial statements. Based on the review and discussions referenced 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.
- Recommended the engagement of Blackman Kallick LLP to audit the NCSBN financial statements for the period ending Sept. 30, 2010.
- Reviewed and discussed the long-range financial reserve forecast.
- 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 quarterly with NCSBN staff and the organization's investment consultant, Becker Burke. Informed the BOD that the current investment policy and strategy appear to be appropriate for NCSBN.
- Reviewed and discussed the property and professional liability coverage for NCSBN with the insurance brokers from USI Midwest. 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, 2010.

Attachments

A. Financial Summary Report for the Period Oct. 1, 2009, to March 31, 2010

B. Report of the Independent Auditors FY09

Members

Randall Hudspeth, MS, APRN-CNS/CNP, FRE, FAANP
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Washington, Area I

Staff
Robert Clayborne, MBA, CPA
Director, Finance

Meeting Dates

- Dec. 1, 2009
- Feb. 2, 2010
- April 26, 2010
- July 7, 2010

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. Maintain and protect a substantial internal financial reserve.

Attachment A

Financial Summary Report for the Period Oct. 1, 2009, to March 31, 2010

On March 31, 2010, the net cash position (cash and marketable securities less current liabilities) equaled $129 million. A total of $4.9 million in investment earnings helped to increase net assets by $6.3 million during the first six months of the fiscal year. Net operating income totaled $1.4 million for the period.

Revenue

NCLEX® revenue for the first six months of fiscal year 2010 (FY10) was down by a total of $519,000 compared to the same period for prior year. A total of 118,904 paid registrations were processed for the six-month period ended March 31, 2010. Registrations were approximate to the fiscal year 2009 (FY09) count of 118,801. There were a total of 6,532 registrations at international test sites during the first six months, compared to a total of 10,149 for the same period last year.

A total of 41 Member Boards are currently using Nur*sys*® for licensure verification. Fee revenue totaling $1,427,000 for Nur*sys* verifications is up by 30 percent compared to the same period last year.

Learning Extension sales revenue increased slightly by two percent for the first six months of FY10 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 61 percent of the e-learning sales revenue. Enrollment increased by 26 percent for the NCLEX-PN® Review Course. The combined sales for the two review courses are expected to generate 90 percent of the total revenue for online courses.

During the first six months of the fiscal year, the international and domestic equity markets remained strong. Increases in stock valuations contributed significantly to the $4.9 million of investment income for the period.

Expenditures

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

Only a few joint research projects for NCLEX have been identified, and as a consequence, only a small portion of the Joint Research Committee (JRC) budget will be expended in FY10.

Operating expenses will also be held down as the result of the deferral of the medication aide job analysis; less-than-anticipated spending on outside professional services for testing department projects; unneeded legal services that were budgeted for exam security issues; reduced travel to test centers; and a less-than-expected need for information technology (IT) project consulting.

The number of proposals for research grants received from external organizations is lower than expected. Also, through the end of the second quarter, only a small portion of the budget for internal NCSBN research projects had been expended. At this point, it is assumed to be a timing difference and that actual spending will increase in the second half of the year.

The FY10 capital budget includes a total of $740,000 for software development and $1.5 million for hardware and software purchases. A total of $992,000 was expended during the first six months of the fiscal year. Total expenditures for these capital assets are projected to be slightly favorable to budget.

Financial Position

As in the past, the third quarter will be critical as NCSBN typically receives 39 percent of its annual NCLEX fee income (the primary source of revenue) during that period.

Positive cash flow is projected for FY10. The net cash position is projected to equal $119 million by Sept. 30, 2010, and is expected to grow to $125 million by October 2010.

Six-Month Summary

- Total NCLEX registrations are approximate to the prior year count. International test center registrations are down 36 percent.
- Strong stock market returns provided significant increases in equity investment valuations. A total of $4.9 million in investment earnings during the six-month period was reported.
- Projected favorable variance on operating expenses:
  - Vacant budgeted positions;
  - Medication aide job analysis deferred;
  - Limited number of JRC projects;
  - Fewer test site visits;
  - Did not require legal services for exam security issues; and
  - Less-than-anticipated need for IT consulting.
- A total of $1.8 million in the 2010 budget is allocated for the data-integrity project. A total of $273,000 was expended during the first six months of the year.
- A total of $2.5 million in the budget is allocated for external research grants. A total of $700,000 of grant money had been awarded through March 2010.
- A total of $773,000 in the budget is allocated for internal research projects conducted by NCSBN. A total of only $65,000 had been expended through March 2010.

NCSBN Statement of Revenue and Expense

Revenue	Year to Date Actual at 3/31/10	Annual Budget	Projected Actual	Variance Favorable/ (Unfavorable)	Variance %	Year to Date as a % of Annual Budget
NCLEX revenue	24,758,200	60,899,600	60,545,000	(354,600)	-1%	41%
NCLEX Program Reports royalty	69,210	71,000	83,000	12,000	17%	97%
NCLEX Quick Results	215,726	440,000	532,000	92,000	21%	49%
Learning Extension	1,043,426	2,258,600	2,179,000	(79,600)	-4%	46%
Nursys license verification fees	1,427,423	2,220,000	2,700,000	480,000	22%	64%
Meeting revenue	27,925	127,100	127,100	0	0%	22%
Publication sales	3,262	100,200	100,200	0	0%	3%
Membership fees	186,000	186,000	186,000	0	0%	100%
NCLA fees	43,000	43,000	43,000	0	0%	100%
Government grants other income	1,737		1,737	1,737		
Total Revenue	**27,775,909**	**66,345,500**	**66,497,037**	**151,537**	**0%**	**42%**

Expense	Year to Date Actual at 3/31/10	Annual Budget	Projected Actual	Variance Favorable/ (Unfavorable)	Variance %	Year to Date as a % of Annual Budget
Salaries	3,039,748	6,915,400	6,738,417	176,983	3%	44%
Fringe benefits	797,770	1,858,700	1,811,113	47,587	3%	43%
NCLEX processing costs	14,725,686	35,147,700	36,005,000	(857,300)	-2%	42%
Other professional service fees	2,344,956	8,225,400	7,415,000	810,400	10%	29%
Supplies & materials	30,680	76,100	76,100	0	0%	40%
Meetings & travel	1,173,694	3,889,600	3,736,600	153,000	4%	30%
Telephone & communications	161,791	391,500	391,500	0	0%	41%
Postage & shipping	55,558	169,900	169,900	0	0%	33%
Occupancy	467,793	944,900	944,900	0	0%	50%
Printing, copying & publications	183,786	748,400	720,000	28,400	4%	25%
Library/memberships	82,583	131,500	131,500	0	0%	63%
Insurance	66,677	59,600	66,677	(7,077)	-12%	112%
Equipment rental & maintenance	1,113,422	1,735,000	1,735,000	0	0%	64%
Depreciation & amortization	1,400,666	3,487,500	3,487,500	0	0%	40%
External research grants	699,894	2,500,000	2,500,000	0	0%	28%
JRC & other expenses	54,355	604,000	254,000	350,000	58%	9%
Total Expense	**26,399,059**	**66,885,200**	**66,183,207**	**701,993**	**1%**	**39%**
Surplus/(deficit)	1,376,850	(539,700)	313,830	853,530		
Investment Income	4,946,899	3,500,000	5,082,000	1,582,000	45%	141%
Capital	991,813	2,234,700	2,234,700	0		

Attachment B

Report of the Independent Auditors FY09

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, 2009 and 2008, 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, 2009 and 2008, and the changes in its net assets and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Legacy Professionals LLP

December 10, 2009

30 North LaSalle Street | Suite 4200 | Chicago, IL 60602 | 312.368.0500 | 312.368.0746 Fax | www.legacycpas.com

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

STATEMENTS OF FINANCIAL POSITION

SEPTEMBER 30, 2009 AND 2008

	2009	2008
ASSETS		
Cash	$ 29,246,205	$ 48,621,831
Accounts receivable	108,618	190,115
Due from test vendor	5,811,596	5,840,113
Accrued investment income	560,601	507,712
Prepaid expenses	1,450,468	1,317,641
Investments	101,666,473	66,896,909
Property and equipment - net	4,670,912	4,130,203
Intangible asset - net	1,156,250	-
Cash held for others	409,060	291,443
Total assets	$ 145,080,183	$ 127,795,967
LIABILITIES AND NET ASSETS		
LIABILITIES		
Accounts payable	$ 1,071,956	$ 1,294,055
Accrued payroll, payroll taxes and compensated absences	568,047	548,109
Due to test vendor	10,260,493	9,941,741
Deferred revenue	311,552	338,410
Grants payable	562,570	1,321,647
Deferred rent credits	248,962	323,661
Cash held for others	409,060	291,443
Total liabilities	13,432,640	14,059,066
UNRESTRICTED NET ASSETS	131,647,543	113,736,901
Total liabilities and net assets	$ 145,080,183	$ 127,795,967

See accompanying notes to financial statements.

National Council of State Boards of Nursing, Inc.

Statements of Activities

Years Ended September 30, 2009 and 2008

	2009	2008
Revenue		
Examination fees	$ 60,650,700	$ 63,156,300
Other program services income	5,583,909	5,698,590
Net realized and unrealized loss on investments	(722,547)	(7,471,337)
Interest and dividend income	3,651,908	4,466,763
Membership fees	181,500	177,000
Total revenue	69,345,470	66,027,316
Expenses		
Program services		
Nurse competence	36,320,749	37,288,471
Nurse practice and regulatory outcome	5,085,136	6,456,365
Information	7,070,994	6,615,912
Total program services	48,476,879	50,360,748
Supporting services		
Management and general	2,957,949	2,782,725
Total expenses	51,434,828	53,143,473
Net increase	17,910,642	12,883,843
Unrestricted net assets		
Beginning of year	113,736,901	100,853,058
End of year	$ 131,647,543	$ 113,736,901

See accompanying notes to financial statements.

National Council of State Boards of Nursing, Inc.

Statements of Cash Flows

Years Ended September 30, 2009 and 2008

	2009	2008
Cash flows from operating activities		
Net increase	$ 17,910,642	$ 12,883,843
Adjustments to reconcile net increase to net cash provided by operating activities		
Depreciation and amortization	2,503,815	2,158,840
Net realized and unrealized loss on investments	722,547	7,471,337
(Increase) decrease in assets		
Accounts receivable	81,497	91,652
Due from test vendor	28,517	(24,825)
Accrued investment income	(52,889)	161,484
Prepaid expenses	(132,827)	(93,420)
Increase (decrease) in liabilities		
Accounts payable	(222,099)	556,173
Accrued payroll, payroll taxes and compensated absences	19,938	145,390
Due to test vendor	318,752	(314,634)
Deferred revenue	(26,858)	96,106
Grants payable	(759,077)	(320,719)
Deferred rent credits	(74,699)	(74,698)
Net cash provided by operating activities	20,317,259	22,736,529
Cash flows from investing activities		
Purchases of property and equipment	(2,950,774)	(2,665,996)
Purchase of intangible assets	(1,250,000)	-
Purchases of investments	(73,142,286)	(28,323,891)
Proceeds on sale of investments	37,650,175	13,478,890
Net cash (used in) investing activities	(39,692,885)	(17,510,997)
Net increase (decrease)	(19,375,626)	5,225,532
Cash		
Beginning of year	48,621,831	43,396,299
End of year	$ 29,246,205	$ 48,621,831

See accompanying notes to financial statements.

NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 2009 AND 2008

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, 2009 and 2008 were $108,618 and $190,115 respectively. An allowance for doubtful accounts was not considered necessary.

Investments - Investments of NCSBN are reported at fair value. The fair value of a financial instrument is the amount that would be received to sell that asset (or paid to transfer a liability) in an orderly transaction between market participants at the measurement date (the exit price).

Some U.S. Government obligations are traded in active markets on national and international securities exchanges and are valued at closing prices on the last business day of each period presented.

Most U.S. Government and Government Agency obligations and corporate bonds are generally valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. To the extent that quoted prices are not available, fair value is determined based on a valuation model that include inputs such as interest rate yield curves and credit spreads. Securities traded in markets that are not considered active are valued based on quoted market prices, broker or dealer quotations, or alternative pricing sources with reasonable levels of price transparency. Securities that trade infrequently and therefore have little or no price transparency are valued using the investment manager's best estimates.

Mutual funds and the international equity fund - limited liability company represent investments with various investment managers. The respective fair values of these investments are determined by reference to the funds' underlying assets, which are principally marketable equity and fixed income securities. Shares held in mutual funds are traded on national securities exchanges and are valued at the net asset value as of September 30, 2009 and 2008. Units held in the international equity fund - limited liability company are valued at the unit value as reported by the investment manager as of September 30, 2009 and 2008.

The real estate investment trust represents an ownership interest in a private equity fund. The fair value is determined by reference to the fund's underlying assets, which are principally real estate properties. The value of interests held in the real estate investment trust is determined by the general partner, based upon third-party appraisals of the underlying real estate assets.

Money market funds are valued at cost which approximates their fair value.

Certificates of deposit values are determined from new issue market and direct dealer quotes.

Purchases and sales of the investments are reflected on a trade-date basis.

Dividend income is recorded on the ex dividend date. Interest income is recorded on the accrual basis.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

New Accounting Pronouncement - The Financial Accounting Standards Board (FASB) has issued SFAS No. 157, Fair Value Measurements, which defines fair value, establishes a framework for measuring fair value, and expands disclosures about fair value measurements. SFAS 157 applies to reporting periods beginning after November 15, 2007. As of October 1, 2008, NCSBN has adopted SFAS 157. (See Note 6, Fair Value Measurements.) There was no material impact to the financial statements of NCSBN upon adoption of SFAS 157

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, 2009 and 2008 were $5,811,596 and $5,840,113 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

Intangible Asset - The intangible asset represents the purchase of the intellectual property rights for the National Nurse Aide Assessment Program nurse aid certification examination and the medication aid certification examination. The investment is carried at cost and amortization is computed using the straight-line method over a ten year period. Amortization expense was $93,750 and $0 for the years ended September 30, 2009 and 2008, respectively.

Due to Test Vendor - Due to test vendor represents unpaid amounts to Pearson VUE for candidate testing, which includes approximately $7,033,000 at September 30, 2009 and $6,673,000 at September 30, 2008 for registered candidates who as of year end had not taken the exam. The amounts owed to Pearson VUE at September 30, 2009 and 2008 were $10,260,493 and $9,941,741 respectively

Deferred Revenue - Deferred revenue consists of membership fees of $181,500 for 2009 and 2008 and online course revenue of $130,052 for 2009 and $156,910 for 2008.

Grants Payable - Represents Nurse Practice and Regulatory Outcome research grants that are generally available for periods of one to two years. NCSBN awarded four grants ranging in amounts from $35,000 to $300,000 during the current year. At September 30, 2009, the amount remaining to be paid on grants awarded for 2009 and 2008 is $297,439 and $265,131, 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.

Subsequent Events - Subsequent events have been evaluated through December 10, 2009, which is the date the financial statements were available to be issued.

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, 2009 and 2008 consisted of the following:

	2009	2008
JP Morgan Chase		
Checking account	$ 5,153,039	$ 782,906
Money market account	23,372,418	15,153,219
Certificates of deposit	-	32,086,910
Wells Fargo Bank		
Checking account	672,777	562,158
Harris Bank		
Checking account	100	-
Credit card merchant accounts	47,621	36,388
Petty cash	250	250
Total	$ 29,246,205	$ 48,621,831

NOTE 4. CASH CONCENTRATIONS (CONTINUED)

NCSBN places its cash with financial institutions deemed to be creditworthy. Effective October 3, 2008, balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 and balances in non-interest bearing transaction accounts are insured without limit. The $250,000 limit will be in effect through December 31, 2013. Balances in non-interest bearing transaction accounts are fully insured through June 30, 2010. Balances may at times exceed insured limits.

NOTE 5. INVESTMENTS

The investments as of September 30, 2009 and 2008 consisted of the following:

	2009	2008
U.S. Government and Government Agency obligations	$ 27,869,551	$ 13,426,931
Corporate bonds	12,207,601	22,639,119
Mutual funds:		
DWS Equity 500 Index Fund	20,196,047	16,125,471
Spartan Extended Market Index Fund	6,476,947	4,901,473
Spartan International Index Fund	4,615,274	4,533,646
Others	47,200	30,832
International equity fund - limited liability company	3,163,536	-
Real estate investment trust -		
Clarion Lion Real Estate Properties	2,741,621	5,224,499
Money market funds	494,316	14,938
Certificates of deposits	23,854,380	-
Total	$ 101,666,473	$ 66,896,909

NCSBN assets are invested in various securities, including United States government securities, corporate debt instruments, 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. FAIR VALUE MEASUREMENTS

As of October 1, 2008, NCSBN adopted SFAS No. 157, Fair Value Measurements. SFAS 157 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under SFAS 157 are described below:

Basis of Fair Value Measurement

Level 1	Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities
Level 2	Quoted prices in markets that are not considered to be active or financial instruments for which all significant inputs are observable, either directly or indirectly
Level 3	Prices or valuations that require inputs that are both significant to the fair value measurement and unobservable

The following table sets forth, by level within the fair value hierarchy, NCSBN's investment assets at fair value as of September 30, 2009. As required by SFAS 157, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. Total NCSBN investment assets at fair value classified within Level 3 were $2,741,621 at September 30, 2009, which consist of NCSBN's real estate holding. Such amounts were approximately 3% of total investments as reported on the statement of net assets available for benefits at fair value as of September 30, 2009.

NOTE 6. FAIR VALUE MEASUREMENTS (CONTINUED)

		Fair Value Measurements at 9/30/09 Using		
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
U.S. Government and Government Agency obligations	$ 27,869,551	$ 14,780,961	$ 13,088,590	$ -
Corporate bonds	12,207,601	-	12,207,601	-
Mutual funds	31,335,468	31,335,468	-	-
International equity fund - limited liability company	3,163,536	-	3,163,536	-
Real estate investment trust	2,741,621	-	-	2,741,621
Money market funds	494,316	494,316	-	-
Certificates of deposits				
Harris Bank CDARS program	23,091,937	-	23,091,937	-
Harris Bank certificate of deposits	762,443	-	762,443	-
Total	$ 101,666,473	$ 46,610,745	$ 52,314,107	$ 2,741,621

The table below sets forth a summary of changes in the fair value of the Plan's Level 3 assets for the year ended September 30, 2009.

	Fair Value Measurements Using Significant Unobservable Inputs (Level 3)
	Real Estate Investment Trust
Balance at 10/1/08	$ 5,224,499
Net realized and unrealized loss on investments	(2,580,399)
Interest and dividend income	148,478
Sale of investments	(50,957)
Balance at 9/30/09	$ 2,741,621

NOTE 7. PROPERTY AND EQUIPMENT

The composition of property and equipment at September 30, 2009 and 2008 is as follows:

	2009	2008
Property and equipment		
Furniture and equipment	$ 1,437,879	$ 1,356,482
Course development costs	271,729	271,729
Computer hardware and software	16,288,240	13,418,864
Leasehold improvements	440,183	440,183
	18,438,031	15,487,258
Less accumulated depreciation and amortization	(13,767,119)	(11,357,055)
Net property and equipment	$ 4,670,912	$ 4,130,203

Depreciation and amortization expense was $2,410,065 and $2,158,840 for the years ended September 30, 2009 and 2008, respectively. In 2009, there is an also $93,750 amortization expense on the intangible asset (not included in the above amount).

NOTE 8. 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, 2009:

Year ending September 30,	
2010	$ 522,343
2011	538,011
2012	554,276
2013	186,668
Total	$ 1,801,298

Rent expense for the years ended September 30, 2009 and 2008 was $905,797 and $841,392, respectively. Rent expense includes both base rent and common area maintenance expenses.

NOTE 9. 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 $479,696 and $433,749 for the years ended September 30, 2009 and 2008, respectively.

NOTE 10. COMMITMENTS

NCSBN has entered into contracts for services and accommodations for future meetings. These contracts include penalty clauses which would require NCSBN to pay certain amounts if a meeting were to be canceled or guarantees for room blocks are not fulfilled. At September 30, 2009, the requirements to fulfill these commitments approximated $329,400.

NCSBN has also entered into various contracts for futures services. At September 30, 2009, the requirements to fulfill these commitments approximate $425,200 and are expected to be completed within one year.

Report of the Institute of Regulatory Excellence (IRE) Committee

Background

2009-2010 was the seventh year of the Institute of Regulatory Excellence (IRE). This program remains dedicated to the leadership development of nurse regulators. In addition to the Annual IRE Conference, which focuses on various aspects of regulation, participants enhance their knowledge and skills in research design, evidence-based regulation and project management.

The committee evaluates the program, as well as the progress of participants, on an ongoing basis. Currently, a total of 21 Fellows participate in the program. These individuals belong to the following cohorts:

Year 4 (2007 cohort): two Fellows (includes one Fellow from the 2006 cohort)

Year 3 (2008 cohort): five Fellows

Year 2 (2009 cohort): seven Fellows

Year 1 (2010 cohort): seven Fellows

The following is a report on the committee's 2010 charges.

- Select 2010 IRE Fellowship participants and mentors, and approve fellowship project proposals and final reports.
  - There were seven individuals who applied to the program for the 2010 cohort. The committee reviewed all applications for admission into the program and determined that they all met the qualifications for an IRE fellowship. This was the first year that Associate Members have applied to the program and were accepted as IRE Fellows.
  - The committee decided that mentors would be chosen during the second year of the fellowship after the participants have had an opportunity to develop a learning plan and literature review. This would allow enough time to ensure successful mentor-fellow matchups, as mentors lay the groundwork to u nderstand each Felow's future direction.
  - Final project reports for the 2007 cohort were due June 1, 2010. IRE Committee members will review the projects 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.
    - A Fellow Success Toolkit and Syllabus was developed for the IRE that clearly outlines the program and expectations of Fellows.
    - The committee recommended assistance be provided to Fellows in obtaining Institutional Review Board (IRB) approval. Fellows who do not have access to an internal IRB will be referred to the New England IRB. This is an independent IRB that does timely and comprehensive reviews. Fellows can use part of their IRE resource funds to pay for this service.

Members

Connie Kalanek, PhD, RN, FRE
North Dakota, Area II, Chair

Louise Bailey, MEd, PHN, RN
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Staff
Maryann Alexander, PhD, RN,
Chief Officer, Nursing Regulation

Kathy Dolter, PhD, MA, RN
Associate, Nursing Regulation

Meeting Dates

- Oct. 27-28, 2009
- Dec. 7-8, 2009
- May 12-13, 2010

Relationship to Strategic Plan

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

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

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

Strategic Objective 1
Promote ongoing regulatory excellence.

- Advise staff regarding the content of the IRE Annual Conference and annual induction ceremony.
  - The theme of the 2010 conference was Continued Competence.
    - The IRE preconference/orientation day for Fellows was held for the second time. This year, Fellows were divided into breakout sessions that allowed them to hear presentations geared specifically to their needs according to their year in the program. Presentations included how to write a learning plan, conduct a literature review and write a proposal. One session was devoted to presentations by Fellows about their projects. Many felt this session was not only a great learning experience, but they also enjoyed the opportunity to participate and share their ideas and perspectives.
    - An IRE toolkit was distributed to every participant; it contained valuable references and resources for project development and writing a proposal.
    - The conference was well-received by participants who all gave high ratings to the speakers and felt the conference met the objectives.
  - The induction ceremony was addressed by the Awards Committee and it was decided that this would remain part of the Annual Meeting Awards Dinner.
  - Discussions on the 2011 conference, which will take place in Orlando, Fla,. and focus on organizational management and behavior, have begun.

Overall, the IRE continues to improve on an annual basis and provide a unique learning experience for those who participate. There is no other program/conference that is so aptly geared toward 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 FY10 Activities

- The addition of seven new IRE Fellows in the 2010 IRE cohort.
- Participation by Associate Members.
- The 2010 IRE Annual Conference on Continued Competence, including the IRE preconference day with sessions devoted to presentations by the IRE Fellows about their literature reviews and projects.
- Development of new and improved resource materials for IRE Fellows.

Future Activities

- Select 2011 IRE Fellows and mentors, and approve project proposals and final reports.
- Advise staff on issues related to the implementation of the IRE Fellowship Program.
- Approve the content of the IRE Annual Conference.

Attachments

None

Report of the National Nurse Aide Assessment Program (NNAAP™) and the Medication Aide Certification Examination (MACE™) Department

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 or oral examination and a skills demonstration.

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 developed for boards of nursing (BONs) and became effective Jan. 1, 2010. MACE will help to evaluate the competence of unlicensed individuals allowed to administer medications to clients in long-term care settings.

Pearson VUE is the exclusive test administrator for NNAAP and MACE and continues to be responsible for all delivery, administration, publishing (electronic and paper), sales and market development activities associated with the exams. In addition, Pearson VUE provides the following testing services for NNAAP: 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.

NNAAP is consistent with the training requirements for nurse aides/nursing assistants (NAs) delineated in the Omnibus Budget Reconciliation Act (OBRA) of 1987, 1989. This act states that anyone working as an NA must complete a competency evaluation program. The competency evaluation program must be state approved, 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 MACE. Subject matter experts (SMEs) are selected to participate in item writing and review workshops, using criteria delineated in the above-stated resources. MACE is designed to assess entry-level competence of unlicensed direct care providers who have been approved by their state/jurisdiction to administer medications in long-term care settings.

NCSBN continues to serve as the premier organization that advances regulatory excellence for public protection. 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 FY10 Activities

- In October 2009, the NNAAP™ & MACE™ Examinations department conducted its first nurse aide job analysis. The nurse aide job analysis survey was mailed to 6,500 health care facilities. The survey closed in December 2009. It was published in summer 2010.
- In October 2009, the Nurse Aide Knowledge, Skills and Abilities/Knowledge Statements Workshop was held.
- In November 2009, the director of the NNAAP™ & MACE™ Examinations department and the senior program manager for Health & Professional Services from Pearson VUE visited Maine to discuss the NNAAP program.
- In November 2009, there was a site visit to an NA training center in Charlotte, N.C.

Staff

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Director, NNAAP™ & MACE™ Examinations

Marijana Dragan, MS
Statistician, NNAAP™ & MACE™ Examinations

Melissa Franke
Coordinator, NNAAP™ & MACE™ Examinations

Meeting Dates

- Oct. 20-22, 2009 (Nurse Aide Knowledge, Skills and Abilities/ Knowledge Workshop)
- Nov. 17-18, 2009 (North Carolina MACE™ Workshops)
- Feb. 17-18, 2010 (NNAAP™ Test Specifications/Test Plan Workshop)
- Feb. 24, 2010 (North Carolina MACE™ Standard-Setting Webinar)
- March 2-4, 2010 (NNAAP™ Item Writing and Review Workshop)
- April 13-17, 2010 (NNAAP™ Industry Day and Test Site Visits in Virginia)
- April 21-22, 2010 (NNAAP™ Written or Oral Exam Standard-Setting Workshop)
- June 29-30, 2010 (Unlicensed Nursing Assistive Personnel Workshop)

Relationship to Strategic Plan

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

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 November 2009, an online application and database for licensed nurses who want to participate in test development opportunities for the NNAAP and MACE programs was deployed. As of March 2010, 124 volunteers have signed up to participate.
- In late November 2009, a Facebook page was created and is now followed by 67 fans.
- In January 2010, six new NNAAP written forms went into operational use; a total of 120 items will be pretested annually.
- In February 2010, the department conducted its first NA knowledge survey, which was mailed to 6,500 health care settings.
- In February 2010, the department hosted its first NNAAP™ Test Plan/Test Specifications Workshop.
- In February 2010, the department conducted the North Carolina MACE™ Standard-Setting Workshop via webinar.
- In March 2010, the second annual NNAAP™ Item Writing and Review Workshop took place.
- In April 2010, the NNAAP™ Written or Oral Examination Standard-Setting Workshop was held.
- NNAAP e-push subscribers increased from 58 to 294 since April 2008.
- MACE e-push subscribers increased from 55 to 268 since April 2008.
- From April 2009 to March 2010, 79 volunteers were recruited and approved to participate in test development activities.
- In June 2010, the first two-day Unlicensed Nursing Assistive Personnel Workshop was held in Chicago.

Program Highlights and Test Development Activities

NNAAP™ JOB ANALYSIS AND KNOWLEDGE SURVEYS

In October 2009 the department conducted its first NA job analysis survey. In preparation for the survey, a job analysis workshop was held July 21–22, 2009. A panel of 10 registered nurses (RNs) and one certified entry-level NA was assembled to assist with the job analysis. Panel members worked with and/or supervised the work of certified entry-level NAs one year postcertification. The SMEs asked the certified entry-level NAs whom they supervised to submit detailed daily logs describing the activities they performed on the job. Additionally, SMEs were asked to submit job descriptions, orientation and professional evaluations from their work settings. Using activity logs, past activity statements, job descriptions, performance evaluation documents, as well as their own knowledge of certified entry-level NA work, the SMEs identified the category structure describing the types of activities performed by certified entry-level NAs. They were careful to review and modify the current category structure to ensure that it was clear, understandable and logical.

Once the list of categories was created, the SMEs worked to create a list of activities performed by the certified entry-level NA. Each activity was reviewed for applicability to certified entry-level work and the relationship to the delivery of safe nursing care to members of the public. Care was taken to create the activity statements at approximately the same level of specificity and to avoid redundancy. There were 115 NA activity statements that were incorporated into a job analysis survey.

In February 2010, the department also conducted its first nurse aide knowledge survey to identify appropriate knowledge required for each of the work activities established in the job analysis survey. In preparation for the survey, NCSBN hosted a workshop Oct. 20–22, 2009. A panel of 14 RNs and one certified entry-level NA was assembled to assist with the knowledge statement job analysis.

During the workshop, SMEs reviewed entry-level NA work activities and identified the knowledge necessary to perform each of the work activities. The SMEs then reviewed the existing list of activity statements required for entry-level NA job performance/work to ensure that all activities were connected to some required knowledge. Once this review was complete, the SMEs were able to develop a complete list of knowledge, skills and abilities (KSA) statements for safe and effective entry-level NA work.

NNAAP™ TEST SPECIFICATIONS WORKSHOP

On Feb. 17-18, 2010, the NNAAP™ & MACE™ Examinations department hosted a NNAAP™ Test Specifications Workshop with SMEs from the four NCSBN geographic regions. During the meeting, the SMEs reviewed the 2010 NNAAP™ Written (Oral) Content Outline and activity statements from the *2009 Job Analysis of Nurse Aides Employed in Nursing Homes/Long-term Care, Hospitals/Acute Care and Community/Home Health Care Settings.* There were 119 NA activity statements identified in the 2005 NA Job Analysis Study and 115 in the 2009 NA Job Analysis Study. There were two activity statements eliminated by SMEs: filling out a meal menu and preparing for a diagnostic test.

The SMEs found no major changes in the existing content categories and recommended the adoption of a 2011 NNAAP™ Written or Oral Content Outline based on the review of data from the 2009 NA Job Analysis Study findings. With the review and validation of the data obtained from the mailed and nonresponder survey results, the inclusion of the activity statements from the 2009 NA Job Analysis Study and the NNAAP curricula for current and prospective clients, the exam will continue to meet the educational needs of candidates interested or currently participating in NNAAP.

NNAAP™ ITEM WRITING AND REVIEW WORKSHOP

From March 2-4, 2010, SMEs engaged in test-development activities for the NNAAP written or oral examination.

The meeting began with an introduction to NCSBN and continued with an item writing workshop that included specific guidelines to use when writing new items; the important statistical characteristics to apply in the review of items; a practice session in the writing and reviewing of items; a list of knowledge statements and activity statements to write new items based on an analysis of item bank needs; and an explanation of how to use the NNAAP™ Written or Oral Examination Content Outline.

SMEs discussed the guidelines necessary for reviewing active and problem items. Active items are items that are scored; problem items are approved items that are not currently on testing forms, but have been administered during a real testing situation and were found to perform poorly statistically. Statistical information is used to evaluate the usefulness of the items for testing. In preparation for the meeting, 830 approved and pretest items were analyzed by the statistician using a gap analysis, which evaluates the content areas in need of items. This evaluation determines the activity statements that items will need to be written to by the SMEs.

During the NNAAP™ Item Writing and Review Workshop, the SMEs wrote 69 new items and reviewed a total of 153 items. Of the 69 newly written items, 68 were approved and set to pretest status. Of the additional items reviewed, 61 of the 84 previously written items with a problem status were rewritten and approved for pretest. This activity resulted in the approval of 129 pretest items.

NNAAP™ STANDARD-SETTING WORKSHOP FOR WRITTEN OR ORAL EXAMINATION

In 2010, NCSBN used findings from the *2009 Job Analysis of Nurse Aides Employed in Nursing Homes/Long-term Care, Hospitals/Acute Care and Community/Home Health Care Settings* to develop the content outline and test specifications for the 2011 NNAAP written or oral examination. There were 10 SMEs that represented all four NCSBN geographic regions with a wide variety of nursing expertise who served on the NNAAP standard-setting panel. The SMEs

reviewed the findings from the job analysis and used their experience in teaching or working with entry-level NAs and other resources and data to determine the cutscore/passing standard for the 2011 NNAAP forms, effective Jan. 1, 2011. The raw cutscore for the 2011 NNAAP written or oral examination forms is 47 out of 60 scored items.

Across all states, the pass rates for NNAAP were 92 percent for the written or oral examinations and 79 percent for the skills demonstration. The table below provides passing rates by states for the written or oral examination, skills demonstration and overall pass for forms administered in 2009. The overall pass figure provides information on the completion of all requirements for NA certification. A candidate must pass both the written or oral examination and skills demonstration to obtain an overall pass. The number in parentheses represents the number of candidates taking the examination in 2009.

Pass Rates by States in 2009

	Written/Oral (N*)			Skills (N*)			
State	First-time Takers	Repeaters	Total	First-time Takers	Repeaters	Total	Total
Alabama	92%	81%	91%	79%	81%	79%	83%
	(1730)	(180)	(1910)	(1727)	(307)	(2034)	(1891)
Alaska	97%	87%	96%	94%	90%	93%	95%
	(551)	(54)	(605)	(549)	(71)	(620)	(600)
California	92%	72%	90%	92%	85%	91%	92%
	(8637)	(967)	(9604)	(8592)	(881)	(9473)	(9085)
Colorado	96%	77%	94%	77%	69%	75%	85%
	(5556)	(605)	(6161)	(5659)	(1571)	(7230)	(6278)
District of Columbia	82%	60%	76%	77%	76%	76%	77%
	(475)	(151)	(626)	(486)	(163)	(649)	(602)
Georgia	91%	60%	89%	80%	83%	80%	83%
	(9093)	(720)	(9813)	(9179)	(1117)	(10296)	(9569)
Louisiana	87%	58%	83%	77%	91%	80%	88%
	(444)	(85)	(529)	(444)	(113)	(557)	(480)
Maryland	92%	70%	90%	88%	79%	87%	89%
	(3506)	(396)	(3902)	(3525)	(554)	(4079)	(3839)
Minnesota	96%	90%	95%	87%	82%	86%	93%
	(6618)	(1299)	(7917)	(6620)	(1900)	(8520)	(7773)
Mississippi	90%	83%	89%	70%	67%	69%	77%
	(2753)	(544)	(3297)	(2783)	(920)	(3703)	(3258)
New Hampshire	100%	100%	100%	85%	90%	86%	94%
	(27)	(7)	(34)	(27)	(10)	(37)	(34)
New Jersey	85%	62%	78%	95%	95%	95%	72%
	(4533)	(1717)	(6250)	(5402)	(672)	(6074)	(6731)
North Carolina	96%	83%	96%	73%	71%	73%	82%
	(21048)	(1475)	(22523)	(21414)	(4970)	(26384)	(23199)
North Dakota	96%	90%	95%	92%	91%	92%	96%
	(975)	(159)	(1134)	(972)	(190)	(1162)	(1105)
Pennsylvania	94%	80%	93%	81%	79%	80%	86%
	(9690)	(1093)	(10783)	(9810)	(2089)	(11899)	(10842)
Rhode Island	87%	59%	81%	58%	65%	61%	77%
	(1485)	(374)	(1859)	(1475)	(829)	(2304)	(1735)

Pass Rates by States in 2009

State	Written/Oral (N*)			Skills (N*)			Total
	First-time Takers	Repeaters	Total	First-time Takers	Repeaters	Total	
South Carolina	94%	86%	93%	82%	77%	81%	85%
	(5633)	(878)	(6511)	(5683)	(1276)	(6959)	(6505)
Texas	91%	74%	89%	N/A	N/A	N/A	94%
	(22041)	(3389)	(25430)	N/A	N/A	N/A	(23905)
Virgin Islands	82%	33%	79%	61%	63%	62%	64%
	(112)	(9)	(121)	(90)	(51)	(141)	(129)
Virginia	91%	60%	87%	64%	61%	63%	73%
	(5959)	(897)	(6856)	(6040)	(2184)	(8224)	(6914)
Washington	94%	63%	91%	78%	79%	78%	85%
	(7611)	(769)	(8380)	(7687)	(1668)	(9355)	(8335)
Wisconsin	98%	84%	97%	84%	83%	84%	92%
	(10938)	(589)	(11527)	(10956)	(1825)	(12781)	(11589)
Wyoming	98%	91%	97%	85%	82%	85%	91%
	(1020)	(95)	(1115)	(1024)	(210)	(1234)	(1130)
Total	93%	74%	91%	80%	76%	79%	86%
	(130435)	(16452)	(146887)	(110144)	(23571)	(133715)	(145529)
*Number of candidates is in parenthesis							

UNLICENSED NURSING ASSISTIVE PERSONNEL WORKSHOP

In June 2010, the department hosted its first two-day Unlicensed Nursing Assistive Personnel Workshop. Day one of the workshop was devoted to NA topics while day two was devoted to medication aide/assistant (MA) topics. NA and MA regulators, program managers, training managers, as well as long-term care/nursing home administrators, were invited to attend. The purpose of the workshop was for stakeholders to discover, learn and share insights on the evolving role of NAs and MAs in nursing care, and the regulatory implications that may impact the work performed by these direct care providers.

Future Activities

- Share with the public information about NNAAP and MACE.
- Develop new test items, test forms 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 test forms and computer-based test forms for written or oral examination for NNAAP.
- Update skills demonstration test forms and scoring standards for NNAAP.
- Continue to increase the bank of items for MACE and build computer-based forms to meet needs of membership.
- Review NNAAP skills demonstration content with SME panel.
- Enhance the quality of NNAAP and MACE.
- Increase the number of states that use NNAAP and MACE.

Attachment

A. 2011 NNAAP™ Written or Oral Examination Content Outline

Attachment A

2011 NNAAP™ Written or Oral Examination Content Outline

The 2011 National Nurse Aide Assessment Program (NNAAP™)
Written or Oral Examination Content Outline

The revised 2011 NNAAP™ Examination Content Outline is based on the findings from the 2009 job analysis of nurse aides published by NCSBN in spring 2010. The examination content outline will go into effect January 2011.

The NNAAP written examination is comprised of 70 multiple-choice items; 10 are pretest items (nonscored) on which statistical information will be collected. The NNAAP oral examination is comprised of 60 multiple-choice items and 10 reading comprehension (word recognition) items. The candidate is allowed to choose between a written and an oral examination.

	2011 Content Outline		2010 Content Outline	
Content Domain	**Weighting of Content Domain**	**Number of Items in Domain**	**Weighting of Content Domain**	**Number of Items 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	14%	8	13%	8
B. Basic Nursing Skills 1. Infection Control 2. Safety/Emergency 3. Therapeutic/Technical Procedures 4. Data Collection and Reporting	39%	24	40%	24
C. Restorative Skills 1. Prevention 2. Self Care/Independence	7%	4	8%	5
II. Psychosocial Care Skills				
A. Emotional and Mental Health Needs	11%	6	13%	8
B. Spiritual and Cultural Needs	2%	2	2%	1
III. Role of the Nurse Aide				
A. Communication	8%	5	8%	5
B. Client Rights	7%	4	5%	3
C. Legal and Ethical Behavior	3%	2	3%	1
D. Member of the Health Care Team	9%	5	8%	5
	100%	60	100%	60

Report of the Nursys® Committee

Background

The Nursys® Committee was charged by the Board of Directors (BOD) with:

- Creating an Advanced Practice Nurse Information Model for Nursys.
- Developing a model to receive electronic disciplines from Member Boards.

Highlights of FY10 Activities

- Changes to Nursys policy.
- Changes to add initial licensure date to Nursys.com.
- Reviewed all Nursys-related completed projects from 2006 to 2009.
- Strategized and developed a model to collect and display advanced practice registered nurse information in Nursys.
- Strategized and developed a model to receive electronic disciplines from Member Board database to Nursys, potentially eliminating the need for manual discipline entry by Member Board staff.
- Discussed and approved business requirements for discipline auto alert.

Future Activities

The Nursys® Committee will reconvene and work on the charges given to them by the BOD in fiscal year 2012 (FY12).

Attachments

None

Members

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Meeting Dates

- Oct. 19-20, 2009
- Dec. 14-15, 2009
- Feb. 16, 2010 (Teleconference)
- March 22, 2010

Relationship to Strategic Plan

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

Strategic Objective 1
Maintain a comprehensive national nurse licensure database.

Report of the TERCAP® Committee

Background

Evaluate the Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®) protocol to improve the quality of data submitted.

The TERCAP® Committee analyzed the current TERCAP protocol and its utilization by Member Boards to determine changes needed to improve the quality of the data. In addition, the committee looked at other major patient-safety projects and the data reporting format of each.

The committee's analysis of the TERCAP protocol revealed the following concerns that impede the completion of sound, scientifically controlled research:

1. Selection bias. The current protocol was designed to encourage Member Boards' participation in TERCAP by making its use as easy as possible. However, due to a lack of stringent case selection and submission requirements, states were allowed to develop their own case selection criteria. As a result, some states select their most egregious cases; some send cases from specific investigators; and other states randomly select cases. The committee was in agreement that inconsistency in case selection may cause significant selection bias. Because of this, the cases are not representative of the outcomes of practice breakdowns in the general population.
2. Missing data. Not all Member Board investigators routinely collect all the data that is required by TERCAP. Although participating boards of nursing (BONs) are strongly encouraged to have investigators employ the instrument questions contemporaneous to their investigation, some Member Board representatives have reported that investigators do not find this feasible. They are already pressed for time and view the instrument use as impeding the efficiency in which they could otherwise carry out the investigation. BON investigations that are completed prior, rather than contemporary to the utilization of the instrument, perpetuate the problem with missing data.

In December 2008, the NCSBN Research department performed a power analysis to determine the number of submitted cases necessary to complete a statistical analysis to answer the original research questions. The power analysis done for this project indicates that at least 1,300 cases are needed prior to any valid statistical analysis. There are currently 624 submissions. At the current rate, in order to answer the research questions, it is anticipated to take several years before actual data analysis can ensue.

Review of data reporting formats:

The committee examined other patient-safety projects and their reporting methods. Dr. Rodney Hicks, committee consultant, gave the committee an inside look at the MedMarx System's method of reporting. NCSBN staff provided information about other systems that included Joint Commission Sentinel Events Database, Institute for Safe Medication Practices and FDA MedWatch. All of these are national, voluntary, adverse events reporting databases that identify trends, report descriptive statistics and administer alerts. These databases are highly regarded.

The committee engaged in extensive discussion about the option of TERCAP becoming a similar reporting system for practice breakdown. The advantages of converting TERCAP to an adverse event reporting system are as follows:

- An effective reporting system is a measure of progress toward achieving a safety culture. At a minimum, reporting can help identify hazards and risks, and provide information as to where the system is breaking down. This can help target improvement efforts and system changes to reduce the likelihood of injury to future patients.
- Detailed analysis of thousands of reports makes it possible to identify hazards. Natural questions guide analysts through details of context and contributing causes to probe interrelationships among event types, risk factors and contributing causes. Statistical

Members

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Kevin Kenward, PhD, MA
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Meeting Dates

- Nov. 16-17, 2009
- Jan. 25-26, 2010
- March 23-24, 2010
- May 12, 2010 (Teleconference)

Relationship to Strategic Plan

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

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

analysis identifies meaningful relationships and provides analysis that can generate insights into the overall systems of care. These data are classified and fed back to BONs with benchmarking from the entire database and with their own prior experience to identify targets for improvement, and to provide monitoring of progress. The most important function that a large reporting system can perform is to use the results of investigations and data analyses to formulate and disseminate recommendations for system changes. Reports are aggregated and analyzed to understand the frequency of types of incidents, patterns, trends and underlying contributory factors.

- TERCAP data, which would be reported in frequencies as recurring and consistent trends, not inferential statistics, could be reported as soon as sometime this year. Since only descriptive statistics are used, problems with selection bias and lack of generalizability are not of concern. Alerts could be issued describing specific patterns and new trends.
- Member Boards would be provided with data which may encourage additional participation from current users and initial participation by new Member Board users.

The committee does not anticipate that reporting the data as descriptive statistics and trends will affect the data previously collected from TERCAP. The disadvantages of converting TERCAP to a national database, as described above, is that the original research questions identified for TERCAP will not be answered as a primary data analysis. A secondary analysis may be possible, but not in the near future.

As recommended by the BOD, the committee consulted Patricia Benner, PhD, RN, FAAN who conducted the primary research in development of the TERCAP instrument. In March 2010, the committee had an extensive discussion with Benner. She was in full agreement that changing TERCAP into a reporting database would be a positive move as it would allow Member Boards the opportunity to access the aggregate data much sooner than would be available under a strict research protocol.

Benner also suggested that the committee review and determine a minimum data set within the instrument and voiced her recommendations as to what elements of the instrument should be mandatory for Member Boards to complete. Benner believed this would be strategic to instrument utilization as it would shorten the instrument and possibly encourage more participation, since much of the negative feedback about the instrument centers around its length (see Attachment A).

Develop and implement a plan to increase data collection

In addition to the above recommendation regarding the TERCAP protocol, the committee has established an industrious plan for involving more BONs in the participation of TERCAP. This entails:

1. Personal visits to BONs to teach staff about TERCAP;
2. Identifying champions who will answer questions, share their experiences and assist BONs with implementation;
3. Developing a Web-based toolkit and new marketing materials that emphasize the advantages of using TERCAP as an investigative tool;
4. Encouraging BONs that utilize TERCAP to work with health systems, hospitals and other institutions for case submission; and
5. Increasing awareness of other advantages of TERCAP.
    a. Increases transparency. BONs can summarize their data on the types of cases being addressed.
    b. Identifies system issues.
    c. Identifies competency issues.
    d. Encourages collaboration between BONs and institutions.

Kevin Kenward, PhD, MS, director, Research, NCSBN, visited three BONs during fiscal year 2010 (FY10) for TERCAP training: Virginia, New York and Mississippi. The TERCAP database now contains more than 600 cases; 18 states are currently participating. There are four champions that have been identified to assist with the recruitment and training of BONs interested in TERCAP. The TERCAP toolkit and resource materials arebeing updated and streamlined.

Highlights of FY10 Activities

- Development of an interactive, online toolkit, and updating of resource materials and website. Videos have been selected and made ready to embed by the NCSBN Interactive Services department; training materials have been updated; testimonials and the information sheet have been reformulated; other materials have been updated and made more succinct and pleasing. It was decided that release of this toolkit should coincide with the release of TERCAP data.
- Personal training sessions with BONs.
- Addition of four participating states.
- More than 600 cases in database.

Future Activities

- Dissemination of TERCAP data.
- Further development of implementation plan.

Attachment

A. 2010 TERCAP® Data Collection Instrument

Attachment A

2010 TERCAP® Data Collection Instrument

TERCAP™
Taxonomy of Error, Root Cause Analysis and Practice-responsibility

2010
Data Collection Instrument©

TERCAP Case ID Number _____

1. **Full Name of Reviewer** _____

2. **State Board of Nursing** _____

3. **Date of incident** _____ ☐ Unknown

4. **Type of Patient Event Related to Practice Breakdown**

☐ Fall	☐ Abuse	☐ Homicide
☐ Medication Error	☐ Treatment Error/Omission	☐ Other (Specify)
☐ Healthcare Associated Infection	☐ Equipment Error	_____
☐ Allergic/Anaphylaxis/Transfusion Reaction	☐ Suicide	_____

5. **Patient age** _____ ☐ Unknown

6. **Indicate the patient's diagnosis.** *Check no more than TWO diagnoses, those that contributed to the reported situation*

☐ Alzheimer's disease and other dementias (confusion)	☐ HIV / AIDS
☐ Arthritis	☐ Hypertension
☐ Asthma	☐ Infections
☐ Back problems	☐ Ischemic heart disease (CAD, MI)
☐ Cancer	☐ Nervous system disorders
☐ Congestive heart failure	☐ Pneumonia
☐ Depression and anxiety disorders	☐ Pregnancy
☐ Diabetes	☐ Renal / urinary system disorders
☐ Emphysema	☐ Skin disorders
☐ Fractures	☐ Stomach ulcers
☐ Gall bladder disease	☐ Stroke (CVA)
☐ Gastrointestinal disorders	☐ Other (Specify)_____
	☐ Unknown diagnosis

7. **Patient Harm** *Select ONLY one*
☐ No harm - An error occurred but with no harm to the patient
☐ Harm - An error occurred which caused a minor negative change in the patient's condition.
☐ Significant harm - Significant harm involves serious physical or psychological injury. Serious injury specifically includes loss of function or limb.
☐ Patient death - An error occurred that may have contributed to or resulted in patient death.

8. Communication Factors *Check all that apply*

- ☐ Communication systems equipment failure
- ☐ Computer system failure
- ☐ Interdepartmental communication breakdown / conflict
- ☐ Lack of ongoing education / training
- ☐ Lack of or inadequate orientation / training
- ☐ Medical record not accessible
- ☐ No adequate channels for resolving disagreements
- ☐ Patient identification failure
- ☐ Patient name similar / same
- ☐ Patient transfer (hand-offs)
- ☐ Preprinted orders inappropriately used (other than medications)
- ☐ Shift change (patient hand-offs)
- ☐ Other (Specify)_____
- ☐ No communication factors involved
- ☐ Unknown

9. Leadership / Management Factors *Check all that apply*

- ☐ Assignment or placement of inexperienced personnel
- ☐ Inadequate / outdated policies / procedures
- ☐ Inadequate patient classification (acuity) system to support appropriate staff assignments
- ☐ Nurse shortage, sustained, at institution level
- ☐ Poor supervision / support by others
- ☐ Unclear scope and limits of authority / responsibility
- ☐ Other (Specify)_____
- ☐ No leadership/management factors involved
- ☐ Unknown

10. Backup and Support Factors *Check all that apply*

- ☐ Forced choice in critical circumstances
- ☐ Ineffective system for provider coverage
- ☐ Lack of adequate provider response
- ☐ Lack of nursing expertise system for support
- ☐ Lack of adequate response by lab / x-ray / pharmacy or other department
- ☐ Other (Specify)_____
- ☐ No backup and support factors involved
- ☐ Unknown

11. Environmental Factors *Check all that apply*

- ☐ Code situation
- ☐ Equipment failure
- ☐ Frequent interruptions / distractions
- ☐ Increased noise level
- ☐ Lack of adequate supplies / equipment
- ☐ Multiple emergency situations
- ☐ Physical hazards
- ☐ Poor lighting
- ☐ Similar / misleading labels (other than medications)
- ☐ Other (Specify)_____
- ☐ No environmental factors involved
- ☐ Unknown

12. Health team members involved in the practice breakdown *Check all that apply*

- ☐ Floating / temporary staff
- ☐ Health profession student
- ☐ Medication assistant
- ☐ Other Health professional (e.g., PT, OT, RR)
- ☐ Other prescribing provider
- ☐ Other support staff
- ☐ Patient
- ☐ Patient's Family / friends
- ☐ Pharmacist
- ☐ Physician (may be attending, resident or other)
- ☐ Staff nurse
- ☐ Supervisory nurse / personnel
- ☐ Unlicensed Assistive Personnel (nurse aide, certified nursing assistant, CNA or other titles of non-nurses who assist in performing nursing tasks)
- ☐ Other (Specify)_____
- ☐ No health team members involved
- ☐ Unknown

13. Staffing issues contributed to the practice breakdown *Check all that apply*

- ☐ Lack of supervisory / management support
- ☐ Lack of experienced nurses
- ☐ Lack of nursing support staff
- ☐ Lack of clerical support
- ☐ Lack of other health care team support
- ☐ Other (Specify)_____
- ☐ No staffing issues involved
- ☐ Unknown

14. Health Care Team *Check all that apply*

- ☐ Breakdown of health care team communication
- ☐ Care impeded by policies or unwritten norms that restrict communication
- ☐ Illegible handwriting
- ☐ Intimidating / threatening behavior
- ☐ Intradepartmental conflict / non-supportive environment
- ☐ Lack of multidisciplinary care planning
- ☐ Lack of patient involvement in plan of care
- ☐ Lack of family / caregiver education
- ☐ Lack of patient education
- ☐ Majority of staff had not worked together previously
- ☐ Other (Specify)_____
- ☐ No health care team issues involved
- ☐ Unknown

15. Nurse's gender ☐ Female ☐ Male ☐ Unknown

16. Where nurse received nursing education

☐ Unknown ☐ US ☐ Non-US, please list country _____

17. Indicate all degrees the nurse holds and list the year of graduation and year of initial licensure, if applicable.

Degree(s)	Year of Graduation(s)	Year of Initial Licensure(s)	Unknown
_____	_____	_____	☐
_____	_____	_____	☐

18. Which license did you hold at the time of the practice breakdown?

☐ LPN/VN ☐ RN ☐ APRN

- ☐ Nurse Practitioner
- ☐ Clinical Nurse Specialist
- ☐ Nurse Anesthetist
- ☐ Nurse Midwife
- ☐ APRN Category unknown

19. Is English the nurse's primary language?

☐ Yes ☐ No ☐ Unknown

20. Length of time nurse had worked in patient care location where the practice breakdown occurred

☐ Less than one month
☐ One month - Twelve months
☐ One - Two years
☐ Three - Five years
☐ More than five years
☐ Unknown

21. Type of shift

☐ 8 hour
☐ 10 hour
☐ 12 hour
☐ On call
☐ Other (Specify) _____
☐ Unknown

22. Was the nurse working in a temporary capacity?

☐ Yes ☐ No ☐ Unknown

23. How many direct care patients were assigned to the nurse at the time of the practice breakdown?

Number of Patients _____ ☐ Unknown

24. Previous discipline by a board of nursing

☐ Yes ☐ No ☐ Unknown

25. Previous criminal convictions

☐ Yes ☐ No ☐ Unknown

26. Did the reported incident involve intentional misconduct or criminal behavior? *Check all that apply*

☐ No
☐ Yes: Changed or falsified charting
☐ Yes: Deliberately covering up error
☐ Yes: Theft (including drug diversion)
☐ Yes: Fraud (including misrepresentation)
☐ Yes: Patient abuse (verbal, physical, emotional or sexual)
☐ Yes: Criminal conviction
☐ Yes: Other - please specify _____
☐ Unknown

27. Did the practice breakdown involve a medication error?
☐ Yes ☐ No (*Skip to question 30*) ☐ Unknown (*Skip to question 30*)

28. Name of drug involved in the practice breakdown *(Include complete medication order or skip if no medication error involved)*

Drug ordered _____ ☐Unknown

Drug actually given _____ ☐Unknown

29. The type of medication error identifies the form or mode of the error, or how the error was manifested. Select the type of medication error. *Check all that apply*

☐ Abbreviations
☐ Drug prepared incorrectly
☐ Extra dose
☐ Improper dose / quantity
☐ Mislabeling
☐ Omission
☐ Prescribing
☐ Unauthorized drug
☐ Wrong administration technique
☐ Wrong dosage form
☐ Wrong drug
☐Wrong patient
☐ Wrong route
☐ Wrong time
☐ Wrong reason
☐ Other (Specify)_____
☐ Unknown

30. Was a documentation error the cause of the practice breakdown?
☐ Yes ☐ No (*Skip to question 32*) ☐ Unknown (*Skip to question 32*)

31. What kind of documentation error was involved? *Check all that apply*

☐ Charting incorrect information
☐ Charting on wrong patient record
☐ Incomplete or lack of charting
☐ Pre-charting / untimely charting
☐ Other (Specify) _____

32. If Attentiveness / Surveillance was a factor in the Practice Breakdown. *Check all that apply*

☐ Patient not observed for an unsafe period of time
☐ Staff performance not observed for an unsafe period of time
☐ Other (Specify) _____
☐ Attentiveness/Surveillance was not a factor

33. If Clinical Reasoning was a factor in the Practice Breakdown. *Check all that apply*

☐ Clinical implications of patient signs, symptoms and/or responses to interventions not recognized
☐ Clinical implications of patient signs, symptoms and/or interventions misinterpreted
☐ Following orders, routine (rote system) without considering specific patient condition
☐ Poor judgment in delegation and the supervision of other staff members
☐ Inappropriate acceptance of assignment or accepting a delegated action beyond the nurse's knowledge and skills
☐ Lack of knowledge
☐ Other (Specify) _____
☐ Clinical reasoning was not a factor

34. If Prevention was a factor in the Practice Breakdown. *Check all that apply*
- ☐ Preventive measure for patient well-being not taken
- ☐ Breach of infection precautions
- ☐ Did not conduct safety checks prior to use of equipment
- ☐ Other (Specify) _____
- ☐ Prevention was not a factor

35. If Intervention was a factor in the Practice Breakdown. *Check all that apply*
- ☐ Did not intervene for patient
- ☐ Did not provide timely intervention
- ☐ Did not provide skillful intervention
- ☐ Intervened on wrong patient
- ☐ Other (Specify) _____
- ☐ Intervention was not a factor

36. If Interpretation of Authorized Provider's Orders was a factor in the Practice Breakdown. *Check all that apply*
- ☐ Did not follow standard protocol / order
- ☐ Missed authorized provider's order
- ☐ Misinterpreted telephone or verbal order
- ☐ Misinterpreted authorized provider handwriting
- ☐ Unauthorized intervention (not ordered by an authorized provider)
- ☐ Undetected authorized provider error resulting in execution of an inappropriate order
- ☐ Other (Specify) _____
- ☐ Interpretation of provider's orders was not a factor

37. If Professional Responsibility / Patient Advocacy was a factor in the Practice Breakdown. *Check all that apply*
- ☐ Breach of confidentiality
- ☐ Boundary crossings / violations
- ☐ Lack of respect for patient / family concerns and dignity
- ☐ Nurse did not recognize limits of own knowledge and experience
- ☐ Nurse attributes responsibility to others
- ☐ Nurse does not refer patient to additional services as needed
- ☐ Nurse fails to advocate for patient safety and clinical stability
- ☐ Patient abandonment
- ☐ Specific patient requests or concerns unattended
- ☐ Other (Specify) _____
- ☐ Professional responsibility/patient advocacy was not a factor

38. Select which Practice Breakdown categories you selected above is most significant (*Primary*)
- ☐ Attentiveness/Surveillance
- ☐ Clinical Reasoning
- ☐ Prevention
- ☐ Intervention
- ☐ Interpretation of provider's orders
- ☐ Professional responsibility / patient advocacy

39. Board of Nursing Outcomes

- ☐ Dismissed, no action
- ☐ Referral to another oversight agency
- ☐ Recommendations to the health care agency involved in the practice breakdown
- ☐ Non-disciplinary action (e.g., letter of concern)
- ☐ Alternative Program – The nurse was given the opportunity to participate in a non-discipline program to address practice and / or impairment concerns
- ☐ Board of Nursing disciplinary action

Provide any additional comments and feedback regarding the TERCAP Instrument:

_____

_____

Report of the Transition to Practice Committee

Background

NCSBN's Transition to Practice Committee members recategorized the Transition to Practice Modules to be more in line with the Institute of Medicine (IOM) competencies and the Quality and Safety Education in Nursing (QSEN) initiative. The modules include patient-centered care, communication and teamwork, evidence-based practice, quality improvement and informatics. Committee members developed objectives, content outlines and interactive exercises, and identified sources for the modules (Attachment A). If the Board of Directors (BOD) approves the Transition to Practice business plan, NCSBN's Interactive Services department will use this document to develop online, interactive modules for the pilot study and those employers who don't develop a transition program that meets NCSBN standards. The module outlines will also be the document employers use when they develop their own transition program to meet NCSBN standards.

Committee members provided input so NCSBN could work with Ground Floor Partners to formulate a business plan to develop the online modules and conduct a multisite pilot study of the Transition to Practice model, which was presented to the BOD. See Attachments C and D for business plan templates for boards of nursing and employers. The committee members also provided feedback to the Transition Advisory Panel, research experts hired by NCSBN to assist with the planning and conduct of the pilot study (Attachment B).

Highlights of FY10 Activities

- Recategorized NCSBN modules to be more in line with national initiatives.
- Developed objectives, content and interactive exercises, and identified sources for the following modules:
  - Patient-centered Care;
  - Communication and Teamwork;
  - Evidence-based Practice;
  - Quality Improvement;
  - Informatics; and
  - Preceptors.
- Collaborated with stakeholders to inform them about, and to gain feedback on, NCSBN's transition model. Over the past two years, the committee members have collaborated with more than 35 stakeholders and policy makers.
- Held a conference call with Susan Boyer of the Vermont Nurse Internship Program (VNIP) for input into the design of the preceptor module.
- Sent the recategorized modules out to NCSBN's membership for information and comment.
- Presented a draft of the module outlines at NCSBN's Midyear Meeting and made revisions based on suggestions.
- Working with consultants, developed a business plan for:
  - NCSBN's module development and conduct of the multisite pilot study;
  - Business plan template for boards of nursing; and
  - Business plan template for employers.

Members

Marcy Echternacht, MS, RN
Nebraska, Area II, Chair

Lanette Anderson, JD, MSN, RN
West Virginia-PN, Area II

Carol Komara, MSN, RN
Kentucky, Area III

Joyce W. Roth, MSN, RN, NE-BC
North Carolina, Area III

Carol Silveira, MS, RN
Massachusetts, Area IV

Carol Reineck, PhD, RN, NEA-BC, FAAN, CENP
American Organization of Nurse Executives, External Member

Pamela McCue, MS, RN
Rhode Island, Area IV,
Board Liaison

Guest Member

Jean Barry, MSN, RN
Director of Regulatory Policy,
Canadian Nurses Association

Staff

Nancy Spector, PhD, RN
Director, Regulatory Innovations

Meeting Dates

- July 8-10, 2009
- Sept. 30-Oct. 2, 2009
- Dec. 3-4, 2009
- Feb. 8, 2010 (Teleconference)

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.

- Developed a research plan, timeline and outcome measures for the Transition Pilot Study through consultation with research experts.
- Met with NCSBN's Marketing and Communications department to develop a logo for the marketing materials (see Attachment E).

Future Activities

- The committee members completed their charges and recommend that NCSBN go forward with developing the modules and conducting the Transition to Practice pilot study.

Attachments

A. NCSBN's Transition to Practice Modules

B. Report of Transition to Practice Advisory Panel

C. Business Plan Template for Boards of Nursing (BONs)

D. Business Plan Template for Employers

E. Transition to Practice Design

Attachment A

NCSBN's Transition to Practice Modules

INTRODUCTION

The goal of NCSBN's Transition to Practice Model is to promote public safety by supporting newly licensed nurses during their critical entry period and progression into practice.

Guiding Principles

- The mission of boards of nursing (BONs) is to protect 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 education levels.
- Regulation criteria for transition programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection.
- Transition program outcomes are consistent with the knowledge, skills and attitudes required for safe and effective provision of nursing care.

Relevant Definitions

Competent—The ability to demonstrate an integration of the knowledge, skills and attitudes 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 occurs 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 newly licensed nurses (registered nurses [RNs] and licensed practical/vocational nurses [LPN/VNs]) designed to support their progression from education to practice.

See NCSBN's Transition to Practice toolkit for further information about the NCSBN model.

CONTENT OF MODULES

The following modules include the objectives, content outlines, suggested exercises and references for the five evidence-based modules that were developed for the Transition to Practice model:

- Communication and Teamwork;
- Patient-centered Care;
- Evidence-based Practice;

- Quality Improvement; and
- Informatics.

In addition, there is a module for preceptor training and some information about how employers can support newly licensed nurses in the last six months of the new graduate's first year in practice. Integrated in the patient-centered care module are ideas for employers to consider for supporting the learning of specialty content. Research has suggested that transition programs are more successful when they provide experiential learning within the specialty where the newly licensed nurse is working. Safety and clinical reasoning were specifically considered when designing all the modules, and have been integrated throughout. Similarly, strategies for providing feedback and opportunities for reflection during the new nurses' first year in practice have been identified.

It has been the vision that NCSBN's Transition to Practice Model is flexible; that is, employing agencies can develop the transition program, incorporating the standards as spelled out in the NCSBN modules. Employers are encouraged to partner with other organizations that hire new nurses or with academic settings in order to develop their own modules. However, since this is a regulatory model that requires new nurses to complete a standardized transition program before they can renew their license after the first year of practice, the online modules will be available so that every newly licensed nurse will have the opportunity to meet this requirement. Similarly, preceptor training is required in this model and there are a number of programs available where preceptors could meet this requirement.

NCSBN's Transition to Practice Model has been designed to promote experiential learning, rather than relearning material that should have been learned in the nursing program. Interactive exercises have been developed to promote this in the face-to-face programs. Further, the online modules will be designed to encourage experiential learning. In these interactive online modules, the new nurses will make decisions, set priorities and choose appropriate pathways using cutting- edge technologies.

The committee members have reviewed pocket-sized texts that new graduates would be able to use during this program. While no firm decisions have been made, *Clinical Coach for Nursing Excellence* by Campbell, Gilbert & Lausten (2010) seems to be general enough that it could be used across settings and education. It was designed for new graduates and has considerable emphasis on patient safety, organization and prioritization, communication and collaboration, delegation, responding to changing patient situations and ethical decision making, all of which are highlighted in NCSBN's model.

All of this material will become part of a manual that will be made available to practice settings, beginning with the participating pilot sites during next year's pilot study.

Transition to Practice Model

REFERENCES

While each module is followed by a list of resources, the following are some general sources that support NCSBN's Transition to Practice Model:

Barton, A. J., Armstrong, G., Preheim, G., Gelmon, S. B., & Andrus, L. C. (2009). A national Delphi to determine developmental progression of quality and safety competencies in nursing education. *Nursing Outlook, 57*, 313-322.

Benner, P. E., Malloch, K., & Sheets, V. (Eds.) (2010). *Nursing pathways for patient safety.* St. Louis, MO: Mosby Elsevier.

Campbell, L., Gilbert, M. A., & Lausten, G. R. (2010). *Clinical coach for nursing excellence.* Philadelphia: F.A. Davis Company.

Cronenwett, L., et al. (2007). Quality and safety education for nurses. *Nursing Outlook, 55*(3), 122-131.

Finkleman, A., & Kenner, C. (2009). *Teaching IOM: Implications of the Institute of Medicine reports for nursing education* (2nd ed.). Silver Spring, MD: ANA.

Greiner, A. C., & Knebel, E. (Eds.) (2003). *Health professions education: A bridge to quality.* Washington, DC: National Academies Press.

Grif Alspach, J. (2000). *Preceptor handbook.* Aliso Viejo, CA: American Association of Critical Care Nurses.

PATIENT-CENTERED CARE

__ Contact Hours

Development and Implementation Guidelines: This module must be tailored so it is consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Considerations for Specialty Care: The evidence supports that newly licensed nurses need experiential learning in the practice areas where they are employed. The focus will be on specific populations, practice settings and specialty competencies. This experiential learning must be provided by the employer.

Tips for agency support when incorporating specialty content: (a) consider development of partnerships between facilities, nursing programs, etc.; and (b) consider using specialty organization resources, online continuing education (CE) programs, etc.

In order to understand specialty care, it is recommended that the new nurse:

1. Interact with key individuals in specialty area;
2. Meet with the interprofessional team to include the nurse administrator and charge nurse; and
3. Review national standards, state requirements, and agency-specific policies and procedures as related to the specialty.

Learning Objectives

1. Appreciate the multiple dimensions of patient-centered care.
    a. Patient, family, community.
    b. Consider values and preferences.
    c. Consider cultural, ethnic, social and religious backgrounds.
    d. Examine how quality, safety and health care costs can be improved with involvement of patients and families.
    e. Consider ethical and legal implications of care.
2. Advocate for the patient.
    a. Put the patient first.
    b. Teach and learn principles for patient-centered care.
    c. Understand that the nurse is the patient's last line of defense.
    d. Reflect on ways nurses advocate for patients.
3. Make sound decisions when caring for patients, based on recognition and validation of relevant patient data.
    a. Consider ways of looking at a clinical issue, utilizing:
        i. Basic natural and social sciences, including pathophysiology and psychopathology;
        ii. Ethical decision-making framework;
        iii. Reflective thinking, contemplation and deliberation; and
        iv. Policies, procedures, clinical standards, protocols, pathways and guidelines.
    b. Incorporate the following actions when making sound clinical decisions:
        i. Systematically gather, retrieve and weigh relevance of multiple types of data (e.g.,

signs and symptoms; diagnostic testing; laboratory results);

ii. Identify missing data;

iii. Distinguish relevant from irrelevant data;

iv. Organize and interpret clinical cues;

v. Define patient/client health problem(s);

vi. Recognize desired outcomes; and

vii. Identify specifics related to patient populations/settings:

- Patient teaching;
- Patient data collection and/or assessment;
- Common diagnoses;
- Common medications;
- Common procedures;
- Policies, procedures, practice standards, protocols, pathways and clinical guidelines applicable to the practice setting;
- Setting, age and cultural competencies;
- Safety and quality-improvement initiatives;
- Key members and roles of the interprofessional team;
- Evidence-based practice in specialty area;
- Continuity of care considerations;
- Emergency/code response; and
- End of life.

c. Recognize changes in patient status, including imminent threats to patient/client safety, and intervene appropriately.

i. Document and communicate/notify (substantiate decision making).

4. Anticipate patient/client outcomes based on timely analysis of individual responses to nursing interventions.

a. Use clinical data sources (technology/information systems).

b. See the unexpected; that is, recognize that not all cases look the same.

c. Detect signs that a particular patient is not like most people and thus, may not be helped or may even be harmed by following standard protocols.

d. Ask "Why?" and "Why not?"

e. Identify patterns, trends and red flags specific to patient populations and settings.

f. Understand and anticipate risks.

g. Recognize complications of treatments and procedures and intervene appropriately.

h. Know when and how to call the patient's health care provider.

i. Phone orders

ii. Rapid response teams, when available

5. Prioritize patient care.
    a. Review the levels of priority ranking for patient needs:
        i. First order priority need—immediate threat to health, safety or survival;
        ii. Second order priority need—actual problem for which immediate help has been requested by the client or family;
        iii. Third order priority need—actual or potential issue that the client or family is not aware of; and
        iv. Fourth order priority need—actual or potential issue that is anticipated in the future and for which help will be needed.
    b. Recognize and discuss the "priority-setting traps" (Vaccaro, 2001):
        i. "Path of least resistance";
        ii. "Squeaky wheel";
        iii. "Whatever hits first"; and
        iv. "Default."
    c. Demonstrate sound clinical reasoning when deciding what activities should take priority depending upon client situations, based on safety, quality and systems considerations:
        i. Understand one's own power, accountability and responsibility in the process of prioritizing/organizing nursing care;
        ii. Determine the short- and long-term goals for the patient/client;
        iii. Ask "Is the task/activity important?" and "Does the activity/task need to be done right now?";
        iv. Assess one's own skill level;
        v. Assess the availability of resources, including assistance from other more experienced staff;
        vi. Recognize the need to delegate tasks to others appropriately;
        vii. Assess patient's/client's needs and preferences at the time of decision making;
        viii. Recognize the need to evaluate and potentially change the priority/order in which tasks are to be done;
        ix. Keep track of multiple responsibilities; and
        x. Consider patient and system costs, and analyze ways to decrease them.
    d. Manage self with respect to time, while at the same time incorporating patient safety standards:
        i. Understand the importance of safety, while attempting to achieve efficiency in prioritizing/organizing client care;
        ii. Allow time for planning care including establishing priorities;
        iii. Eliminate time wasters; i.e., group activities together that are in the same location, gather all needed supplies before beginning an activity, etc.;
        iv. Eliminate interruptions, if at all possible;
        v. Delegate appropriately; and

vi. Assess/personally reflect on organizational skills (e.g., how and why time is wasted, what is the best time of day to work, considering safety standards, etc.) and seek feedback on how to improve.

6. Evaluate effectiveness of patient-centered care.
   a. Utilize strategies for prioritizing and analyzing data.
   b. Be mindful when caring for patients.
   c. Seek and use constructive feedback.
   d. Consider factors affecting clinical reasoning and patient safety (e.g., anxiety, stress, fatigue, environmental distractions, personal factors, ethical dilemmas).
   e. Analyze strategies to enhance efficiency of the system:
      i. Demonstrate knowledge of the nursing service delivery patterns and systems in the facility or organization;
      ii. Recognize that nursing is one part of a larger environment;
      iii. Understand the types of nursing care delivery methods (e.g., team nursing, primary nursing, case management, etc.) that are utilized at the facility; and
      iv. Know how the facility uses information and technology in client care.
7. Maintain professional boundaries with patients and key parties (see NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules, Article XI). Understand the following:
   a. Principles of professional boundaries;
   b. Professional boundary crossings;
   c. Professional boundary violations; and
   d. Cautions with disseminating patient information via Internet/cell phone cameras.

Interactive Exercises

1. Journal to focus your thinking and reflect on what you did (or did not do), why you did it and what you could do differently in daily patient/client care situations.
2. Think aloud with preceptor(s) and/or experienced staff to develop questioning skills at higher cognitive levels of analysis (e.g., compare, discriminate, examine), synthesis (e.g., perform, propose, organize) and evaluation (e.g., prioritize, rank) to increase knowledge and understanding of complex patient/client situations commonly found on unit.
3. Think aloud with preceptor(s) and/or experienced unit nursing staff using each of the steps of the nursing process to work through a complex patient/client situation.
4. Think aloud with preceptor(s) and/or experienced unit nursing staff to examine actions that result in adverse events or undesirable patient/client outcomes.
5. Think about and discuss with preceptor: "What evidence do you have or need to collect to determine the effectiveness of your intervention?"
6. Using case studies corresponding to the clinical focus of the unit, develop written responses addressing pathophysiology related to the case; selection of rapid baseline assessment priorities; clinical judgments with validation and potential alternatives; and nursing interventions. Prioritize and provide rationales to substantiate decisions.
7. Using the case study, critique strength and relevance of how available evidence influences choice of interventions.

8. Simulate learning activities: administer medications to 10 or more patients; provide direct care to more that two patients; rehearse with preceptor(s) how and when to call physician with change in patient/client status; high acuity, less frequent vignettes (Beyea et al., 2007).
9. Reflect upon a near-miss situation that you were involved in and think about what you might have done differently. Seek feedback from your preceptor on the situation and consider alternative ways you might have responded. Consider how patient safety might have been adversely affected if you only had considered your efficiency.
10. Use a priority grid to help prioritize activities. Ask whether the activity is important and urgent, and place it on the grid in the appropriate space. Practice with activities such as giving a shift report ordering a routine medication from the pharmacy for a client, talking to a client's family who has a complaint about a nurse, etc.

Important		**Yes**	**No**
	Yes	**A**	**C**
	No	**B**	**D**

Urgent

11. Make a list of time wasters that you experience during a shift. Include both internal (procrastination, poor planning, etc.) and external (e.g., phone calls, paperwork, socializing, etc.)
12. Make a to-do list at the beginning of your shift, estimating the time that specific tasks/activities will take. Reevaluate it at the end of the shift to determine your effectiveness and efficiency of prioritizing and organizing. What could you have done differently?
13. Reflect upon a day when you felt disorganized or overwhelmed and think about what you might have done differently. Seek feedback from your preceptor on the situation and consider alternative ways you might have responded. Consider how patient safety might have been adversely affected if you only had considered your efficiency.
14. Examine relationships that you have built and reflect on how they have helped you in safely managing care in difficult situations.
15. Develop a teaching plan for your patient with feedback from your preceptor.
16. View NCSBN's "Crossing the Line" videos and reflect, with your preceptor, on boundary crossings/violations that could occur where you work. Particularly talk about the implications of today's society of information disclosure (i.e., via cell phone cameras, social networking, blogging, Internet forum postings, etc.) related to patient boundaries and confidentiality.

Suggested References

Ashcraft, A. S. (2004). Differentiating between pre-arrest and failure-to-rescue. *Medsurg Nursing, 13*(4), 211-216.

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

Beyea, S. C., von Reyn, L., & Slattery, M. J. (2007). A nurse residency program for competency development using patient simulation. *Journal for Nurses in Staff Development, 23*(2), 77-82.

Del Bueno, D. (2005). A crisis in critical thinking. *Nursing Education Perspectives, 26*(5), 278-282.

LaCharity, L., Bartz, B., & Kumagai, C. K. (2005). *Prioritization, delegation, and assignment: Practice exercises for medical-surgical nursing.* St. Louis, MO: Elsevier.

Oberleitner, M. G. (n.d). *Responding in writing to clinical cases: The development of clinical reasoning in nursing.* Retrieved June 16, 2010, from http://wac.colostate.edu/llad/v5n1/oberleitner.pdf

Orsolini-Hain, L., & Malone, R. E. (2007). Examining the impending gap in clinical nursing expertise. *Policy, Politics, & Nursing Practice, 8*(3), 158-169.

Simmons, B., Lanuza, D., Fonteyn, M., Hicks, F., & Holm, K. (2003). Clinical reasoning in experienced nurses. *Western Journal of Nursing Research, 25*(6), 701-719.

University of New Mexico College of Nursing. (n.d). *What is critical thinking?* Retrieved June 16, 2010, from http://hsc.unm.edu/consg/critical/what_ct.shtml

Vaccaro, P. J. (2001). Five priority-setting traps. *Family Practice Management, 8*(4), 60.

Virginia Board of Nursing. (2009). Guidance Document #90-24: The use of simulation in nursing education. Retrieved June 16, 2010, from http://www.dhp.state.va.us/nursing/guidelines/90-24_Patient%20Simulation.doc

COMMUNICATION AND TEAMWORK MODULE

__ Contact Hours

Development and Implementation Guidelines: This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Learning Objectives

Upon completion of the Communication Module, the licensed nurse will be able to:

1. Determine strategies for socializing to the organization.
    a. Recognize that the NCSBN's Transition to Practice Model occurs during the first year of practice and assumes a separate orientation; understand that orientation is the process of introducing staff to the philosophy, goals, policies, procedures, role expectations and other factors needed in a specific work setting. Orientation occurs for new employees and when changes in nurses' roles, responsibilities and practice settings occur; therefore, as nurses progress in their professions, they may have many orientations.
    b. Make the transition from student to licensed, accountable nurse.
    c. Understand a healthy work environment, where there is mutual respect and collaboration and where each team member is valued and has a voice in patient-centered care.
    d. Know the role of newly licensed nurses and how they fit into the organization.
    e. Know manager/supervisor expectations.
    f. Understand interpersonal dynamics and expectations of immediate co-workers and colleagues in other work areas. Identify and seek out resources/social support systems in institutions.
    g. Recognize and respond to negative behaviors that impact clinical practice.
    h. Expect the culture to be that nurses should ask for assistance whenever questions arise.
    i. Evaluate the importance of role socialization as a key strategy for supporting high standards of nursing practice.
    j. Participate in shared (team) decision making, evidence-based practice and quality improvement group dynamics of the work environment.
    k. Clarify roles and perceptions of health care team members.

l. Develop communication techniques for approaching experienced co-workers and other essential members of the health care team.

2. Evaluate personal effectiveness when communicating with co-workers, preceptors, supervisors and members of the interprofessional team.
   a. Self-reflection.
   b. Know thyself (strengths/limitations).
   c. Know own biases and stereotypes.
   d. Know nonverbal cues.
   e. Examine the ability to give and receive constructive feedback regarding performance expectations.
   f. Understand the perception of feedback.
   g. Foster assertiveness.
   h. Understand factors affecting clinical reasoning and patient safety (e.g., anxiety, stress, fatigue, environmental distractions, personal factors, ethical dilemmas)
3. Demonstrate the ability to clearly communicate and collaborate with the interprofessional team to ensure quality care and patient safety.
   a. Hand-offs (transfer of care).
   b. Use SBAR (Situation, Background, Assessment and Recommendation) for reports.
   c. Use of other TeamSTEPPS (Team Strategies and Tool to Enhance Performance and Patient Safety) strategies:
      i. Two-challenge rule (voice concerns at least twice to assure being heard);
      ii. CUS (I am concerned; I am uncomfortable; this is a safety issue!);
      iii. Call-out (e.g., "Airway status?"); and
      iv. Check-back (double check messages received).
   d. Understand the diverse perspectives of the health care team (Garman, Leach & Spector, 2006).
   e. Learn team-building concepts.
   f. Understand group dynamics.
   g. Know documentation procedures.
4. Use clear and concise communication in the delegation process.
   a. Utilize the delegation decision-making process safely and effectively.
      i. Recognize that there is both individual and organizational accountability for delegation:
         - Nursing employers need to recognize that a newly licensed nurse is a novice who is still acquiring foundational knowledge and skills. In addition, many nurses lack the knowledge, skill and confidence to delegate effectively, so ongoing opportunities to enforce the theory and apply the principles of delegation are an essential part of employment orientation and staff development, as well as topics for continuing education offerings, mentoring opportunities and other continued competence strategies (NCSBN, 2005).
         - Appropriately assign care
   b. Know key concepts and steps of the delegation decision-making process.

c. Definitions:

i. Assignment—Describes the distribution of work that each staff member is to accomplish on a given shift or work period (NCSBN, 2005).

ii. Delegation—Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation (NCSBN, 2005).

iii. Supervision—Provision of guidance or direction, oversight, evaluation and follow-up by the licensed nurse for the accomplishment of a nursing task delegated to nursing assistive personnel.

- Direct supervision involves the presence of the licensed nurse who is working with other nurses and/or nursing assistive personnel to observe and direct the assistant's activities. The proximity of this supervision is such that immediate intervention is possible if problems occur.
- Indirect supervision occurs when the licensed nurse is not present and supervision is provided by other-than-direct observation of the nurses and/or nursing assistive personnel. The absence of proximity of the licensed nurse requires processes being in place for the direction, guidance, support and monitoring of the LPN or nursing assistive personnel activities (NCSBN, 2005).

iv. Surveillance and monitoring—The process of observing and staying attuned to client status and staff performance (NCSBN, 2005).

v. Unlicensed assistive personnel—Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated (NCSBN Model Nursing Practice Act and Model Nursing Adminstrative Rules).

d. Understand the steps of delegation (NCSBN, 2005):

i. Assess and plan;

ii. Communication;

iii. Surveillance and supervision; and

iv. Evaluation and feedback.

e. Learn the delegation decision tree:

i. Practice pervasive functions of assessment, planning, evaluation and nursing judgment, which cannot be delegated;

ii. Consider the patient's needs/status/acuity;

iii. When competencies have been established, tasks can be delegated; and

iv. Refer to NCSBN's delegation decision tree.

5. Differentiate between the RN and LPN/VN scope of practice related to delegation, according to your state/jurisdiction.

a. Know the nurse practice act, and rules and regulations:

i. Accountability;

ii. Assignment;

iii. Delegation;

iv. Supervision;

v. What can and cannot be delegated according to the nurse practice act and rules and regulations (some states/jurisdictions delineate areas where RNs and LPNs/VNs cannot delegate);

vi. Review and understand the scope of practice of RNs versus LPN/VNs; and

vii. Review the state/jurisdiction definition of unlicensed personnel, where available.

b. Review policies and procedures (institutional level).

6. Discuss situations in which the nurse should not delegate.
   a. Does not have the authority to intervene and take corrective action if needed.
   b. Has never performed the activity to be performed.
   c. Does not have the opportunity to provide effective monitoring.
   d. Staffing adequacy for supervision.
   e. Would not be able to intervene if there were a problem.
   f. Accepting assignment to supervise the unlicensed assistive personnel (NCSBN, 2005).
7. Examine strategies to improve team functioning within the system.
   a. Understand team functioning and how it affects safety and quality.
   b. Reflectively think, contemplate and deliberate when working with the team.
   c. Utilize effective communication techniques in challenging situations.
   d. Develop action plans to address performance deficiencies and rectify problematic situations.
   e. Learn conflict resolution techniques.
   f. Learn problem-solving skills.
   g. Develop decision-making skills.
   h. Appreciate differences in communication styles.
   i. Know how to respond assertively when feedback is perceived to be negative or inaccurate.
   j. Understand high-risk behavior.
   k. Examine end-of-life situations.
8. Discuss professional development opportunities within the work setting, as well as outside nursing organizations:
   a. Agency staff development offerings;
   b. In-house offerings, such as Clinical Ladder;
   c. CE offerings;
   d. State and national professional organizational offerings/opportunities;
   e. Specialty organizations;
   f. Other consultation and resources; and
   g. BON open session meetings.

Interactive Exercises

1. Communicating with preceptors:
   a. Make an appointment with your preceptor(s) to openly and honestly discuss your clinical performance.
   b. Devise a way to address and correct deficiencies that were identified in this discussion with your preceptor(s).

c. How would you handle the preceptor's critical appraisal of your performance if you believe the unfavorable criticism is not accurate?

d. What steps would you take if you believe your professional development needs are not being met/adequately addressed by your preceptor?

e. How would you propose a change of preceptors?

2. Communicating with your supervisor:

a. Schedule an appointment (10-15 minutes) to meet with your nursing supervisor who is responsible for reviewing your performance.

b. Clarify with your supervisor how your performance will be evaluated, by whom and how often.

c. Request a copy of the performance evaluation tool that will be used to appraise your performance. Seek clarification so performance expectations are clearly understood prior to the actual evaluation.

d. Rehearse how you would begin discussion of your clinical performance to date, including examination of areas in which you feel confident/competent as well as areas in which skill development/performance improvement is needed.

e. Develop written goals. Design a plan with your supervisor to facilitate your continued skill development and monitor your performance.

3. Interprofessional communication:

a. Introduce yourself to key team members, such as physicians, occupational therapists, physical therapists, respiratory therapists and laboratory personnel. Find out what led each person to enter their chosen profession and what they enjoy the most about their professional work.

b. Contact a physician to report your focused assessment findings that reflect a change of patient condition. Reflect on the effectiveness of your communication and patient care/advocacy outcomes.

c. Problem solve how to handle a situation involving a physician who is not responding to an emergent patient situation that you have assessed as needing an immediate response (e.g., physician refuses to come in to do a face-to-face assessment of patient; physician not willing to make a referral to a specialist).

d. Describe a challenging person/department in your workplace. What are some of the problems you have encountered when working with this person/department? What factors would you change if you could? Can you identify a possible solution to this situation? What resources are available to help you handle this situation? What, if anything, have you tried to do to handle this situation? Devise a plan of action to try to resolve this situation.

4. Communicating effectively when assigning and delegating patient care:

a. What information would you give to an unlicensed assistive staff member who has floated to your unit where she will be assigned to provide one-on-one monitoring of a suicidal patient?

b. Rehearse giving directions to this unlicensed staff member regarding:

i. Environmental considerations (i.e., no sharp items, no belts, no metal silverware, etc.) to ensure patient safety; and

ii. Physical proximity requirements (i.e., no more than an arm's length away from the patient) when providing one-on-one monitoring of a patient who is on suicide precautions.

c. What information do you expect this unlicensed staff member to report to you immediately?

d. What information do you need from this staff member prior to the change of shift?

e. What support do you anticipate this unlicensed staff member will need to safely and effectively carry out the one-on-one patient care assignment?

f. What are the supervisory expectations of you, as a charge nurse, in this situation?

g. How would you respond if you found the suicidal patient unattended, taking a shower with a razor and shaving cream left in the bathroom, while the unlicensed staff member was reading the newspaper in the staff break room?

5. Analyze a patient safety vignette. Go through a root cause analysis and describe what went wrong and why. How could it have been prevented? What is the accountability of the new nurse?
6. Use the TeamSTEPPS strategies with your preceptor's feedback.
7. Give report using SBAR.
8. Interactive exercises related to delegation:
   a. View NCSBN video clips.
   b. Discuss a scenario where the organization does not have adequate staffing for the new nurse to delegate. This will incorporate safety, systems and assertiveness (communication) issues.
   c. Delegation exercise: Complete the following, indicating which scenarios can be delegated to an LPN/VN or unlicensed assistive personnel. The computer will alert the new graduate to variances across states/jurisdictions or clinical situations.
9. Interactive exercises related to socialization to the role:

Procedure	Personnel to whom it can be delegated
▪ Stocking of supplies ▪ Feeding a patient with a recent cerebral vascular accident (CVA) ▪ Suctioning a tracheostomy ▪ Providing transportation to an eye clinic ▪ Providing transport to ICU for status change ▪ Administering a Fleet enema ▪ Teaching a diabetic patient about diet and exercise ▪ Assisting physician with a central line insertion ▪ Ambulating a first-day postoperative patient ▪ Taking routine postoperative vital signs ▪ Clarifying physician orders ▪ Preoperative teaching ▪ Administering tube feedings ▪ Bathing a patient with dyspnea	

a. Socialization is best facilitated when the new nurse feels a part of the group. Based on your entry into practice, reflect on the differences of being a licensed, accountable nurse versus a student nurse. Identify quality-improvement teams and how you might participate.

b. Identify evidence-based practice initiatives and how you might participate.

c. Identify who you might contact for questions that might arise.

d. Identify your team members and strategies on how to become an effective team member.

e. All work environments have unwritten rules of expectations for performance. A new nurse may feel isolated if he/she doesn't know them and may experience failure for not recognizing the need to gradually be acclimated to the work setting. As that new nurse, what kinds of questions could you ask to find out these unwritten expectations?

f. How would you handle these situations?

   i. Some physicians want nurses to round with them and plan for specific times to have that done. What steps could you take to make sure this is communicated and incorporated during the plan of care?

   ii. Assignments may seem strange. For instance, if Jane Doe is a seasoned nurse on a 15-bed unit and she is just rehabilitating from knee surgery, how would you respond to the situation when other nurses gripe unnecessarily that Jane's assignment has all of the patients in the front hall?

g. Describe how you would handle the following scenario and with whom would you discuss the problem:

   Your preceptor, Julie, continues to hover when you administer medication. She believes you are slow. What can you do to improve and meet her expectations for patient safety? What are the institutional policies related to timely medication administration? Write a plan for improvement, identifying some personal and/or other barriers.

h. Plan a meeting with your manager/supervisor and review the job description, competency checklists and the agency's organizational chart.

i. Describe and discuss with your preceptor the adjustment you have had with your personal and professional role balance. Would you relate any of it to "reality shock"?

j. Attend a staff development offering, complete a continuing education session or participate in a professional development opportunity.

Suggested References

Agency for Healthcare Research and Quality. (n.d). TeamSTEPPS®: National implementation. Retrieved June 16, 2010, from from http://teamstepps.ahrq.gov

Bittner, N. P., & Gravlin, G. (2009). Critical thinking, delegation, and missed care in nursing practice. *JONA, 39*(3), 142-146.

Boychuck-Duschler, J., & Myrick, F. (2008). The prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum, 43*(4), 191-206.

Clynes, M. P., & Rafferty, S. E. C. (2008). Feedback: An essential element of student learning in clinical practice. *Nursing Education in Practice, 8*, 405-411.

Edwards, H., & Chapman, H. (2004). Caregiver-carereceiver communication part 2: Overcoming the influence of stereotypical role expectations. *Quality in Ageing, 5*(3), 3-12.

Fallowfield, L., & Jenkins, V. (2004). Communicating sad, bad, and difficult news in medicine.

The Lancet, 363, 312-319.

Garman, A., Leach, D., & Spector, N. (2006). Worldviews in collision: Conflict and collaboration across professional lines. *Journal of Organizational Behavior. 27*, 1-21.

Goodman, G. R. (2004). How can nurses help patients to work more effectively with nurses to improve the safety of patient care? *Nursing Economics, 22(*2), 100-102, 70.

Jones, J. H. (2007). Patient illiteracy. *AORN Journal, 85*(5), 951-955.

Ladden, M. D., Bednash, G., Stevens, D. P., & Moore, G. T. (2006). Educating interprofessional learners for quality, safety and systems improvement. *Journal of Interprofessional Care, 20*(5), 497-505.

McKay, C.A., & Crippen, L. (2008). Collaboration through clinical integration. *Nursing Administration Quarterly, 32*(2), 109-116.

NCSBN. (2005). Working with others: A position paper. Retrieved June 16, 2010, from https://www.ncsbn.org/Working_with_Others.pdf

Norcini, J. (2010). The power of feedback. *Medical Education, 44*, 16-17.

O'Rourke, M. W. (2006). Beyond rhetoric to role accountability: A practical and professional model of practice. *Nurse Leader*, *4*(3), June, 28-33.

Peternelj-Taylor, C. A., & Yonge, O. (2003). Exploring boundaries in the nurse-client relationship: Professional roles and responsibilities. *Perspectives in Psychiatric Care, 39*(2), 55-66.

Sheets, V. R. (2000). Staying in the lines. *Nursing Management*, *31*(8), *29*-33.

Spector, N. (2009). Interprofessional collaboration: A nursing perspective. In Freshman, B., Rubino, L., & Reid-Chassiakos, Y. (Eds.). In *Collaboration across the disciplines in health care* (pp.106-132). Sudbury, MA: Jones & Bartlett Publishers.

Thompson, P., & Stanowski, A. (2009). Maximizing nursing productivity: The benefits of improved collaboration between nursing and support services. *Healthcare Financial Management, 63,* 76-85.

Thompson, S. A., & Tilden, V. P. (2009). Embracing quality and safety education for the 21st century: Building interprofessional education. *Journal of Nursing Education*, *48*(12), 698-701.

Vahabi, M. (2007). The impact of health communication on health-related decision making: A review of evidence. *Health Education, 107*(1), 27-41.

EVIDENCE-BASED PRACTICE MODULE

___ Contact hours

Development and Implementation Guidelines: This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Learning Objectives

1. Define evidence-based practice.
    a. Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.
        i. Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values (Sackett, Straus, Richardson, Rosenberg & Haynes, 2000).
2. Utilize various databases to locate relevant evidence to support practice (RNs only; LPN/VNs participate in using evidence-based protocols under supervision of RNs):
    a. CDSR (Cochrane Database of Systematic Reviews);
    b. CINAHL;

c. ERIC (Education Resources Information Center);

d. Google Scholar has free search strategies;

e. MEDLINE;

f. NGC (National Guidelines Clearinghouse);

g. OVID;

h. PsycINFO; and

i. PubMed.

3. Participate in critiquing research, noting the strength of the evidence presented (RNs only; LPN/VNs participate by utilizing practice guidelines).

   a. With assistance and existing standards, critically appraise original research reports and practice guidelines (RNs only).

   b. Consider the strength of evidence (e.g., the hierarchy of evidence: meta-analysis of randomized clinical trials, one well-designed randomized trial, well-designed clinical trials without randomization, well-conducted systematic review, well-conducted non-experimental studies) (RNs only).

   c. Lower levels of evidence by scrutinizing closely (e.g., poorly controlled or uncontrolled studies; conflicting evidence, consensus reports or published practice guidelines; qualitative studies, including meta-analysis of qualitative data; opinions from experts in the field; and clinical expertise, intuition and anecdote practice guideline evaluation criteria) (RNs only).

4. Evaluate practice changes that are needed or have occurred within the institution based on the evidence. For LPNs/VNs, identify practice gaps and share with preceptors or nurse manager.

   a. Compare actual practice with evidence-based recommendations.

   b. What needs to change or has changed since being hired?

   c. If a change needs to be made, consider who needs to make the change.

   d. What are/were the intended outcomes of the proposed change/or the change that has occurred?

   e. Participate in identifying relevant resources that support practice changes, such as:

      i. Systematic reviews;

      ii. Meta-analyses; and

      iii. Practice guidelines.

5. Identify evidence-based implementation models (RNs only):

   a. Disciplined Clinical Inquiry (DCI) Model offers a pathway to integrate evidence-based practice into organizational and individual performance (Sanares et al., 2009);

   b. Iowa Model of Evidence-Based Practice and Research Utilization (Titler, 2006, 2008);

   c. Academic Center for Evidence-Based Practice (ACE) Model bridges research into practice with the ultimate goal of improving care, patient outcomes and patient safety (http://www.acestar.uthsca.edu/learn_model.htm);

   d. Melnyk's five steps: (1) ask burning question in PICO (population, intervention,

comparison, outcome) format; (2) collect relevant best evidence; (3) critical appraisal; (4) integrate evidence with clinical expertise and patient values; and (5) evaluate the change (Melnyk & Fineout-Overholt, 2005); and

e. Johns Hopkins Nursing Evidence-Based Practice (EBP) Model and Guidelines' goal is to promote effective nursing interventions, efficient care and improved outcomes for patients, and provide the best available evidence for clinical, administrative and educational decision making (Newhouse et al., 2007).

6. Work with the team to utilize evidence-based strategies to implement evidence-based health care improvements.
   a. Examples of strategies include:
      i. Conferences—Participation of health care providers in conferences, lectures, workshops or traineeships.
      ii. Local consensus process—Inclusion of participating providers in discussion to ensure that they agree that the chosen clinical problem is important and the approach to managing the problem (i.e., the clinical practice guideline or definition of adequate care) is appropriate. The consensus process might also address the design of an intervention to improve performance.
      iii. Educational outreach visits—Use of a trained person who meets with providers in their practice settings to provide information with the intent of changing the provider's performance. The information given may include feedback on the provider's performance.
      iv. Local opinion leaders—Use of providers nominated by their colleagues as educationally influential. The investigators must explicitly state that the opinion leaders were identified by their colleagues.
      v. Patient-mediated interventions—Any intervention aimed at changing the performance of health care providers where specific information was sought from or given to patients, e.g., direct mailings to patients; patient counseling delivered by someone other than the targeted providers; clinical information collected from patients by others and given to the provider; educational materials given to patients or placed in waiting rooms.
      vi. Audit and feedback—Any summary of clinical performance over a specified period of time. Summarized information may include the average number of diagnostic tests ordered, the average cost per test or per patient, the average number of prescriptions written, the proportion of times a desired clinical action was taken, etc. The summary may also include recommendations for clinical care. The information may be given in a written or verbal format.
      vii. Reminders (manual or computerized)—Any intervention that prompts the health care provider to perform a specific clinical action.
      viii. Marketing—Use of personal interviewing, group discussion (focus groups), or a survey of targeted providers to identify barriers to change and the subsequent design of an intervention that addresses these barriers.
      ix. Multifaceted interventions—Any intervention that includes two or more of the above.
   b. Strategies that are generally effective include educational outreach (for prescribing

behavior) and reminders.

c. Multifaceted interventions based on assessment of potential barriers to change are more likely to be effective than single interventions.

Interactive Exercises

1. Review textbooks on evidence-based practice (see reference list). Complete online tutorial on EBP at http://www.biomed.lib.umn.edu/learn/ebp. Topics include key steps of EBP, hierarchy of evidence, finding the evidence, critiquing evidence, summarizing evidence, applying evidence and communicating evidence.
2. Determine a topic of interest to you and choose something you need more knowledge about. Go onto a computer (the library, on the unit, etc.) where databases are accessible. Search your topic and print at least one related article.
   a. Read the articles. Search http://www.ahrq.gov for any related clinical practice guidelines.
   b. Classify the article using a recognized evidence hierarchy tool.
   c. Access a variety of models, such as the Johns Hopkins Nursing EBP Model and Guidelines; the ACE Star Model of EBP; the DCI model; the Iowa Model of Evidence-based Practice and Research Utilization; or Melnyk's Five Steps of Evidence-based Practice.
   d. Summarize findings.
3. Discuss with colleagues actual practice changes within your institution based on the evidence.

   Example: Discontinuing the use of heparin in IV reservoirs/locks and changing to saline, which improved patient safety and lowered costs

   Example: Evidence driven Magnet Status for health care organizations.
4. Work in a group, depending on your setting, and determine a clinical problem/situation that you feel could be improved. Research the literature on the topic, formulate a synthesis/summary of findings, design an EBP protocol and implementation plan, and communicate findings to nursing management (See Heye & Stevens, 2009, for an excellent example).

   Suggested topics could include: smoking cessation; pain; prevention of gastric irritation during chemotherapy; patient education after various procedures like colonoscopy, pacemaker insertion or gastric bypass; fall prevention; restraint use; high-risk medication administration; etc.
5. Identify an actual clinical problem and suggest a practice change based on the gap between actual practice and evidence-based practice (for RNs or LPNs/VNs).
   a. Consider what really bothers you or what changes are needed.
   b. Consider who needs to work with you on this project:
      i. Review communications and teamwork module on problem solving/decision making; and
      ii. Reflect on the differences between the participation of the LPN/VN versus RN.

Suggested References

Agency for Healthcare Research and Quality. (2008). *Will it work here? A decisionmaker's guide to adopting innovations.* Retrieved October 19, 2009, from http://www.innovations.ahrq.gov/resources/InnovationAdoptionGuide.pdf

Evans, D. (2003). Hierarchy of evidence: A framework for ranking evidence evaluating healthcare interventions. *Journal of Clinical Nursing, 12*, 77-84.

Farquhar, C. M., Stryer, D., & Slutsky, J. (2002). Translating research into practice: The future ahead. *International Journal for Quality in Health Care, 14*(3), 233-249.

Grimshaw, J., et al. (2001). Changing provider behavior: An overview of systematic reviews of interventions to promote implementation of research findings by healthcare professionals. In Haines, A., & Silagy, C. (Eds.), *Evidence-based practice in primary health care*. London: BMJ Books.

Heye, M., & Stevens, K. (2009). Using new resources to teach evidence-based practice. *Journal of Nursing Education, 48*(6), 334-339.

Melnyk, B., & Fineout-Overholt, E. (2005). *Evidence-based practice in nursing & healthcare: A guide to best practice*. Philadelphia, PA: Lippincott Williams & Wilkins.

Newhouse, R., Dearholt, S., Poe, S., Pugh, L., & White, K. (2007). *Johns Hopkins Nursing evidence-based practice model and guidelines*. Indianapolis, IN: Sigma Theta Tau International.

Polit, D., & Beck, C. (2009). *Essentials of nursing research: Appraising evidence for nursing practice*, 7th ed. Philadelphia: Lippincott Williams & Wilkins.

Rogers, J. L. (2009). Transferring research into practice: An integrative review. *Clinical Nurse Specialist, 23*(4), 192-199.

Royal Nurses Association of Ontario. (2002). *Toolkit: Implementation of clinical practice guidelines*. Toronto: Registered Nurses Association of Ontario. Retrieved October 19, 2009, from http://www.rnao.org/Storage/12/668_BPG_Toolkit.pdf

Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence-based medicine: How to practice and teach EBM*. London: Churchill Livingstone.

Sanares-Carreon, D., Waters, P. J., & Heliker, D. (2009). A framework for nursing clinical inquiry: Pathway toward evidence-based practice. In Malloch, K., & Porter-O'Grady, T. (Eds.), *Introduction to evidence-based practice in nursing and health care* (275-299). Sudbury, MA: Jones & Bartlett Publishers.

Sigma Theta Tau International. (2005). Evidence-based nursing position statement. Retrieved August 13, 2009, from http://www.nursingsociety.org/aboutus/positionpapers/pages/ebn_positionpaper.aspx

Stevens, K. (2009). ACE: Learn about EBP. Retrieved August 22, 2009, from http://www.acestar.uthscsa.edu/Learn_Model.htm

Titler, M. G. (2006). Developing an evidence-based practice. In LoBiondo-Wood, G., & Haber, J. (Eds.). *Nursing research: Methods and critical appraisal for evidence-based practice*. St. Louis, MO: Mosby Elsevier.

Titler, M. (2008). The evidence for evidence-based practice implementation. In Hughes, R.G. (Ed.). *Patient safety and quality: An evidence-based handbook for nurses*. AHRQ Publication No. 08-0043. Retrieved June 16, 2010, from http://www.ahrq.gov/qual/nurseshdbk/

Online Tutorials

"Welcome to Evidence-Based Practice: An Interprofessional Tutorial" at http://www.biomed.lib.umn.edu/learn/ebp

ARHQ Innovations Web site: http://www.innovations.ahrq.gov

Online References

Healthlinks/University of Washington at http://healthlinks.washington.edu/ebp

American Psychiatric Association Practice Guidelines at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm

Cochrane Collaboration Reviews: http://www.cochrane.org/reviews

QUALITY IMPROVEMENT MODULE

___ Contact hours

Development and Implementation Guidelines: This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Learning Objectives

Upon completion of the Quality Improvement Module, the licensed nurse will be able to:

1. Use available data to identify and prioritize health care improvement or practice gap opportunities. Such data may include, but are not limited to:
    a. Prevention guidelines or process-outcome measures;
    b. Condition-management guidelines or process-outcome measures;
    c. Sentinel event root-cause analyses;
    d. Reason's Swiss Cheese Model (http://patientsafetyed.duhs.duke.edu/module_e/swiss_cheese.html);
    e. Utilization data;
    f. Readmission/transfer to higher level of care data;
    g. Morbidity/mortality data;
    h. Admission/discharge data;
    i. Length of stay data;
    j. Incident/risk management reports;
    k. Nursing-sensitive care performance measures;
    l. Medication error data;
    m. Infection control data;
    n. National patient safety goals across settings (http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals); and
    o. Never events (http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863)
        i. Prioritize identified practice gaps based on:
            - Population impact—decrease in morbidity/mortality;
            - Cost;
            - Leadership interests; and
            - Ease of implementation.
2. Identify the best method to address improvement/practice gap opportunities at the point of care and within the system:
    a. Policy and procedure;
    b. Practice guidelines;
    c. Quality improvement systems:

i. Six Sigma uses a systematic methodology that utilizes information and statistical analysis to measure and improve systems.; and

ii. Lean is a principle of continuous improvement and respect for people.

d. Case management;

e. Discharge/transition planning;

f. Patient self-management education;

g. Community-based initiative;

h. Legislation; and

i. Reliability of the health care delivery system.

3. Evaluate barriers to implementing improvements through the support of:

a. Leadership;

b. Physician and other health care provider stakeholders;

c. Patient;

d. Resource availability:

i. Money;

ii. Personnel;

iii. Equipment;

iv. Supplies; and

v. Time.

e. Burden of health care improvement initiative.

4. Utilize evidence-based implementation strategies to facilitate improvement (Grimshaw, Shirran, Thomas, Mowatt, Fraser, Bero, et al., 2001):

a. Develop mindfulness and vigilance.

b. Understand systems thinking; e.g., analyzing why people decided to work around safety systems.

5. Develop an implementation plan for quality improvement, considering the following:

a. Identify outcome measures to determine the success of an improvement;

b. Pilot the implementation plan on a small scale using Plan Do Study Act (PDSA) methodology until the identified outcomes are achieved on a small scale (http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowtoImprove/testingchanges.htm);

c. Implement the improvement full scale using the revised implementation plan;

d. Measure the success of the full-scale implementation of the improvement using the established outcome measures;

e. Revise the improvement implementation plan as needed to achieve the targeted improvement outcome; and

f. Continue measurement and measurement feedback until maintenance of the change is achieved as demonstrated by outcome measure attainment.

Interactive Exercises

1. Complete one or more of the following Institute for Healthcare Improvement Open

School quality improvement training opportunities:

a. Institute for Healthcare Improvement Open School training:
    i. Quality Improvement: http://ihi.org/lms/onlinelearning.aspx; and
    ii. Patient Safety: http://ihi.org/lms/onlinelearning.aspx.
b. Health Improvement Skills Center training: http://www.improvementskills.org.

2. Complete the Food and Drug Administration Medwatch and Patient Safety tutorial: http://www.accessdata.fda.gov/videos/MedWatch/tutorial/tutorial_video_flash.htm.
3. Identify the organizational structures and/or personnel in your organization that participate in quality-improvement activities.
4. Identify current and future improvement initiatives for your patient population from among the following national improvement initiatives:
    a. Joint Commission Performance Measurements Initiatives: http://www.jointcommission.org/NR/exeres/5A8BFA1C-B844-4A9A-86B2-F16DBE0E20C7.htm
    b. Joint Commission National Patient Safety Goals: http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/
    c. Center for Medicare and Medicaid Quality Initiatives: http://www.cms.hhs.gov/QualityInitiativesGenInfo/
    d. Nursing Quality Indicators: https://www.nursingquality.org/
    e. National Quality Forum indicators: http://www.qualityforum.org/Measures_List.aspx
    f . Institute for Health Care Improvement 5 Million Lives Campaign and other initiatives:
        i. 5 Million Lives: http://www.ihi.org/IHI/Programs/Campaign
        ii. Other: http://www.ihi.org/IHI/Programs/StrategicInitiatives
    g. Institute for Safe Medication Practice initiatives and alerts:
        i. Guidelines: http://www.ismp.org/Tools/guidelines/default.asp
        ii. Newsletter alerts: http://www.ismp.org/newsletters/default.asp
    h. Food and Drug Administration medication and device safety alerts:
        i. Alerts: http://www.fda.gov/Safety/Recalls/default.htm
        ii. Broadcasts: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/index.cfm
        iii. MedWatch: http://www.fda.gov/Safety/MedWatch/default.htm
    i. Prevention guidelines through the U.S. Preventive Services Task Force (USPSTF): http://www.ahrq.gov/clinic/uspstfix.htm
    j. Prevention process-outcome measures: http://www.qualitymeasures.ahrq.gov
    k. Condition management guidelines: http://www.ngc.gov
    l. Condition management process outcome measures: http://www.qualitymeasures.ahrq.gov
    m. Patient safety initiatives:
        i. Agency for Healthcare Research and Quality: http://www.ahrq.gov/qual/errorsix.htm
        ii. National Patient Safety Foundation: http://www.npsf.org/hp
        iii. The Joint Commission: http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals

5. Identify future improvement initiatives from setting-specific data, as appropriate:
    a. Risk-management data:
        i. Sentinel event root-cause analyses;
        ii. Failure to rescue and cardiac arrest data;
        iii. Readmission/transfer to a higher level of care data;
        iv. Mortality/morbidity data;
        v. Incident/risk-management reports;
        vi. Medication error data; and
        vii. Infection control data.
    b. Utilization data:
        i. Admission/discharge data; and
        ii. Length of stay data.
    c. Customer/patient satisfaction data.
    d. Employee satisfaction data.
    e. Financial data.
6. Participate in a health care improvement initiative at your facility.
7. Participate in a root-cause analysis in your facility.
8. Support new and ongoing improvement initiatives in your setting through active participation, provision of feedback and compliance.

Suggested References

Agency for Healthcare Research and Quality. (2000). *20 tips to help prevent medical errors.* Patient fact sheet. AHRQ Publication No. 00-PO38. Retrieved October 16, 2009, from http://www.ahrq.gov/consumer/20tips.htm

Agency for Healthcare Research and Quality. (2001). *Making health care safer: A critical analysis of patient safety practices.* Retrieved October 16, 2009, from http://www.ahrq.gov/clinic/ptsafety

Agency for Healthcare Research and Quality. (2002). *Dissemination and implementation: Put Prevention Into Practice (PPIP).* Retrieved October 16, 2009 from http://www.ahrq.gov/clinic/ppipix.htm

Agency for Healthcare Research and Quality. (2002). *20 tips to help prevent medical errors in children. Patient Fact Sheet.* AHRQ Publication No. 02-P034. Retrieved October 16, 2009, from http://www.ahrq.gov/consumer/20tipkid.htm

Agency for Healthcare Research and Quality. (2003). *National healthcare quality report.* Retrieved October 10, 2004, from http://www.ahrq.gov/qual/nhqr03/nhqr03.htm

Agency for Healthcare Research and Quality. (2004). *Closing the quality gap: A critical analysis of quality improvement strategies: Volume 1—Series overview and methodology.* AHRQ Publication No. 04-0051-1. Retrieved October 16, 2009, from http://www.ahrq.gov/clinic/tp/qgap1tp.htm

Agency for Healthcare Research and Quality. (2005). *Advances in patient safety: From research to implementation.* AHRQ Publication Nos. 05-0021-1 (Vol. 1), 05-0021-2 (Vol. 2), 05-0021-3 (Vol. 3) and 05-0021-4 (Vol. 4). Retrieved October 16, 2009, from http://www.ahrq.gov/qual/advances.

Agency for Healthcare Research and Quality. (2005). *30 safe practices for better health care*. Fact sheet. AHRQ Publication No. 04-P025. Retrieved October 16, 2009, from http://www.ahrq.gov/qual/30safe.htm

Agency for Healthcare Research and Quality. (2008). *Patient safety and quality: An evidence-based handbook for nurses*. Hughes, R.G. (Ed.). AHRQ Publication No. 08-0043. Retrieved October 19, 2009, from http://www.ahrq.gov/qual/nurseshdbk/nurseshdbk.pdf

Agency for Healthcare Research and Quality. (2008). *Will it work here? A decisionmaker's Guide to adopting innovations*. Retrieved October 19, 2009, from http://www.innovations.ahrq.gov/resources/InnovationAdoptionGuide.pdf

Chassin, M. R. (1998). Is health care ready for Six Sigma quality? *The Milbank Quarterly, 76*(4), 565-591.

Farley, D.O., et al. (2005). *Implementation of the diabetes practice guideline in the Army Medical Department: Final evaluation*. Retrieved October 16, 2009, from http://www.rand.org/pubs/monographs/2005/RAND_MG277.pdf

Grimshaw, J., et al. (2001). Changing provider behavior: An overview of systematic reviews of interventions to promote implementation of research findings by healthcare professionals. In Haines, A., & Silagy, C. (Eds.), *Evidence-based practice in primary care*. London: BMJ Books.

Institute for Healthcare Improvement. (2005). The 5 million lives campaign. Retrieved October 16, 2009, from http://www.ihi.org/IHI/Programs/Campaign

Institute of Medicine. (1999). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.

Institute of Medicine. (2001). *Crossing the quality chasm*. Washington, DC: National Academy Press.

Institute of Medicine. (2003). *Leadership by example: Coordinating government roles in improving health care quality*. Washington, DC: National Academy Press.

Joosten, T., Bongers, I., & Janssen, R. (2009). Application of lean thinking to health care: Issues and observations. *International Journal for Quality in Health Care, 21*(5), 341-347.

Kane, R.L., et al. (2004). Economic incentives for preventive care: Summary. Evidence report/technology assessment: Number 101. AHRQ Publication Number 04-E024-1. Retrieved October 16, 2009, from http://www.ahrq.gov/clinic/epcsums/ecincsum.htm

Nicholas, W., Farley, D.O., Vianna, M.E., & Cretin, S. (2001). Putting practice guidelines to work in the Department of Defense medical system: A guide for action. Santa Moinca, CA: RAND. Retrieved October 16, 2009, from http://www.rand.org/pubs/monograph_reports/2007/MR1267.pdf

Royal Nurses Association of Ontario. (2002). Toolkit: Implementation of clinical practice guidelines. Toronto: Registered Nurses Association of Ontario. Retrieved October 19, 2009, from http://www.rnao.org/Storage/12/668_BPG_Toolkit.pdf

Titler, M. (2008). The evidence for evidence-based practice implementation. In Hughes, R.G. (Ed.). *Patient safety and quality: An evidence-based handbook for nurses*. AHRQ Publication No. 08-0043. Retrieved June 16, 2010, from http://www.ahrq.gov/qual/nurseshdbk/nurseshdbk.pdf

Walsh J., et al. (2005). *Closing the quality gap: A critical analysis of quality improvement strategies*. Volume 3. Hypertension care. Publication No. 04-0051-3. Retrieved June 29, 2005, from http://www.ahrq.gov/clinic/tp/hypergap3tp.htm#Report

Supplemental Resources

Agency for Healthcare Research and Quality (AHRQ)

Evidence-based Practice Centers
http://www.ahcpr.gov/clinic/epcindex.htm

National Guideline Clearinghouse
http://www.guideline.gov

Prevention Guidelines/USPSTF
http://www.ahrq.gov/clinic/uspstfix.htm

Guide to Clinical Preventive Services, 2009
Recommendations of the U.S. Preventive Services Task Force
http://www.ahrq.gov/clinic/pocketgd.htm

AHRQ Health Care Innovations Exchange
http://www.innovations.ahrq.gov

National Healthcare Quality & Disparities Reports
http://www.ahrq.gov/qual/measurix.htm#quality

Outcomes and Effectiveness
http://www.ahrq.gov/clinic/outcomix.htm

Putting Prevention Into Practice
http://www.ahrq.gov/clinic/ppipix.htm

Quality and Patient Safety
http://www.ahrq.gov/qual

Technology Assessments
http://www.ahrq.gov/clinic/techix.htm

Research Findings
http://www.ahrq.gov/research

AHRQ E-mail Updates
https://subscriptions.ahrq.gov/service/subscribe.html?code=USAHRQ_102

Quality Indicators
http://www.qualityindicators.ahrq.gov

Understanding Quality Measurement
http://www.ahrq.gov/chtoolbx/understn.htm

Advances in Patient Safety: From Research to Implementation
http://www.ahrq.gov/qual/advances

Medical Errors & Patient Safety
http://www.ahrq.gov/qual/errorsix.htm

Health Care 411
http://healthcare411.ahrq.gov

Online Web M&M
http://www.webmm.ahrq.gov

Patient Safety Network
http://psnet.ahrq.gov

Patient Safety Fact Sheets

- Provider: (Example) 30 Safe Practices for Better Health Care
  http://www.ahrq.gov/qual/30safe.htm
- Patient: (Example) 20 Tips to Help Prevent Medical Errors
  http://www.ahrq.gov/consumer/20tips.htm

Supplemental Resources: Veteran Health Association/Department of Defense—VHA/DoD

National Center for Patient Safety
http://www.patientsafety.gov

Falls Toolkit
http://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html

VHA Hand Hygiene Information and Tools
http://www.patientsafety.gov/SafetyTopics/HandHygiene/index.html

Supplemental Resources: Other Federal Government Agencies

CDC

Guide to Community Preventive Services
http://www.thecommunityguide.org

Institute for Clinical Systems Improvement
http://www.icsi.org/knowledge

Institute for Healthcare Improvement
http://www.ihi.org/ihi

Institute for Healthcare Improvement Improvement Map
http://www.ihi.org/IHI/Programs/ImprovementMap

Institute for Healthcare Improvement 5 Million Lives Campaign
http://www.ihi.org/IHI/Programs/Campaign

Centers for Medicare & Medicaid Services

Medicare/Medicaid
http://www.cms.hhs.gov/HospitalQualityInits/11_HospitalCompare.asp

Hospital Compare
http://www.hospitalcompare.hhs.gov/

Home Health Compare
http://www.medicare.gov/HHCompare

Nursing Home Compare
http://www.medicare.gov/NHCompare

American Nurses Association

National Database of Nursing Quality Indicators
https://www.nursingquality.org

National Quality Forum
http://www.qualityforum.org

The Joint Commission
http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement

FDA

Educational Resources
http://www.fda.gov/Safety/MedWatch/ucm133050.htm

Medwatch
http://www.fda.gov/Safety/MedWatch/HowToReport/default.htm

Patient Safety Alerts
http://www.fda.gov/cdrh/safety.html

Update Sign-up
http://www.fda.gov/AboutFDA/ContactFDA/StayInformed/GetEmailUpdates/default.htm

Supplemental Resources: Other International Governmental

Registered Nurses Association of Ontario

- Clinical Practice Guidelines
  http://www.rnao.org/Page.asp?PageID=861&SiteNodeID=270
- Guideline Implementation Tool Kit
  http://www.rnao.org/Storage/12/668_BPG_Toolkit.pdf

United Kingdom National Health Service National Patient Safety Agency
http://www.npsa.nhs.uk/

Supplemental Resources: Other Private Organizational

Institute for Healthcare Improvement (IHI)

- 5 Million Lives Campaign
  http://www.ihi.org/IHI/Programs/Campaign
- Patient Safety
  http://www.ihi.org/IHI/Topics/PatientSafety

Institute for Safe Medication Practices (ISMP)
http://www.ismp.org

ISMP Medication Safety Tools and Resources
http://www.ismp.org/Tools/default.asp

Supplemental Resources: The Joint Commission

General
http://www.jointcommission.org

National Patient Safety Goals
http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals

Patient Safety Speak Up Initiatives
http://www.jointcommission.org/PatientSafety/SpeakUp

Supplemental Resources: National Patient Safety Foundation (NPSF)
http://www.npsf.org

Supplemental Resources: Safe Care Campaign
http://www.safecarecampaign.org

Agency for Healthcare Research and Quality Evidence Reports
http://www.ahrq.gov/clinic/epcindex.htm

Institute for Safe Medication Practices List of High-Alert Medications
(http://www.ismp.org/Tools/highalertmedications.pdf)

Class/Category of Medications:

- Adrenergic agonists, IV (e.g., epinephrine, phenylephrine, norepinephrine)
- Adrenergic antagonists, IV (e.g., propranolol, metoprolol, labetalol)
- Anesthetic agents, general, inhaled and IV (e.g., propofol, ketamine)
- Antiarrhythmics, IV (e.g., lidocaine, amiodarone)
- Antithrombotic agents (anticoagulants), including warfarin, low-molecular-weight
- Heparin, IV unfractionated heparin, Factor Xa inhibitors (fondaparinux), direct

- Thrombin inhibitors (e.g., argatroban, lepirudin, bivalirudin), thrombolytics (e.g., alteplase, reteplase, tenecteplase) and glycoprotein IIb/IIIa inhibitors (e.g., eptifibatide)
- Cardioplegic solutions
- Chemotherapeutic agents, parenteral and oral
- Dextrose, hypertonic, 20 percent or greater
- Dialysis solutions, peritoneal and hemodialysis
- Epidural or intrathecal medications
- Hypoglycemics, oral
- Inotropic medications, IV (e.g., digoxin, milrinone)
- Liposomal forms of drugs (e.g., liposomal amphotericin B)
- Moderate sedation agents, IV (e.g., midazolam)
- Moderate sedation agents, oral, for children (e.g., chloral hydrate)
- Narcotics/opiates, IV, transdermal and oral (including liquid concentrates, immediate and sustained-release formulations)
- Neuromuscular blocking agents (e.g., succinylcholine, rocuronium, vecuronium)
- Radiocontrast agents, IV
- Total parenteral nutrition solutions

National Guideline Clearinghouse (NGC) Features (AHRQ, 2009)

- Structured abstracts (summaries) about the guideline and its development.
- Links to full-text guidelines, where available, and/or ordering information for print copies.
- Smartphone downloads of the complete NGC summary for all guidelines represented in the database.
- A guideline comparison utility that gives users the ability to generate side-by-side comparisons for any combination of two or more guidelines.
- Using guideline comparisons called Guideline Syntheses, prepared by NGC staff, compare guidelines covering similar topics, highlighting areas of similarity and difference. NGC Guideline Syntheses often provide a comparison of guidelines developed in different countries, providing insight into commonalities and differences in international health practices.
- An electronic forum, NGC-L for exchanging information on clinical practice guidelines, their development, implementation and use.
- An annotated bibliography database where users can search for citations for publications and resources about guidelines, including guideline development and methodology, structure, evaluation and implementation.
- An expert commentary feature written/reviewed by the NGC/National Quality Measures Clearinghouse (NQMC) Editorial Board.

ELEMENTS OF INFORMATICS MODULE

___ Contact hours

Development and Implementation Guidelines: This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Learning Objectives

Upon completion of the Informatics Module, the licensed nurse will be able to effectively utilize information at the point of care to support quality patient care by being able to:

1. Identify all electronic and/or print information data available at the point of care, as available in the agency:
    a. Patient history and physical;
    b. Patient diagnosis(es);
    c. Patient orders/treatment plan;
    d. Progress notes;
    e. Laboratory data;
    f. Medication information;
    g. Reference materials;
    h. Policies and procedures;
    i. Adverse event reporting systems;
    j. Consultation reports/referral information;
    k. Community resources; and
    l. Health information resources for patients and family members.
2. Determine the information needed at the point of care.
3. Access the needed information effectively, efficiently and in accordance with agency security requirements.
4. Recognize the various tools and technologies available to improve the quality of care, including electronic health records (EHRs), bar code medication administration (BCMA), computerized provider order (CPO), CPO entry with decision support systems (DSS), data capture, care planning tools, clinical decision support systems (CDSSs) and telehealth.
5. Identify the challenges of integrating health care information technology into practice.
6. Ensure confidentiality of all patient health information (PHI), whether print or electronic, relative to the Health Insurance Portability and Accountability Act (HIPAA), and other applicable laws and institution-specific policies.
7. Demonstrate compliance with laws, regulations, institutional policies and etiquette related to the access and use of information resources.

Interactive Exercises

1. Systems-related activities:
    a. Locate the policies and procedures at your work setting (e.g., How long did it take you? Were you able to find what you were looking for?).
    b. Review a policy/procedure for a common activity/situation, comparing what is written with the standard of current practice observed in your work setting.
    c. Propose a plan for developing a new policy/procedure or revising an existing policy/procedure if revision is needed to reflect current practice standards. Who would you

approach regarding the need for policy development/revision? Where would you go to access references or resources to support your claim that a new policy/procedure is needed (i.e., online literature searches, CINAHL, WebMD, Medline, standards of care)?

2. Access the Technology Informatics Guiding Educational Reform (TIGER) Informatics Competencies Collaborative (TICC) Final Report at http://tigercompetencies.pbworks.com/f/TICC_Final.pdf. See the list of competencies at the end and decide which competencies you have now and which ones you need to develop in the future. How might you work to develop the competencies?
3. Think about a patient with whom you have recently worked. How did you use informatics to locate the information you needed? Were you able to find everything you needed? If not, consult with your preceptor.
4. Choose one of the systems outlined in the objectives above (HER, BCMA, CPOE with DSS, data capture tools, care-planning tools, telehealth). What are the challenges of the system you chose?

Suggested References

Agency for Healthcare Research and Quality. (2006). *Cost and benefits of health information technology.* Retrieved July 14, 2008, from http://www.ahrq.gov/downloads/pub/evidence/pdf/hitsyscosts/hitsys.pdf

Agency for Healthcare Research and Quality. (2007). *Health information technology initiative major accomplishments: 2004-2006.* Retrieved April 24, 2008, from http://www.hhs.gov/healthit/news/Accomplishments2006.html

Altarum Institute & NHII Advisors. (2007). *Nationwide health information network workforce study.* Retrieved April 23, 2008, from http://aspe.hhs.gov/sp/reports/2007/NHIN/NHINReport.pdf

American Health Information Management Association & American Medical Informatics Association. (2005). *Building the workforce for health information transformation*. Retrieved April 22, 2008, from http://www.ahima.org/emerging_issues/Workforce_web.pdf

American Hospital Association. (2007). *Continued progress: Hospital use of information technology.* Retrieved April 22, 2008, from http://www.aha.org/aha/content/2007/pdf/070227-continuedprogress.pdf

American Nurses Association. (2008). *Scope and standards of nursing informatics practice*. Washington, DC: American Nurses Publishing.

Belanger, J. (2006). Nursing informatics on the move. *Online Journal of Nursing Informatics, 10*(1). Retrieved June 16, 2010, from http://ojni.org//10_1/belanger.htm

Bell, M. J., Hannah, K., Newbold, S. K., Douglas, J. V., & Donaldson, S. K. (2000). *Nursing informatics: Where caring and technology meet.* New York: Springer.

Center for Information Technology Leadership. (2007). *CITL publishes latest research: Provider-to-provider telehealth technologies will save $4.28 billion annually.* Retrieved May 2, 2008, from www.citl.org/news/Telehealth_PR.pdf

Gray, C., Bee, S., & Bertka, K. (2010). Nurses and computerized systems: Is "hands-on" most helpful? *Nursing Management, 41*(1), 35-38.

Health Resources and Services Administration. (n.d.). Health information technology. Retrieved April 18, 2008, from http://hrsa.gov/healthit

Hebda, T., Czar, P., & Mascara, C. (2004). *Handbook of informatics for nurses & health care professionals.* Upper Saddle River, NJ: Prentice-Hall.

Hyun, S., Bakken, S., Douglas, K., & Stone, P. W. (2008). Evidence-based staffing: A role for informatics. *Nursing Economics, 26*(3), 151-158, 173.

Institute of Medicine, Committee on Maintaining Privacy and Security in Health Care Applications of the National Information Infrastructure. (1997). *For the record: Protecting electronic health information.* Retrieved May 2, 2008, from http://nap.edu/catalog.php?record_id=5595.

McKesson Corporation. (2004). *Patient safety and nursing: Transforming the work environment with technology.* Retrieved May 2, 2008, from http://www.himss.org/content/files/Nursing_Informatics_Toolkit/White%20paper/McKesson%20Nursing%20Pt%20Safety%20Paper.pdf

National Advisory Council in Nurse Education and Practice. (2009). *Challenges facing the nurse workforce in a changing environment.* Retrieved June 8, 2010, from http://bhpr.hrsd.gov/nursing/NACNEP/reports/seventh.pdf

National League for Nursing. (2007). *NLN shares in HRSA grant to create scholars project set to transform nursing education through integration of information technology.* Retrieved May 2, 2009, from http://nln.org/newsreleases/hrsa_release_091207.htm

President's Information Technology Advisory Committee. (2004). *Revolutionizing health care through information technology.* Retrieved May 2, 2008, from http://www.nitrd.gov/pitac/reports/20040721_hit_report.pdf

RAND Corporation. (2005). *Health information technology: Can HIT lower costs and improve quality?* Retrieved May 2, 2008, from http://www.rand.org/pubs/research_briefs/RB9136/index1.html

Skiba, D. (2007). Flipping the novice to expert continuum. *Nursing Education Perspectives, 28*(6), 342-344.

Staggers, N., Gassert, C. A., & Curran, C. (2002). A Delphi study to determine informatics competencies at four levels of practice. *Nursing Research, 51*(6), 383-390.

Technology Informatics Guiding Education Reform (TIGER). (2009). *Collaborating to integrate evidence and informatics into practice and education: An executive summary.* Retrieved May 10, 2010, from http://www.tigersummit.com/uploads/TIGER_Collaborative_Exec_Summary_040509.pdf

Thede, L. Q., & Sewell, J. P. (2009). *Informatics and nursing: Competencies and applications*. Philadelphia: Lippincott Williams & Wilkins.

Additional References

Technology Informatics Guiding Educational Reform (TIGER). (2009). TIGER Informatics Competencies Collaborative (TICC) final report. Retrieved June 8, 2010, from http://tigercompetencies.pbworks.com/f/TICC_Final.pdf

ELEMENTS OF TRANSITION TO PRACTICE PRECEPTOR TRAINING MODULE

__ Contact Hours

Development and Implementation Guidelines: This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Learning Objectives

1. Describe the role and responsibilities of the preceptor.
    a. Role socialization.
    b. Differentiate between staff nurse and preceptor.
    c. Understand delegation and accountability.
    d. Develop work-life balance (self-care).
    e. Role modeling.
    f. Describe how to establish an ongoing preceptor-nurse relationship.

g. Foster the development of clinical reasoning in the novice nurse.

h. Assist novice nurse to gather information about practice gaps and identify potential interventions.

i. Emphasize the importance of reflective practice.

j. Develop trusting relationship/confidentiality.

k. Identify support systems:

   i. Staff development;

   ii. Manager;

   iii. Peer; and

   iv. Board of Nursing.

l. Team preceptorship as an option.

m. Recognize and celebrate the novice nurse's success.

2. Examine the principles of teaching-learning.

   a. Adult learning principles.

   b. Benner's Novice to Expert Model emphasizes that newly licensed nurses are functioning at advanced beginner stage; goal of the Transition to Practice program is to reach the competency stage.

   c. Diversity in learning styles (e.g., auditory, visual, tactile, etc.).

   d. Generational and cultural differences in learning.

   e. Learning domains:

      i. Cognitive;

      ii. Affective; and

      iii. Psychomotor.

   f. Providing a positive learning environment.

3. Demonstrate effective communication.

   a. Understand systems.

   b. Understand teamwork and collaboration across disciplines.

   c. Learn group dynamics.

   d. Know feedback, reflection and evaluation process:

      i. Ways to deliver—techniques and timing;

      ii. Summative and formative evaluation;

      iii. Written/verbal;

      iv. Importance of providing feedback and evaluation;

      v. Positive and negative/corrective;

      vi. Perception of feedback;

      vii. Critical self-reflection; and

      viii. Formal documentation.

e. Utilize different strategies, such as SBAR and TeamSTEPPS.

f. Learn about conflict management.

4. Incorporate elements of NCSBN's Transition to Practice Model when precepting.
   a. Orientation to unit/agency is entirely separate.
   b. Review manual and essential elements of the Transition to Practice modules; review handbook newly licensed nurses use.
   c. Integrate principles of safety and how to accept accountability for actions:
      i. Regulatory model: Mission of BONs is to protect the public;
      ii. Nurse practice act, scope of practice, rules and regulations;
      iii. Legal/ethical;
      iv. Policy and procedures;
      v. Standards of practice;
      vi. Evidence-based practice;
      vii. Competence development;
      viii. Root-cause analysis;
      ix. Incident reports;
      x. Protection of new nurse from making errors that might threaten patients, self and/or others;
      xi. Requirements when assigning or delegating to others, according the state's nurse practice act;
      xii. Importance of stressing professional boundaries to newly licensed nurses; and
      xiii. Fostering a reliable health care system (e.g., avoiding work-arounds, etc.).
   d. Integrate clinical reasoning, which is defined by Benner, Sutphen, Leonard & Day (2010) as "The ability to reason as a clinical situation changes, taking into account the context and concerns of the patient and family."
   e. Threading reflection and feedback throughout while building confidence.
   f. After preceptorship, six more months of support; development of long-term mentor.

Interactive Exercises

1. Complete the Index of Learning Styles questionnaire (http://www.engr.ncsu.edu/learningstyles/ilsweb.html).
2. Take Myers-Briggs and analyze results.
3. Examine the INSIGHT tool (AONE suggested; insightinstitute.com).
4. Discuss conflict situations, such as:
   a. New protégé who is not meeting performance expectations;
   b. Resources when the preceptor is not a good fit; and
   c. Physicians/other nurses/patients/other health care personnel who only want to work with a "seasoned" nurse.
5. Review concepts of TeamSTEPPS scenario and SBAR (see Communication and Teamwork module), and develop a scenario where they can assist new nurses to use these principles.

Suggested References

Beecroft, P., Hernandez, A. M., & Reid, D. (2008). Team preceptorships: A new approach for precepting new nurses. *Journal for Nurses in Staff Development, 24*(4), 143-148.

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

Billay, D., & Myrick, F. (2008). Preceptorship: An integrative review of the literature. *Nurse Education in Practice, 8*, 258-266.

Bossers, A., et al. (2007). Preceptor education program. Retrieved December 29, 2009, from: http://www.preceptor.ca/index.html

Delaney, C. (2003). Walking a fine line: Graduate nurses' transition experiences during orientation. *Journal of Nursing Education, 42*(10), 437-443.

Duffy, A. (2009). Guiding students through reflective practice – The preceptors experiences. A qualitative descriptive study. *Nurse Education in Practice, 9,* 166-175.

Halfer, D. (2007). A magnetic strategy for new graduate nurses. *Nursing Economics, 25*(1), 6-11.

Hickey, M.T. (2009). Preceptor perceptions of new graduate readiness. *Journal for Nurses in Staff Development, 25*(1), 35-41.

Luhanga, F., Yonge, O., & Myrick, F. (2008). Hallmarks of unsafe practice: What preceptors should know. *Journal for Nurses in Staff Development, 24*(6), 267-264.

Luhanga, F., Yonge, O., & Myrick, F. (2008). Strategies for precepting the unsafe student. *Journal for Nurses in Staff Development, 24*(5), 214-219.

Moore, M. (2009). Developing the preceptorship evaluation survey: A multifaceted approach including cognitive interviews. *Journal for Nurses in Staff Development, 25*(5), 249-253.

Myrick, F. (2002). Preceptorship and critical thinking in nursing education. *Journal of Nursing Education, 41*(4), 154-164.

Nicol, P., & Young, M. (2007). Sail training: An innovative approach to graduate nurse preceptor development. *Journal for Nurses in Staff Development. 23*(6), 298-302.

Paton, B. (2010). The professional practice knowledge of nurse preceptors. *Journal of Nursing Education, 49*(3), 143-149.

Paton, B., Thompson-Isherwood, R., & Thirsk, L. (2009). Preceptors matter: An evolving framework. *Journal of Nursing Education, 48*(4), 213-216.

Perry, B. (2009). Role modeling excellence in clinical nursing practice. *Nursing Education in Practice, 9*, 36-44.

Phillips, J. M. (2006). Preparing preceptors through online education. *Journal for Nurses in Staff Development. 22*(3), 150-156.

Pickens, J.M., & Fargotstein, B.P. (2006). Preceptorship: A shared journey between education and practice. *Journal of Psychosocial Nursing and Mental Health Services, 44*(2), 31-36.

Sedgwick, M., Yonge, O., & Myrick, F. (2009). Rural-hospital-based preceptorship: A multidisciplinary approach. *Journal for Nurses in Staff Development, 25*(5), E1-E7.

Smedley, A., & Penney, D. (2009). A partnership approach to the development of preceptors. *Nursing Education Perspectives, 30*(1), 31-36.

Troxel, D. (2009). Connections: Online preceptor education. *Nursing Management, 40*(10), 32-37.

Udlis, K.A. (2008). Preceptorship in undergraduate nursing education: An integrative review. *Journal of Nursing Education, 47*(1), 20-29.

Vermont Nurses In Partnership, Inc. (VNIP). (2010). Retrieved June 8, 2010, from http://www.vnip.org

Yonge, O., Hagler, P., Cox, C., & Drefs, S. (2008). Listening to preceptors. *Journal for Nurses in Staff Development*, *24*(1), 21-26.

INSTITUTIONAL SUPPORT FOR TRANSITION TO PRACTICE

NCSBN's Transition to Practice Model requires a six-month preceptor program, followed by six months of institutional support. These are some tips for those last six months of support.

The following are some resources that the employer should plan for:

- Planning, preparation and oversight time for educators/managers;
- Preceptor education and support/mentoring time;
- Approval of and support for preceptor and new nurse transition activities (staffing, patient/client assignments, preceptor support and mentoring, etc.);
- Implementation of policies, competencies and evaluation tools related to preceptor and new nurse transition activities;
- Organizational leadership preparation for implementation of transition to practice activities;
- Implementation of evaluation strategies that identify best practices and measure the impact of implementing best practice transition activities; and
- Provision and maintenance of equipment, software and space needs to implement transition to practice activities.

Organizational Implementation Steps

The organization will:

1. Educate organizational leadership, nursing management and nursing personnel on the goals and components of the nurse residency program.
2. Enlist nursing management, human resource, quality improvement and other organization personnel in the development of organization-specific components and implementation of the transition to practice program:
    a. Policies;
    b. Procedures;
    c. Logistical support (personnel, equipment, space);
    d. Preceptor education;
    e. Preceptor support;
    f. Nurse orientation program;
    g. Transition to practice program; and
    h. Evaluation tools (resident, preceptor, program).
3. Identify the individual(s) within the organization who will be responsible for:
    a. Preceptor education;
    b. Preceptor coordination and support; and
    c. Nurse resident coordination and support.
4. Ensure integration of all components of the nurse residency into all relevant organizational processes:
    a. Human resources;
    b. Performance/quality improvement;
    c. Risk management;

d. Nursing management;

e. Support services (pharmacy, respiratory therapy, physical therapy, occupational therapy); and

f. Service lines.

5. Provide opportunities for:

a. Feedback and reflection of practice (e.g., "What would I have done differently?" What lessons were learned?);

b. Committee work (e.g., quality improvement, implementing safety measures) or participation in grand rounds to encourage engagement in the agency;

c. Evaluation of program/participant/preceptor/nurse manager;

d. Peer support; sharing their stories;

e. Postsentinel event/near-miss discussion of root-cause analysis (see *Nursing Pathways for Patient Safety,* 2009). Be sure all new nurses have gone through this;

f. Feedback to share professional development goals for the next year/strengths/weaknesses; understanding what a performance appraisal is; and

g. Celebrating the end of the program.

Resources

1. Overall support:

a. NCSBN will provide online modules and support for those agencies that cannot develop the resources and don't have partnership opportunities.

i. Website address (when available)

ii. Transition to practice toolkit: https://www.ncsbn.org/1603.htm

b. Commission on Collegiate Nursing Education (CCNE): http://www.aacn.nche.edu/Education/NrsResToolkit.htm

2. See preceptor training modules.

3. Support for competency development:

a. Transition to practice modules

b. Quality and Safety Education for Nurses: http://www.qsen.org

4. Commission on Collegiate Nursing Education (CCNE) accreditation information: http://www.aacn.nche.edu/accreditation/pdf/resstandards08.pdf

Suggested References

Johnstone, M. J., & Kanitsaki, O. (2006). Processes influencing the development of graduate nurse capabilities in clinical risk management: An Australian study. *Quality Management in Health Care, 15*(4), 268-278.

Johnstone, M. J., Kanitsaki, O., & Currie, T. (2008a). The nature and implications of support in graduate nurse transition programs: An Australian study. *Journal of Professional Nursing, 24*(1), 46-53.

Johnstone, M. J., & Kanitsaki, O. (2008b). Patient safety and the integration of graduate nurses into effective organizational clinical risk management systems and processes: An Australian study. *Quality Management in Health Care, 17*(2), 162-173.

Attachment B

Report of Transition to Practice Advisory Panel

TRANSITION TO PRACTICE ADVISORY PANEL MEMBERS

- Jane Barnsteiner, PhD, RN, FAAN, professor, University of Pennsylvania. Areas of expertise: safety and quality research; QSEN Advisory Board.
- Mary Blegen, PhD, RN, FAAN, professor, University of California, San Francisco. Areas of expertise: safety and quality research.
- Mary Lynn, PhD, RN, professor, University of North Carolina, Chapel Hill. Areas of expertise: measuring graduate competencies; has analyzed Health Resources and Service Administration (HRSA) transition data and University HealthSystem Consortium (UHC/AACN) residency program data.
- Elizabeth Ulrich, EdD, RN, FACHE, FAAN, senior vice president, Business Analytics & Research, Versant. Areas of expertise: workforce research and analysis of new graduate transition data.

DATE OF MEETING

All four consultants met at NCSBN's offices March 25-26, 2010, with Nancy Spector, PhD, RN, director, Regulatory Innovations, NCSBN, and Kevin Kenward, PhD, MA, director, Research, NCSBN.

CONSULTATION AGREEMENT

The consultants have agreed to assist NCSBN with planning the Transition to Practice Pilot Study and provide ongoing advice throughout the conduct of the pilot. Most meetings will be via conference call and each meeting will have specific objectives. The objectives for the March 2010 meeting were:

- Provide recommendations for conducting a multisite, pilot study of NCSBN's transition model; and
- Develop outcomes for NCSBN's pilot study, with an emphasis on quality and safety measures.

For each day of consultation (in-person or via conference call), NCSBN will pay the consultants $200. NCSBN will also pay for travel expenses for in-person meetings.

SUMMARY OF MARCH 2010 MEETING

The Transition Advisory Panel described NCSBN's model as revolutionizing how nurses are brought into the profession. Because of this, it is important to conduct a sophisticated pilot study that will provide evidence upon which to make decisions. The outcomes will be important for transition policy decisions, but the study will also provide implementation best practices.

NCSBN's Transition Pilot Study will be conducted in two phases:

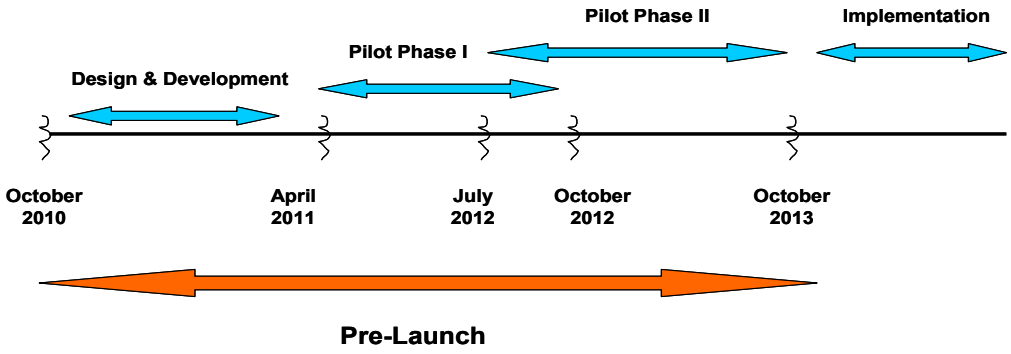
Phase I.	Phase I will establish internal validity of NCSBN's transition model and therefore should be conducted under more controlled conditions. It will be conducted with registered nurses (RNs) in hospital settings since 85 percent of newly graduated RNs work in the hospital setting.
Phase II.	Phase II will establish external validity to see if the program can be generalized across settings and levels of licensure. During this phase, outcomes of the model will be measured on licensed practical/vocational nurses (LPN/VNs) in long-term settings and other settings, and with RNs in settings other than hospitals, such as school nursing, visiting nursing, correctional facilities, office nursing, etc.

Sample:	Three states will be selected for the study to provide some geographic diversity. State selection will also be made based on board of nursing (BON) willingness and interest by various nursing stakeholders within the state to mount this pilot study, as well as an adequate number of new graduates. It was feared that the study would become too unwieldy and costly for NCSBN to manage were more states and sites involved. Each state will have a state coordinator who will make sure the data from all sites are consistently and accurately being put into the computer program. These three roles will be crucial to the study and therefore must be paid adequately. ▪ Each state will have 25 sites: 10 experimental and 15 control. Sites within states will be chosen by: · Permission to use a centralized Institutional Review Boards (IRBs) or willingness to shepherd through the institution's IRB on NCSBN's timeline. · Minimum number of new graduates from April through July; · Administration commitment; · No standardized programs in place (the only two standardized programs are Versant's and UHC/AACN's); · Willingness to pay site coordinators to work with the study, though each site will receive a $2,000 bonus at the end of the study to be used for education purposes within the institution; · Staff has access to computers; · Willingness to share their data related to safety and quality; and · Collect nurse sensitive quality indicator (NSQI) data. ▪ If possible, data from the experimental and control sites will be compared to data from two national standardized programs: Versant and UHC/AACN. Ulrich with Versant and Lynn with UHC/AACN have worked with those programs and will look into it for the panel. It was agreed that comparing NCSBN's model to other standardized program outcomes, as well as control outcomes, would be valuable.
Outcomes:	Since many institutions already collect a number of statistics, including patient safety measures, NSQI data and patient satisfaction, it would be efficient to use the data they collect, whenever possible. Data will be collected on a quarterly basis, when available: ▪ New graduate data · Demographics · New graduate perception tool (revise NCSBN's tool) · Preceptor perception tool (revise NCSBN's tool) · Commitment · Horizontal violence

	▪ Institutional data
	  ▪ Agency for Healthcare Research and Quality (AHRQ) safety indicators
	  ▪ Centers for Medicare & Medicaid Services (CMS) core indicators
	  ▪ NSQI data
	  ▪ Retention at one year
	  ▪ Patient satisfaction
	  ▪ Nurse satisfaction
	  ▪ Incident reports (such as falls data)
	  ▪ Physician and other health care provider satisfaction
	  ▪ Length of stay
	  ▪ Staffing
	▪ Control variables
	  ▪ Case mix (CMS)
	  ▪ Technology
	  ▪ Size
	  ▪ Type (profit/nonprofit; private/public; academic; federal)
	  ▪ Teaching intensity
	  ▪ Cost of hiring new graduates
	  ▪ Magnet
	  ▪ Rural/urban
	  ▪ Nurse supply in state
	  ▪ Unemployment rate in state

Budget:	Cost of conducting this multisite, 30-month study was discussed and shared with the business plan consultants who incorporated the costs into their plan. The consultants emphasized the importance of committed state coordinators because there will be a large amount of data to monitor over the two phases of the study.
Timeline:	If the NCSBN Board of Directors (BOD) approve the business plan for the pilot study at the July 2010 BOD meeting: **Phase I** **May 6–Sept. 30, 2010** ▪ NCSBN's Interactive Services department will begin to develop the modules, though much of that development will take place after Oct. 1, 2010, when the NCSBN's fiscal year begins. ▪ NCSBN's Regulatory Innovations department will develop a plan for meetings with the Transition Advisory Panel, and begin to search for a project manager and assistant. ▪ Tools will be identified. ▪ States that are interested will be contacted and specific sites will be looked at. Selection of pilot states will be made by October 2010.

	Oct. 1, 2010–March 31, 2011 ▪ Online modules will be completed and pretested. ▪ States and sites will be identified. ▪ Three state coordinators will be named. ▪ Site coordinators will be identified. **April 1, 2011–Sept. 30, 2012 (Phase II starts July 1, 2012)** ▪ Collection of data on a quarterly basis. ▪ Preparation for Phase II of study. ▪ Phase II will begin July 1, 2012. ▪ Phase I will end Oct. 1, 2012. ▪ Ongoing data analysis. **Oct. 1, 2012–Sept. 30, 2013** ▪ Phase II data collection continues. ▪ Ongoing data analysis. **Oct. 1, 2013–May, 2014 (Phase III starts Oct. 1, 2013)** ▪ Final analysis and dissemination of results. ▪ Assist interested states/jurisdictions with implementation of the model. ▪ Present results to May BOD for possible vote at 2014 Delegate Assembly.



Attachment C

Business Plan Template for Boards of Nursing (BONs)

The model that NCSBN plans to develop for its Transition to Practice initiative will need to be embraced by BONs in order to enact legislation. As in any profession, newly graduated hires do not possess the same level of knowledge or skills in comparison to others with multiple years of experience. Nurses are no different. Yet, because nurses work on a daily basis with vital health care outcomes, the lack of readiness has potentially greater consequences. Research indicates that newly licensed nurses are susceptible to:

- Increased stress;
- A greater likelihood of committing medical errors;
- Increased level of committing near misses;
- Decreased levels of patient safety and positive health care outcomes; and
- Higher rates of job turnover, which has a negative impact on patient safety.

The NCSBN Transition to Practice Model is designed to support new nurses, promote public safety and achieve greater worker retention in health care settings. It is NCSBN's hope that all new nurse graduates will participate in some form of a transition program. NCSBN would simply like to provide a flexible baseline requirement that new nurses can fulfill upon their entrance into a professional health care practice setting.

While many BONs have shared their enthusiasm about the prospect of a transition program for newly licensed nurses, other BONs have expressed skepticism about their ability to handle the perceived increased workload that would come with the implementation of a transition to practice program within their state, particularly within this economic climate. Although several states have made investments and witnessed progress on the implementation of their own nurse transition or residency programs, only Kentucky has successfully enacted a transition program through legislation. The Kentucky Board of Nursing (KY BON) provides an example of how helpful a transition program can be for new nurses and how relatively easy it is to successfully run, monitor and license these new nurses during and after the participation in their entry into practice program.

CASE STUDY: KENTUCKY

In the mid 1990s, the KY BON was receiving troublesome correspondence from both new graduates and their employers. The new graduates were worried that they were being pushed into practice-setting situations that they were simply unprepared to handle. This lack of confidence in their own level of practice competence caused high levels of stress among many newly licensed nurses. Meanwhile, employers were contacting the KY BON to complain about the readiness and preparedness of these new nurse hires.

As a result, the KY BON Education Committee decided to form a Competency Task Force in 1995 to deal with the issues being raised by new nurses and practice. The task force, which was represented by a diverse group of nurses from both education and practice, came to the conclusion that a capstone experience prior to graduation and an integrated internship after graduation and before licensure would be the best solution. In 2004, the KY BON submitted their required nurse internship plan to the state legislature. Negotiations prior to submission meant that the KY BON had to compromise the postgraduation internship down to 120 required hours over a three-week period, rather than a longer-term engagement for the new nurse.

Effective Jan. 1, 2006, the legislation stated that new nurse graduates would be required to undertake a clinical internship before they received full licensure from the KY BON. The legislation (KY BON, 2008) states, "The key elements of the clinical internship include: direct patient care, supervision by a licensed nurse, 120 hours in duration, and a six-month provisional license time frame." Upon graduation from an accredited school of nursing, new nurses are

awarded a provisional license and allowed to register for the NCLEX® examination. During this provisional period, new nurses are referred to under the title RNA (registered nurse applicant) or LPNA (licensed practical nurse applicant). By the end of this six-month period, if the applicant has not successfully passed the NCLEX and completed the 120-hour clinical internship, he/she will not receive full licensure to work in the state of Kentucky. Even if the new nurse graduate passes the NCLEX, permanent licensure will not be granted without successful completion of a clinical internship.

While some BONs have expressed worry about the costs and time commitment to implement and manage a transition program, the reality in Kentucky indicates that these should not be major concerns. In 2007, the KY BON counted 64,932 registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) in the state. This figure included 3,544 new RNs and 1,030 new LPN/VNs (NCSBN, 2009). Among the costs and time commitment to manage its approximately 4,500 new nurses were:

- Minimal programming costs to update the KY BON nurse license database;
- Fielding calls from new nurse graduates about internship program details;
- Website redesign to explain the internship program;
- Public relations expenditures related to program introduction; and
- Internship preceptors who are not monetarily compensated, but rather, are awarded a full number of mandated yearly continuing education credits.

The Entry to Practice Initiative in Kentucky did NOT require the KY BON to hire any additional staff. Paperwork associated with the clinical internship was mailed to the newly graduated nurse in the same packet as the instructions for the NCLEX examination, which meant that the number of required mailings remained at the same level. The KY BON does not need to spend valuable staff hours continuously monitoring new nurses during the internship because if the new nurse fails to receive sign-off and mail in his/her Verification of Completion of Clinical Internship Form by the end of the six-month trial period, the provisional license is voided by the KY BON and the individual can no longer work in the capacity of a licensed professional within the state.

While the program is still relatively in its infancy, the feedback the KY BON has received from various stakeholder groups has been overwhelmingly positive. Thus, the KY BON has concluded that their Entry into Practice Internship Model has been a demonstrated success within the state.

Nurses are considered to be the heart and soul of health care settings—the frontline caregivers to clients. Supporting nurses through their critical entry into the profession is not only good for the development of the nurse and the employer, but also for good of the patient. Regulation implies the government intervention to accomplish an end beneficial to its citizens. Through the implementation of administrative regulations, KY BON has taken these two steps to assist new graduates in developing entry-level clinical competence under the guidance of an experienced professional (KY BON, 2008).

While Kentucky's clinical internship program is the only model enacted through regulation, other states, such as Mississippi, North Carolina and Vermont, have already begun some form of a transition program. Given the identified need to assist new nurse graduates as they enter their professional careers, it is in the general public's best interest that all states attempt to adopt some form of transition initiative to help provide greater assistance to the nurses who serve within their state.

WHAT DO STATES NEED TO DO?

NCSBN would work with each and every BON to help make the introduction and implementation of a transition model as easy and seamless as possible. If it is decided to develop the online Transition to Practice Modules, they will be available to all new nurses, although NCSBN encourages practice to use whatever transition program they feel best suits their specific needs. For BONs, NCSBN plans to make the implementation of transition programs with each state

as hassle-free as possible. The NCSBN Marketing & Communications department will work to create marketing materials that can be utilized at the state level to persuade various stakeholder groups to support legislation. As NCSBN stays abreast of all the latest research data, they will look to share with states all key findings that can further make the case for transition model adoption. The core goal for NCSBN and BONs should be to work with employers and educators to promote and legislate for some kind of transition model for new nurses.

If BONs decide to implement the model, the following strategies are recommended:

- Identify and approach state legislators who are proponents of continuing education, health care reform and/or better patient safety outcomes.
- If nurse license renewal occurs once every two years, rewrite state guidelines so that new nurses must be evaluated again after one year in practice and demonstrate they took part in a Transition to Practice Program that meets NCSBN's standards. NCSBN provided model statutes and administrative rule language for the BONs in 2009, which is available in the NCSBN Transition to Practice Toolkit at www.ncsbn.org/1603.htm.
- Collect evidence from each new nurse's designated preceptor that the individual successfully completed the modules and has demonstrated competency and understanding of the subject matter. An official form can be sent out to new nurses in a manner similiar to Kentucky's strategy.
- Budget approximately $2 per new nurse for the mailing of forms and correspondence. However, given the heightened Internet usage among these and future generations of nurses, BONs should attempt to use electronic communications whenever possible, since this would reduce costs.
- Budget a modest amount ($5,000-$10,000) for public relations upon introduction of Transition to Practice to get all stakeholders on board.[1]
- Budget about $5,000-$7,000 for website design and content upgrades related to Transition to Practice.

Should larger states feel apprehensive about their ability to afford the additional cost and employee time commitment toward enacting legislation and launching Transition to Practice within their state or jurisdiction, there are alternative methods of financing the program. First, nurse license application and renewal fees could be increased by $2 to $10 to offset any predicted additional costs. Grant funding is possible from a host of sources, including the Health Resources and Services Administration (HRSA), Robert Wood Johnson Foundation, the Carnegie Foundation, Centers for Medicare & Medicaid Services (CMS), Medicaid Transformation Grants, or the State Survey and Certification of Health Care Providers and Suppliers. In addition, if NCSBN develops online modules, NCSBN will pay for and provide most of the operational capacity for the modules, as these might be used in rural settings or those settings without valid preceptors (e.g., schools or long-term care facilities). At this point, BONs simply need to commit to the Transition to Practice initiative and work to induce discussion on the subject within their respective state legislatures.

CONCLUSION

Research suggests that new nurses are more prone to errors, near misses and poorer patient outcomes than more seasoned nurses. The inability to become properly acclimated to practice environments creates higher levels of stress, which further exacerbates the likelihood of performance errors and can lead to increased employee turnover. NCSBN has worked over several years to design an evidence-based transition program that can provide new nurses with proper guidance as they enter their profession.

1 NCSBN plans to provide a portfolio of marketing communications materials that will help make the case for a legislated transition program within a state. In recent years, with the Internet becoming an extremely cost-effective communication channel, costs to announce and promote new initiatives has become far easier and cheaper. Nevertheless, BONs should budget some funds for specific print placements and travel.

REFERENCES

Kentucky Board of Nursing. (2008). Entry into practice: A regulatory initiative. Retrieved from http://www.kbn.ky.gov/practice/entry

Kentucky Board of Nursing. (2008). Clinical internship. Retrieved June 16, 2010, from http://www.kbn.ky.gov/education/pon/entry/internship.htm

NCSBN. (2009). *2007 Nurse licensee volume and NCLEX® examination statistics*. Chicago: NCSBN.

Attachment D

Business Plan Template for Employers

PART I: USING NCSBN'S MODULES

1. Calculate your organization's turnover rate:

   How many new nursing graduates left your organization within the past year? (A): _____

   How many new nursing graduates did your organization hire within the past year? (B): _____

   The new nursing turnover rate at your organization: (Z): A/B = _____

2. Calculate your organization's potential loss of first-year nurses with Transition to Practice:

   A PriceWaterhouseCoopers study estimated that median first-year nurse turnover in the U.S. stands at 27.1%.[1] Under NCSBN's Transition to Practice Program, first-year nursing turnover was X% for the X,000 RNs that took part in the pilot study.

   (Y): B x X%= _____

3. Calculate the estimated turnover cost per nurse at your facility:

   Studies indicate that new-nurse turnover replacement costs may be $46,000 or greater.[2] For your specific health care practice setting, turnover replacement cost typically amounts to 1.3 times the nurse's salary.[3] Median base salary of staff RN is $41,642.

   Enter your practice's average first-year nurse's annual salary (S): _____

   The estimated turnover cost per nurse at your facility is then given by (D): 1.3 x S = _____

4. Calculate your organization's potential cost savings from reduced turnover from the NCSBN Transition to Practice Model:

   (G): (Z x B – Y) x D = _____

   G is the estimated benefit of implementing Transition to Practice at your health care facility. Note that this does NOT include potential savings from reductions in medication errors, nurse-specific poor patient outcome errors and benefits accruing from increased patient satisfaction.

5. Calculate the Transition to Practice program costs for your organization:

   (C1): $100 x B = _____

   Median new nurse salary in the U.S. is $39,000 for an RN and $33,500 for an LPN/VN.[4] This amounts to an hourly wage of $19.50 for a new RN and $16.75 for a new LPN.

   New nurse resident salary for modules taken during work hours (C2):

   60 x (S/12) x B = _____

   Preceptors should be registered nurses with more than three years of experience. The median salary for nurses with more than three years of experience in the U.S. is $47,110 for an RN, or $23.55 an hour.[5]

   Enter your facility's average preceptor hourly rate (P): _____

1 PriceWaterhouseCoopers. (2007). *What works: Healing the health staffing shortage.* Retrieved June 16, 2010, from http://www.pwc.com/us/en/healthcare/publications/what-works-healing-the-healthcare-staffing-shortage.jhtml

2 Halfer, D., Graf, E. & Sullivan, C. (2008). The organizational impact of a new graduate pediatric mentoring program. *Nursing Economics, 26*(4), 243-249.

3 Jones, C.B. (2005). The costs of nursing turnover, part 2: Application of the Nursing Turnover Cost Calculation Methodology. *Journal of Nursing Administration, 35*(1), 41-49.

4 Allied Physicians (2006). Nurse salaries and nursing salary surveys. Retrieved June 24, 2010, from http://www.alliedphysicians.com/salary-surveys/nursing

5 Ibid.

Preceptor nurse resident salary for mentorship and preceptor module taken during work hours (C3): 60 x P x B[6] = _____

Add the three cost factors to find the total Program Cost (C): C1 + C2 + C3 = _____

6. Calculate the potential ROI for your health care facility:

   (ROI): (G – C)/C = _____

PART II: HOW PRACTICE CAN DEVELOP THEIR OWN TRANSITION PROGRAM

Many practice settings may choose to develop a specific transition program that aligns with the unique practice environment at their facility. While any practice setting is welcome to use the online modules designed and developed by NCSBN, organizations may want to provide a more specific transition experience for their new nurse hires. Major topics include:

- Patient-Centered Care;
- Communication and Teamwork;
- Quality Improvement;
- Informatics; and
- Evidence-Based Practice.

Safety and clinical reasoning are to be integrated throughout the topics, and feedback and reflection are to be embedded throughout that first year. Standards for the topics, including objectives, content outline, suggested interactive exercises and sources will be available on the Transition to Practice website. The topics should be presented during the first six months of practice, and during this time new nurses should be assigned to clinical preceptors who have been trained for the role. NCSBN believes that newly licensed nurses will become more effectively transitioned into practice with the help of preceptors. These should be fairly experienced nurses who are trained for the role and can help provide advice to the novice nurses within the organization. During the second six months of practice, ongoing employer support of the newly licensed nurse is an expectation. Tips for providing this support are available in NCSBN's Transition to Practice Modules Standards document.

NCSBN encourages practice settings to collaborate with each other and/or with colleges/universities in order to develop a transition program that meets the NCSBN standards. This might particularly be beneficial to smaller community agencies or long-term care settings.

The Impact

The impetus behind this flexible and robust model (includes all levels of licensure and all settings) is to promote public safety. The NCSBN Transition to Practice initiative provides a regulatory model for new nursing hires designed to promote public safety through:

- Decreased number of medical errors;
- Decreased number of medication errors;
- Better identification of life-threatening complications;
- Enhanced patient health care outcomes;
- Superior response times; and
- Decreased turnover rates among newly hired nurses.

While all of the above points are important from a caregiver-patient relationship standpoint, turnover is a measurable cost to practice organizations. PriceWaterhouseCoopers has estimated that every one percent increase in nursing turnover correlates to $300,000 in additional budget

6 This estimates the time preceptors spend helping new nurses in the transition program while on duty and receiving wages + the number of hours for Preceptor Module (~5-6) x hourly rate of an experienced nurse x number of new nurses in the program (assuming a new nurse:preceptor ratio of 1:1).

expenses for a large health care organization. The Transition to Practice Model provides a robust, evidence-based platform to create better patient outcomes and ensure greater worker satisfaction. Adoption of the Transition to Practice program within an organization will help with cost savings and greater patient satisfaction. The cost factors associated with replacing nurses are quite substantial, and include:

- Advertising and recruitment;
- Vacancy costs (e.g., paying for agency nurses, overtime, closed beds, hospital diversions, etc.);
- Interviews and hiring decisions;
- Orientation and training;
- Decreased worker productivity at initiation of work;
- Termination/unemployment benefits;
- Added potential for errors, compromised quality of care;
- Loss of organizational knowledge; and
- Poor existing employee morale leads to additional turnover (Jones & Gates, 2007).

Implementation of a transition program at a facility can save management from the costs and hassels that occur in instances of frequent staff turnover. Several other practice settings have adopted transition programs and the results have been quite positive.

UHC/AACN NURSE RESIDENCY PROGRAM

At the multistate, national level in the U.S., the University HealthSystem Consortium and American Association of Colleges of Nursing (UHC/AACN) have introduced their own Nurse Residency Program. The standardized model is currently being offered in 61 university health care sites in 27 U.S. states. The program is implemented in addition to the typical orientation process at these health care facilities.

The core curriculum includes course modules on leadership, research-based practice, professional development, communication, critical thinking, patient safety and nurse skills, all of which are complemented with clinical guidance from a preceptor. This residency program meets the standards of NCSBN's Transition to Practice Model.

Preliminary results indicate that health care facilities where the Nurse Residency Program was adopted realized a reduction in first-year nurse turnover to 12 percent compared to prior studies that indicated turnover ranged from 36 percent to 55 percent for new nurse graduates.

CHILDREN'S MEMORIAL HOSPITAL, CHICAGO

Diane Halfer published a case study on the introduction of an RN internship program to nurture new nurse graduates as they entered their pediatric careers. In 2002, Children's Memorial Hospital in Chicago calculated that the new graduate nurse turnover in the first year had reached 29.5 percent. Because the cost per new graduate hire stood at $41,624, management at the hospital understood action needed to be taken.

The nurse internship program began in 2003, thanks in part to three Health Resources and Services Administration (HRSA) grants that totaled $639,000. The program called for classroom time for new graduate nurses that included 80 hours of general content and 32 to 72 hours of specialty-specific content related to the nurse's intended health care focus. Interns also have the flexibility of completing the pediatric courses through an online educational Web-based subscription service. The program also implemented group discussions with facilitators to help others express worries, feelings and personal instances where they could receive constructive group feedback.

The internship program not only helped the hospital retain more first-year nursing graduates (Children's Memorial has averaged 12.3 percent turnover per class since 2003), but saw "multiple applications for every one intern hired, allowing nursing directors to select the most highly qualified candidates who completed the NCLEX® exam, best fit the medical center's culture, and often came with relevant experience." (Halfer, 2007) This has directly led to a 28 percent increase in recruitment at the hospital. Moreover, since the inception of the graduate nurse internship program, there have been an average of 17 more nurses staying at the medical center each year, yielding a calculated cost savings of $707,608 annually.

Methodist Hospital of Houston

Rosemary Pine and Kathryn Tart wrote about return-on-investment (ROI) opportunities for health care facilities that adopted the nurse residency program from UHC/AACN. At Methodist Hospital in Houston, retention rates for first-year nurses reached an all-time low of 50 percent in 2003. Administrators knew they needed to do something to turn this phenomenon around.

The University Health Consortium (UHC) Baccalaureate Nurse Residency Program was introduced in 2004. The one-year program is based on Patricia Benner's theoretical framework on transition to professional nursing called *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* (Benner, 1984).

The UHC program received buy-in from senior executive leadership, including the chief nurse executive. There were 48 first-year resident nurses enrolled in the UHC program at a total cost of $93,100 to the hospital. As a result of the residency program, turnover was reduced to 13 percent in 2005, thus realizing ~$1,098,000 in cost savings and a net program benefit of ~$824,000 and ROI of 884.7 percent (Pine, Tart, 2007). The research study indicates that investment in a residency transition program leads directly to increased first-year nurse retention and substantial cost savings for the hospital, which in turn leads to better health outcomes for patients.

Considerations for Practice

Many practice settings will want to consider the design and use of their own transition program. The administrative management at the practice setting will need to work with the chief nursing officer (CNO), unit leaders and other experienced nurses within the organization to develop what the practice-specific program should entail, while at the same time, meeting the standards of NCSBN's Transition to Practice Model. Subject matter experts may need to be hired to develop content and teaching strategies for the various subjects that will be covered in the transition program. Activities incorporated within the program might include roundtable discussions, classroom lectures, simulation games, guest speakers for certain subjects, written or oral presentations given by new nurses, and other options that provide a dynamic and interactive transition experience for new nurses.

> The decision to develop and conduct a comprehensive residency program included recognition of the required investment of the significant human and financial resources that are necessary to support these new graduate nurses in their successful role transition. The costs of the program can be grouped into expenses that directly support the program and indirect costs associated with resident time spent away from the clinical setting. Analysis of the ROI must also include evaluation of the expected cost avoidance associated with decreased turnover and the benefits of hiring employees who are anticipated to have long tenures in the organization. These benefits also include the anticipated future returns of the clinical practice of these nurses in the context of improved outcomes of care, patient safety, clinical productivity, and patient and staff satisfaction. (Keller, Meekins & Summers, 2006)

Direct program costs will likely include tuition for online modules, text and journal subscriptions, photocopy and office supplies, speaker and consultant fees, refreshments and administrative management. The transition program implemented at the University of Texas Medical Center found that the direct costs came to approximately $1,000 per new nurse while the program has witnessed nurse retention rise to 89.2 percent.

CONCLUSION

NCSBN plans to work with states/jurisdictions to legislate for new nurse transition programs. While NCSBN will make its six online modules for new nurses and preceptors available for any practice organization that needs them, employers are encouraged to use whatever transition model fits best with their organization. The end goal is for everyone involved to provide greater patient care that enhances public safety. New nurses who experience a transition program become acclimated more effectively and show increased clinical competence. This in turn will lead to less stress and, as research indicates, greater retention rates and better practice outcomes. NCSBN and employers should come together to provide these positive outcomes for the next generation of new nurses.

REFERENCES

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley Publishers.

Jones, C., & Gates, M. (2007). The costs and benefits of nurse turnover: A business case for nurse retention. Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume122007/No3Sept07/NurseRetention.aspx

Halfer, D. (2007). A magnetic strategy for new graduate nurses. *Nursing Economics, 25*(1), 6-12.

Pine, R., & Tart, K. (2007). Return on investment: Benefits and challenges of a baccalaureate nurse residency program. *Nursing Economics*, *25*(1), 13-18.

Keller, J.L., Meekins, K., & Summers, B.L. (2006). Pearls and pitfalls of a new graduate academic residency program. *JONA 38*(12), 589-598.

Attachment E

Transition to Practice Design

Transition to Practice

ENGAGING · EXPERIENCING · EMPOWERING

Report of Uniform Licensure Requirements and Portability Committee

Background

In 1999, NCSBN undertook a major initiative to develop minimal licensure requirements for adherence by every Member Board. Upon recommendation by an appointed committee, a set of uniform core licensure requirements (UCLRs) were adopted by the Delegate Assembly. Adoption by individual boards of nursing (BONs), however, varied to wide degrees. As defined by the 1999 committee, the UCLRs were minimal requirements for BONs. This gave BONs the flexibility to adopt the requirements in many ways, often adding further requirements if their state chose to do so. As a result, while many of the BONs adopted the requirements, many variances emerged and licensure requirements were no longer uniform throughout the jurisdictions.

During the 10 years that followed, both intrinsic and extrinsic environmental factors have affected the nursing profession. Workforce shortages, a technological boon that rapidly advanced the capabilities of telehealth and globalization, among other factors, have impacted health care delivery and have stakeholders requesting uniformity among state nursing laws and regulations in regards to licensure. During the 2008 Delegate Assembly, a resolution was made and passed requesting that the UCLRs to be reviewed and updated. In response, the current Uniform Licensure Requirements and Portability Committee was established.

The Committee is made up of 10 members: five from compact states and five from noncompact states. All four areas of the U.S. are represented on the committee. The committee consists of four members from umbrella BONs and six members from independent BONs.

The 2009-2010 committee used a variety of resources in its deliberations. They consulted legal counsel, thoroughly examined each state's requirements, as well as variances, and considered all comments made at the 2008 UCLR conference, in which two members of every BON were invited and sponsored by NCSBN to attend. In addition, the following resources were used by the committee:

a. The 1999 UCLRs;

b. The 2008 UCLR Survey to Member Boards;

c. The comments, feedback and concerns that emerged from the 2008 UCLR Conference small-group breakout sessions;

d. Positions of the NCSBN Delegate Assembly and the Board of Directors (BOD) that relate to licensure;

e. State information on criminal background checks and fingerprint systems, including the Rap-Back System;

f. The Americans with Disabilities Act (ADA);

g. NCSBN Member Board Profiles; and

h. The report from the NCSBN and Nurse Licensure Compact Administrators (NLCA) action plan that emerged from the 2008 focus groups.

The following is a comprehensive summary of the committee's charges:

- Review and recommend revisions to the 1999 Delegate Assembly UCLRs. Include initial, renewal, endorsement and international requirements.
- Review and recommend actions regarding variances to core requirements.

The committee spent a great deal of time in thoughtful deliberation reviewing the licensure requirements (initial, renewal, endorsement and international) of all 60 NCSBN Member Boards. In addition, every variance was noted and discussed by the committee.

Members

Brenda McDougal
North Carolina, Area III, Chair

Karla Bitz, PhD, RN, FRE
North Dakota, Area II

Mary Blubaugh, MSN, RN
Kansas, Area II

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

Staff
Maryann Alexander, PhD, RN
Chief Officer, Nursing Regulation

Meeting Dates

- Sept. 1-3. 2009
- Oct. 21, 2009
- Dec. 15-17, 2009
- Feb. 17-18, 2010
- March 25-26, 2010

Relationship to Strategic Plan

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

Strategic Objective 1
Promote ongoing regulatory excellence.

The committee's first set of draft requirements was distributed during fall 2009 to executive officers and Member Board presidents in all jurisdictions. All feedback was carefully reviewed and discussed. Modifications were made based on the Member Board's feedback; a revised draft was constructed and presented to the BOD in February 2010. A second draft of the ULRs was presented and discussed at the 2010 NCSBN Midyear Meeting. All comments and suggestions were carefully examined and discussed. Based on this feedback, further modifications were made.

When the completed document was submitted to the BOD at the May 2010 meeting, the BOD felt as though there was not enough consensus by the membership on two issues: (1) whether graduation from a nursing program should be required for licensure; and (2) whether permanent bars to licensure should be required by certain states. The BOD requested the committee reconvene to find further evidence to support the recommendations related to these issues. In addition, they requested further evidence for removing the ULR related to functional abilities. For that reason, the ULRs will not be voted on by this year's Delegate Assembly. See Attachment A for the most recent draft.

- Develop a strategic plan for assisting Member Boards to implement the ULRs.

The committee has developed a comprehensive strategic plan that contains strategies for enactment of the ULRs through statute or rule/regulation through the process of implementation. During fall 2009, when the first draft of the ULRs was distributed, Member Boards were asked to comment on potential barriers to implementation in their state and how NCSBN can assist in implementation. The information received was incorporated into a comprehensive strategic plan.

The plan is currently on hold until the ULRs are completed and adopted by the Delegate Assembly.

- Recommend solutions for issues identified regarding the interface between the two licensure models (Attachment B).

Highlights of FY10 Activities

- Development of 2010 ULRs.
- Development of a strategic plan for implementation.
- Recommended solutions for issues identified regarding the interface between the two licensure models.

Future Activities

- Develop a common licensure application.

Obtain further evidence for final draft of ULRs.

Attachments

A. Uniform Licensure Requirements (ULRs) Draft (May 2010)

B. Recommended Solutions for Issues Regarding the Interface Between the Two Licensure Models

Attachment A

Uniform Licensure Requirements (ULRs) Draft (May 2010)

ULRs are the essential prerequisites for initial, endorsement, renewal and reinstatement licensure needed in every NCSBN jurisdiction to ensure the safe and competent practice of nursing.

ULRs protect the public by setting consistent standards and promoting a health care system that is fluid and accessible by removing barriers to care and maximizing portability for nurses. They also assure the consumer that a nurse in one state has met the requirements to practice nursing in every other state. ULRs support the fact that the expectations for the education and responsibilities of a nurse are the same throughout every NCSBN Member Board jurisdiction in the U.S.

It is recommended that Member Boards unite in a common goal of adopting the ULRs into their state practice act/ regulations by 2016.

A. Initial Licensure			
1999 UCLR Education Requirement: RN	**1.A Nursing Education Requirements: RN**		
Graduation from or verification of completion and eligibility for graduation from state-approved registered nurse (RN) program.	**Applicant Responsibility**	**Board Duty**	**Rationale for Change**
	As of 2016: Graduation from a Member Board approved* professional nursing education program.	As of 2016: Verification of graduation from a Member Board approved* professional nursing education program. Grandfather students licensed or enrolled in a nursing program prior to 2016.	1. Language changed to "Member Board," as defined in the ULR definitions, to include all jurisdictions. 2. This requirement applies to full members of NCSBN only, not associate members, as defined by NCSBN. 3. Graduation has been added as a defined exit point and assures the public that all requirements are met. 4. New language will require that generic master's programs confer a degree to their students once they have completed the RN requirements of the program in order for the students to be eligible for licensure prior to completing their master's degree.

	Applicant Responsibility	Board Duty	Rationale for Change
			5. This ULR is also meant to protect students. There is nothing that provides assurance that students in a generic master's program will complete all program requirements and receive a degree if they are allowed to take the NCLEX® examination prior to graduation. Not having a degree in nursing may place them in a compromised position at some point during their career. 6. The recommended year for compliance is 2016. This will allow time for nursing programs to adjust their requirements and accommodate this change in curriculum should they need to do so. 7. No other health care profession allows licensure without graduation. 8. Allowing licensure without graduation adds another method of becoming a nurse and further confuses the public and other professions as to the true requirements for becoming a nurse. 9. The grandfathering clause has been inserted as not to penalize nurses enrolled in a generic master's program prior to 2016.

1999 UCLR Education Requirement: LPN/VN	2.A Nursing Education Requirements: LPN/VN		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
Graduation from or verification of completion and eligibility for graduation from state-approved licensed practical/vocational nurse (LPN/VN) program.	As of 2016: Graduation from a Member Board approved* practical nursing education program. Includes: ▪ Graduation from a Member Board approved military LPN/VN program. ▪ Graduates from RN programs who have successfully completed a Member Board approved LPN/VN role delineation course.	As of 2016: Verification of graduation from a Member Board approved* practical nursing education program. Includes: ▪ Graduation from a Member Board approved military LPN/VN program. ▪ Graduates from RN programs who have successfully completed a Member Board approved LPN/VN role delineation course.	1. New language is inclusive of applicants from two-step or ladder programs; however, it will require that these programs confer a degree to their students once they have completed the LPN/VN requirements of the program in order for the students to be eligible for licensure. 2. This eliminates the requirement that an RN-prepared applicant would have to first fail the NCLEX-RN® Examination prior to sitting for the NCLEX-PN® Examination. 3. RN and LPN/VN roles are distinct. Individuals taking the NCLEX-PN® Examination must have complete understanding of the PN role. This keeps educated individuals in the workforce. There is no evidence that supports or reflects an increase in discipline or practice issues when RNs are allowed to work as LPN/VNs. 4. Military Corpsman programs are NOT equivalent to LPN/VN programs and graduates from these programs should not be considered eligible for PN licensure.

1999 UCLR Education Requirement for Foreign-Educated Candidates: RN	3.A Nursing Education Requirements of International Candidates: RN		
Graduation from nursing programs comparable to U.S. state-approved RN nursing programs as verified by credentials review agency.	**Applicant Responsibility**	**Board Duty**	**Rationale for Change**
	Graduation from a nursing program substantially equivalent to a Member Board approved RN program.	Verification by a credentials review of graduation from a nursing program substantially equivalent to a Member Board approved RN program.	Revision requires graduation from a nursing program. In foreign nursing programs, "program completion" may have different meanings. Graduation is a defined exit point and universally understood. This change will help ensure that nursing education of foreign graduates is consistent across jurisdictions, will make verification easier and may decrease the number of fraudulent applicants.
1999 UCLR Education Requirement for Foreign Educated Candidates: LPN/VN	**4.A Nursing Education Requirements of International Candidates: LPN/VN**		
Graduation from nursing program comparable to U.S. state-approved LPN/VN nursing programs as verified by credentials review agency.	**Applicant Responsibility**	**Board Duty**	**Rationale for Change**
	Graduation from a nursing program substantially equivalent to a Member Board approved LPN/VN program.	Verification by a credentials review of graduation from a nursing program substantially equivalent to a Member Board approved LPN/VN program.	Same as 3.A.
1999 UCLR NCLEX® Requirements	**5.A NCLEX® Requirements**		
▪ U.S. Candidates-RN: NCLEX-RN, unlimited attempts. ▪ U.S. Candidates-LPN/VN: NCLEX-PN, unlimited attempts ▪ Foreign-educated Candidates-RN: NCLEX-RN, unlimited attempts. ▪ Foreign-educated Candidates-LPN/VN: NCLEX-PN, unlimited attempts.	**Applicant Responsibility**	**Board Duty**	**Rationale for Change**
	Passage of NCLEX-RN or NCLEX-PN exam.	Verification of NCLEX-RN or NCLEX-PN exam.	This ULR applies to both U.S. and internationally educated graduates. Individual Member Boards may determine the timeframe required for NCLEX passage, as this does not affect mobility.

1999 UCLR Additional Requirements for Foreign-educated Nurses	6.A Additional Requirements for Foreign-educated Candidates		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
▪ Foreign-educated RN Candidates: Commission on Graduates of Foreign Nursing Schools (CGFNS) certificate or equivalent credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English. ▪ Foreign educated LPN/VN Candidates: Credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English.	▪ Self-disclosure of nursing licensure status in country of origin, if applicable. ▪ Successful passage of an English proficiency exam that includes the components of reading, speaking, writing and listening, except for applicants from countries where English is the native language, and the nursing program where the applicant attended was taught in English and used English textbooks.	▪ Verification of nursing licensure status in country of origin, if applicable. ▪ Verification of successful passage of an English proficiency exam that includes the components of reading, speaking, writing and listening, except for applicants from countries where English is the native language, and the nursing program where the applicant attended was taught in English and used English textbooks.	1. Licensure in the country of education is not required; however, if the nurse has been licensed in the country of origin, the board of nursing (BON) should determine whether the license has ever been disciplined. 2. The English proficiency requirement was changed to include four English language testing components. This provides for additional public protection and makes the requirements consistent with the government's minimal eligibility requirements for an occupational visa. 3. Credentials review has been placed under 3.A and 4.A: Nursing Education Requirements of International Candidates: RN and LPN/VN.

1999 UCLR Criminal Background Check Requirements: RN and LPN/VN	7.A Additional Public Protection Requirements: Criminal Background Check		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
Self-report regarding all felony convictions and all plea agreements and misdemeanor convictions of lesser-included offenses arising from felony arrests. Local/state and federal background checks using current technology (i.e., fingerprinting) to validate self-reports.	Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld).	▪ Identification of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure. ▪ State and federal fingerprint checks. ▪ Deny license for any felony conviction, pursuant to NCSBN Model Act Article 6 § 3.	Expanded to provide BONs with maximum information to make licensure decisions regarding all violations of the law. See NCSBN Model Act Article 6 § 3.
1999 UCLR Chemical Dependency and Functional Abilities Requirements: RN and LPN/VN	**8.A Additional Public Protection Requirements: Substance Abuse**		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
▪ Chemical Dependency: Self-report regarding any drug-related behavior that affects the candidate's ability to provide safe and effective nursing care. ▪ Functional Abilities: Self-report regarding any functional ability deficit that would require accommodation to perform essential nursing functions.	Self-disclosure of any abusive or excessive use of drugs, including alcohol, narcotics or chemicals, that resulted in physical or psychological dependence within the last five years.	Review of any applicant for renewal or reinstatement of licensure who may have a current drug or alcohol problem that could affect the ability to practice nursing safely.	1. Elimination of functional abilities question: Assessment of functional ability for licensure (according to American Disabilities Act [ADA] standards) would require BONs to have a professional evaluation done on candidates reporting physical/mental disabilities. Interpretation is time-consuming and complex, and should be the responsibility of employers who know the accommodations their institutions can provide. 2. According to the ADA, asking about drug and alcohol use is time-limited. Legal counsel recommends BONs inquire about drug or alcohol use that is limited to the last five years.

	9.A Additional Public Protection Requirements: Other Licenses, Certifications and Registrations		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification.	Review of any actions taken or initiated against a professional or occupational license, registration or certification and consideration of the individual's ability to practice nursing safely.	This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.
B. Renewal/Reinstatement Requirements			
	1.B Criminal Background Check (CBC)		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld) not previously reported to the BON.	▪ Identification of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld) not previously reported to the BON for determination of eligibility for renewal or reinstatement of licensure. ▪ State and federal fingerprint checks using automatic criminal background feedback system (such as Rap-Back). ▪ Deny license for any felony conviction, pursuant to NCSBN Model Practice Act Article 6 § 3.	Recommendation adds state and federal fingerprint checks for renewal. This recommendation takes into account future technology of fingerprint and CBC systems that will allow for automatic feedback to BONs when a licensee is convicted of a crime at any point in their career, i.e., Rap-Back system. This will give real-time data to make accurate licensure decisions on behalf of public protection. It is anticipated that the cost will decrease with development and adoption by BONs. This requirement would move the current CBC check system forward. Fingerprints would be taken at application for initial, renewal or reinstatement of licensure and stored. If a nurse has a criminal violation, the BON would be automatically notified. See NCSBN Model Practice Act Article. 6 § 3.

	2.B Substance Abuse		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	Self-disclosure of any abusive or excessive use of drugs, including alcohol, narcotics or chemicals, that resulted in physical or psychological dependence.	Review of any applicant for renewal or reinstatement of licensure who may have a current drug or alcohol problem that could affect his/her ability to practice nursing safely.	According to the ADA, asking about drug and alcohol use is time-limited. Legal counsel recommends boards inquire about drug or alcohol use that is limited to the last five years.
	3.B Nursing Disciplinary Actions		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	Self-disclosure of any action taken on a nursing license, privilege to practice, or current/pending investigation by a Member Board.	Identification/review of any action taken on a nursing license, privilege to practice or current/pending investigation by a Member Board.	This requirement has been added to ensure that any nursing disciplinary action will be identified and considered prior to renewal/reinstatement of licensure.
	4.B Other Licenses, Certifications and Registrations		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification not previously reported to the BON.	Review of any actions taken or initiated against a professional or occupational license, registration or certification not previously reported to the BON and consideration of the individual's ability to practice nursing safely.	This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.
C. Endorsement Requirements			
	1.C Education, Exam and Licensure Verification		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	▪ Graduation from a Member Board approved professional nursing or practical nursing education program. ▪ Successful passage of the NCLEX/State Board Test Pool Exam. ▪ Self-disclosure of status of all nursing licenses (includes any board actions taken, or any current or pending investigations by a Member Board)	▪ Verification of education. ▪ Verification of successful passage of the NCLEX/ State Board Test Pool Exam. ▪ Verification of all nursing licenses. ▪ Identification/review of any action taken against a nursing license or privilege to practice, including any pending investigation.	Verification of nursing licensure has been added to determine whether a license from any state has an encumbrance, discipline or pending investigation.

	2.C Criminal Background Check		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld).	▪ Identification of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure. ▪ State and federal fingerprint checks. ▪ Deny license for any felony conviction, pursuant to NCSBN Model Practice Act Article 6 § 3.	See NCSBN Model Practice Act Article. 6 § 3. Recommendation is that licensure be denied for the following felonies: murder, felonious assault, kidnapping, rape, aggravated robbery, sexual crimes involving children or vulnerable adults, criminal mistreatment of children or vulnerable adults and exploitation of a vulnerable individual (e.g., financial exploitation in an entrusted role).
	3.C Substance Abuse		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	Self-disclosure of any abusive or excessive use of drugs, including alcohol, narcotics or chemicals that resulted in physical or psychological dependence within the last five years.	Review of any applicant for renewal or reinstatement of licensure who may have a current drug or alcohol problem that could affect his/her ability to practice nursing safely.	According to the ADA, asking about drug and alcohol use is time-limited. Legal counsel recommends boards inquire about drug or alcohol use that is limited to the last five years.
	4.C Other Licenses, Certifications, Registrations		
	Applicant Responsibility	**Board Duty**	**Rationale for Change**
	Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification not previously reported to the BON.	Review of any actions taken or initiated against a professional or occupational license, registration or certification and consideration of the individual's ability to practice nursing safely.	This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.

*Member Board approved also applies to states in which the nursing program approval is done through another state agency such as the Commission on Higher Learning.

Administrative code regulations such as child support, payment of taxes, school loans, etc., are not included in these licensure requirements as those are state specific and do not solely apply to the BON.

Attachment B

Recommended Solutions for Issues Regarding the Interface Between the Two Licensure Models

Uniform licensure requirements (ULRs) assure consistent standards across all jurisdictions in the U.S. and its territories. In doing so, they afford public protection and promote mobility. These alone, however, are not sufficient to allow for fluidity in the licensure process. The licensure process requires an environment of open communication and collaboration that engages regulators across state lines.

Since the 2000 the U.S. and its territories have supported two main licensure models[1] for nursing: the Nurse Licensure Compact (NLC) and the single state model. The NLC requires nurses to be licensed in their home state while authorizing them to work in another party state without obtaining a new license. The single-state model requires every nurse working in a state to be issued a license from that jurisdiction's state board of nursing (BON) and allows them to work only in that state. NLC states use the single-state model for specific circumstances, such as for individuals residing in a noncompact states working in compact states.

The Uniform Licensure Requirements and Portability Committee was given the charge to recommend solutions for issues identified regarding the interface between the two licensure models. The group ascertained the issues regarding the interface between the two licensure models and has made recommendations. This is the first step in building a stronger and more cohesive organization of nurse regulators.

The committee acknowledges the overall positive relationships between Member Boards. The intention of this document is to further strengthen those relationships and resolve pending differences between two equally effective licensure models. The following is a summary of the issues and solutions identified by the Uniform Licensure Requirements and Portability Committee.

LICENSURE-RELATED ISSUES

For the remainder of this report, compact will be used to refer to all states that are currently members of the NLC and noncompact will refer to all states that are not members of the NLC.

Every decision put into legislation or policy may inadvertently impact another state. A state adopts new legislation or a licensing BON issues a new regulation and other states experience sequelae from the other state's action.

Recommended Solution: In order to provide a forum for discussion where both noncompact and compact states can discuss issues of concern, the Uniform Licensure Requirements and Portability Committee recommends the development of a group, such as a Commission on Licensure[2], a working group that is part of NCSBN, designated to address issues involving both licensure models[3]. It is suggested that this group consists of 10 representatives from compact and noncompact states; five representatives from compact states would be selected by the Nurse Licensure Compact Administrators (NLCA) and five representatives from noncompact states would be selected by NCSBN members who are not currently a part of the NLC. The group would meet periodically to discuss licensure issues. In addition, the commission would problem solve, exchange ideas, and discuss changes in state laws and/or regulations and licensure problems experienced by all members, including the implementation of ULRs. The

1 Minnesota has its own model and for the purposes of this document shall be considered a noncompact state.

2 The name of the group, Commission on Licensure, is suggested solely for the purpose of providing a creative title that would distinguish this group from a typical NCSBN committee in which the NCSBN Board of Directors determines membership and charges. It does not, in any way, imply any type of authority or have any legal implications. The definition of the word "commission" in this title is defined simply as "a group with a task."

3 In response to the need to address licensure issues from the interface between licensure models, the NCSBN Board of Directors, at their May 2010 meeting, per the NCSBN Bylaws and consistent with organizational practice, appointed a new committee for fiscal year 2011 with equal members representing single states and compact states. The new Nurse Licensure Models Committee was given the following charges: (1) Identify and recommend solutions to address current and emerging licensure issues that impact patient safety in all jurisdictions; and (2) Develop communications processes for regular sharing of information and promotion of dialogue to enhance the interface among all licensure models.

commission would chose a representative from a noncompact or compact state to speak on one of the licensure models on behalf on NCSBN. It is recommended that the commission would have an outside facilitator and provide reports to the Member Boards about the discussions and decisions made. The objective of this recommendation is to eliminate misunderstanding and educate both compact and noncompact states about contrasting licensure perspectives.

Every BON has a mission to protect the public. A benefit afforded to compact states is the access to significant investigative information of other compact states. When a licensee in a compact state is under investigation, the compact states are notified through an alert on Nursys®. This alert is only seen by compact states as noncompact states do not have access to information in Nursys about a licensee until a board action is taken. The interval from investigation to board action may allow the licensee time to move to a noncompact state and potentially become licensed.

Recommended Solution: In the interest of public protection, the committee recommends that all states should have the authority to share significant investigative information and have access to significant investigative information. The committee recommends that the following be considered for operationalizing this recommendation:

- The alert in Nursys, indicating a licensee is under investigation (currently seen only by members of compact states) is visible to all NCSBN Member Boards (this process is required by compact law). Compact states will continue to have access to details about the investigation.
- Compact states that are not currently restricted by statute or rule from sharing the details of their significant investigative information with noncompact states allow that information to be accessible on Nursys to all Member Boards.
- Noncompact states currently allowed to share investigative information with other states allow that information to be accessible on Nursys to all Member Boards.
- All states that are not currently allowed to share significant investigative information with all Member Boards initiate statutory and/or rule changes to allow all Member Boards access to their significant investigative information.

The goal of this recommendation is that all Member Boards will share and have access to significant investigative information from all jurisdictions in an effort to protect the public.

OTHER ISSUES REGARDING THE INTERFACE OF THE TWO MODELS

The Uniform Licensure Requirements and Portability Committee was focused on licensure issues. In the course of their discussion, other issues and recommendations emerged regarding compact and noncompact states. The committee felt this additional feedback might be useful to BONs and is therefore included in this report.

- The BON should give consideration to separate licensure models when choosing committee members and ensure that compact and noncompact states are represented on the committee.
- Per Policy 1.10 of the NLCA Policies and Procedure Manual, the Uniform Licensure Requirements and Portability Committee believes that notification should be provided to the executive officer of any noncompact state in which a compact administrator is invited to speak. The committee recommends the executive officer be directly contacted as soon as possible, prior to the visit.
- There is a lack of knowledge about the NLC. The committee recommends:
  - Promoting education about the NLC to the membership at large.

- Noncompact states participating in the NLCA meetings/phone calls that are currently open to the entire membership in order to learn more about the compact and bring forth questions.
- NCSBN explaining financial assistance given to the NLCA during the Finance Committee's report at Annual Meeting.

It is the hope of the Uniform Licensure Requirements and Portability Committee that these recommendations will assist in unifying all Member Boards and help them work together to compliment one another, build a stronger organization and provide the highest level of public protection for all consumers of health care.

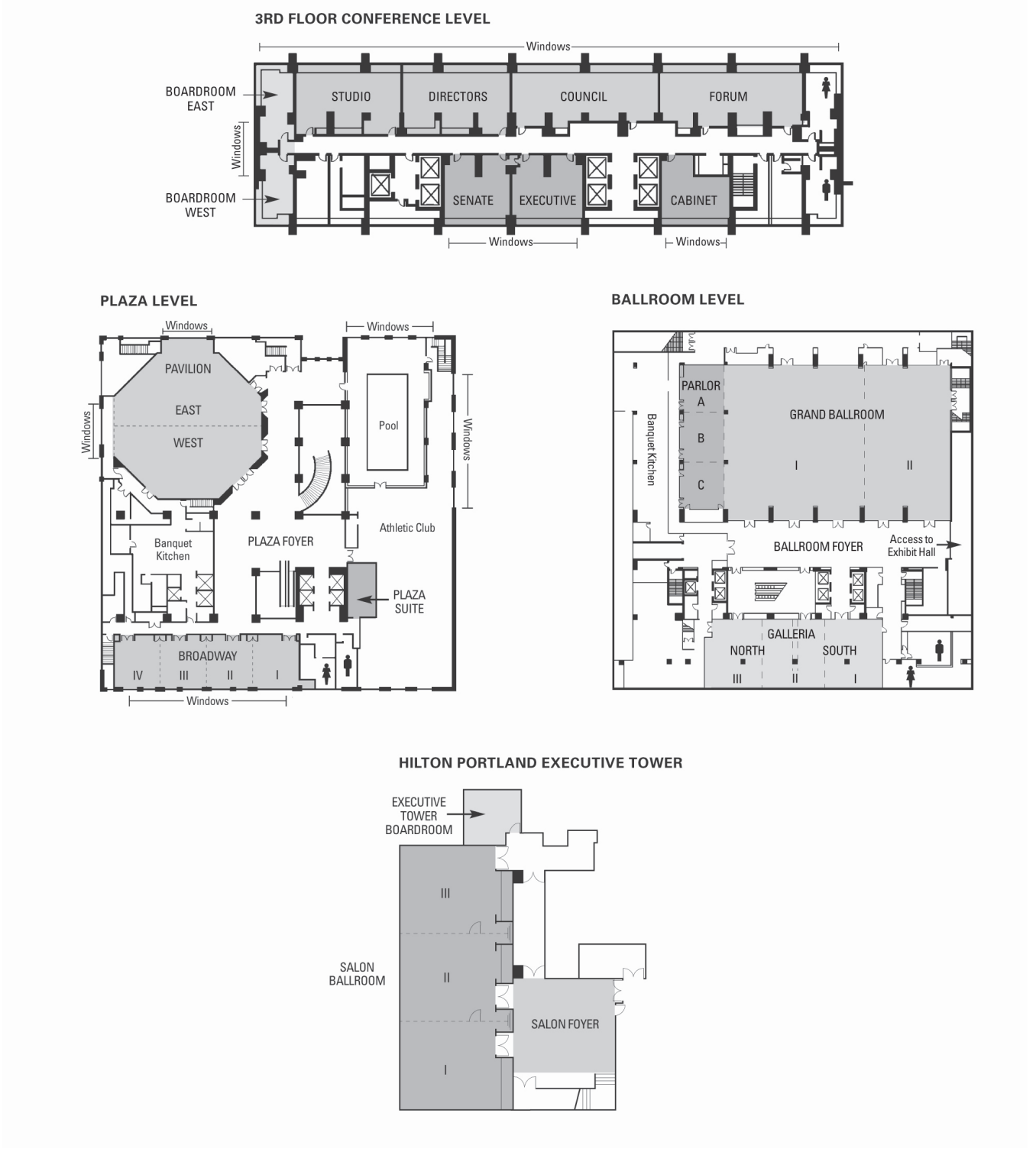
Section III

2010 NCSBN Annual Meeting

SECTION III: RESOURCES AND GENERAL INFORMATION

The current NCSBN Bylaws can by found in Section II on page 83.

Hilton Portland & Executive Tower Hotel Map



Orientation Manual for Delegate Assembly Participants

The purpose of the Orientation Manual is to provide information about the mission, governance and operations of NCSBN. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants as well as the Board of Directors and committee members.

Following a brief discussion of NCSBN's history, this manual will describe the organization's structure, functions, policies and procedures.

History

The concept of an organization such as NCSBN had its roots as far back as August 1912 when a special conference on state registration laws was held during the American Nurses Association (ANA) convention. At that time, participants voted to create a committee that would arrange an annual conference for people involved with state boards of nursing to meet during the ANA convention. It soon became evident that the committee required a stronger structure to deal with the scope of its concerns. However, for various reasons, the committee decided to remain within the ANA.

Boards of nursing also worked with the National League for Nursing Education (NLNE), which, in 1932, became the ANA's Department of Education. In 1933, by agreement with ANA, NLNE accepted responsibility for advisory services to the State Boards of Nurse Examiners (SBNE) in all education and examination-related matters. Through its Committee on Education, NLNE set up a subcommittee that would address, over the following decade, state board examination issues and problems. In 1937, NLNE published A Curriculum Guide for Schools of Nursing. Two years later, NLNE initiated the first testing service through its Committee on Nursing Tests.

Soon after the beginning of World War II, nurse examiners began to face mounting pressures to hasten licensing and to schedule examinations more frequently. In response, participants at a 1942 NLNE conference suggested a "pooling of tests" whereby each state would prepare and contribute examinations in one or more subjects that could provide a reservoir of test items. They recommended that the Committee on Nursing Tests, in consultation with representative nurse examiners, compile the tests in machine-scorable form. In 1943, the NLNE board endorsed the action and authorized its Committee on Nursing Tests to operate a pooling of licensing tests for interested states (the State Board Test Pool Examination or SBTPE). This effort soon demonstrated the need for a clearinghouse whereby state boards could obtain information needed to produce their test items. Shortly thereafter, a Bureau of State Boards of Nursing began operating out of ANA headquarters.

The bureau was incorporated into the ANA bylaws and became an official body within that organization in 1945. Two years later, the ANA board appointed the Committee for the Bureau of State Boards of Nurse Examiners, which was comprised of full-time professional employees of state boards.

In 1961, after reviewing the structure and function of the ANA and its relation to state boards of nursing, the committee recommended that a council replace it. Although council status was achieved, many people continued to be concerned about potential conflicts of interest and recognized the often-heard criticism that professional boards serve primarily the interests of the profession they purport to regulate.

In 1970, following a period of financial crisis for the ANA, a council member recommended that a free-standing federation of state boards be established. After a year of study by the state boards, this proposal was overwhelmingly defeated when the council adopted a resolution to remain with the ANA. However, an ad hoc committee was appointed later to examine the feasibility of the council becoming a self-governing incorporated body. At the council's 1977 meeting, a task force was elected and charged with the responsibility of proposing a specific plan for the formation of a new independent organization. On June 5, 1978, the Delegate Assembly of ANA's

Council of State Boards of Nursing voted 83 to 8 to withdraw from ANA to form the National Council of State Boards of Nursing.

Organizational Mission, Strategic Initiatives and Outcomes

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

NCSBN currently has six strategic initiatives for FY 2008-1010:

- Strategically advance patient safety for the health and welfare of the public.
- Contribute to Member Board excellence by providing resources, communication, education and technology.
- Advance evidence-based nursing regulation and regulatory solutions for public protection.
- Provide comprehensive data management for use by Member Boards and external stakeholders.
- Be the premier organization to define and measure entry and continued competence.
- Advance the development of regulatory excellence worldwide.

To achieve its strategic initiatives, NCSBN identifies expected outcomes, under which performance measures for achieving these outcomes are developed, assessed and refined each fiscal year and provide the organization with a flexible plan within a disciplined focus. Annually, the Board of Directors evaluates the accomplishment of strategic initiatives and objectives, and the directives of the Delegate Assembly.

Organizational Structure and Function

MEMBERSHIP

Membership in NCSBN is extended to those boards of nursing that agree to use, under specified terms and conditions, one or more types of licensing examinations developed by NCSBN. At the present time, there are 60 Member Boards, including those from the District of Columbia, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands. Boards of nursing may become Member Boards upon approval of the Delegate Assembly, payment of the required fees and execution of a contract for using the NCLEX-RN® examination and/or the NCLEX-PN® examination. Revisions to the bylaws by the membership in 2007 also allow for advanced practice nurse boards to become full members.

Member Boards maintain their good standing through remittance of fees and compliance with all contract provisions and bylaws. In return, they receive the privilege of participating in the development and use of NCSBN's licensure examinations. Member Boards also receive information services, public policy analyses and research services. Member Boards that fail to adhere to the conditions of membership may have delinquent fees assessed or their membership terminated by the Board of Directors. They may then choose to appeal the Board's decision to the Delegate Assembly.

Associate Members are authorized nurse regulatory bodies from other countries, must pay an annual membership feed and be approved for membership by the Delegate Assembly. The following jurisdictions are Associate Members: College of Registered Nurses of Alberta, College of Registered Nurses of British Columbia, College of Registered Nurses of Manitoba and College of Nurses of Ontario.

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 delegates who are designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates. The Delegate Assembly meets at NCSBN's Annual Meeting, traditionally held in early August. Special sessions can be called under certain circumstances. Regularly scheduled sessions are held on a rotation basis among Areas.

At the Annual Meeting, delegates elect officers and directors and members of the Leadership Succession Committee by majority and plurality vote respectively. They also receive and respond to reports from officers and committees. They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly adopts the mission statement, strategic initiatives of NCSBN, and approves the substance of all NCLEX® examination contracts between NCSBN and Member Boards, adopts test plans to be used for the development of the NCLEX examination, and establishes the fee for the NCLEX examination.

OFFICERS AND DIRECTORS

NCSBN officers include the president, vice president, and treasurer. Directors consist of four area directors and 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.

BOARD OF DIRECTORS

The Board of Directors, the administrative body of NCSBN, consists of eleven elected officers. The Board is responsible for the general supervision of the affairs of NCSBN between sessions of the Delegate Assembly. The Board authorizes the signing of contracts, including those between NCSBN and its Member Boards. It also engages the services of legal counsel, approves and adopts an annual budget, reviews membership status of noncompliant Member Boards and renders opinions, when needed, about actual or perceived conflicts of interest.

Additional duties include approval of the NCLEX® examination test service, appointment of committees, monitoring of committee progress, approval of studies and research pertinent to NCSBN's purpose, and provision for the establishment and maintenance of the administrative offices.

MEETINGS OF THE BOARD OF DIRECTORS

All Board meetings are typically held in Chicago, with the exception of the pre- and post- Annual Meeting Board meetings that may be held at the location of the Annual Meeting. The call to meeting, agenda and related materials are mailed to Board officers and directors two weeks before the meeting. The agenda is prepared by staff, in consultation with the president, and provided to the membership via the NCSBN Web site (www.ncsbn.org).

A memo or report that describes the item's background and indicates the Board action needed accompanies items for Board discussion and action. Motion papers are available during the meeting and are used so that an accurate record will result. Staff takes minutes of the meeting.

Resource materials are available to each Board officer and director for use during Board meetings. These materials are updated periodically throughout the year and include copies of the articles of incorporation and bylaws, strategic plan, policies and procedures, contracts, budget, test plan, committee rosters, minutes and personnel manual.

COMMUNICATIONS WITH THE BOARD OF DIRECTORS

Communication between Board meetings takes place in several different ways. The chief executive officer communicates weekly with the president regarding major activities and confers as needed with the treasurer about financial matters. Monthly updates are provided to the full board by the chief executive officer.

LEADERSHIP SUCCESSION COMMITTEE

The Leadership Succession Committee consists of eight elected members. Four members are elected from each area and are elected for two-year terms in even-numbered years. Four designated members are elected for two-year terms in odd-numbered years, and include a current or former committee chair; a board member of a member board, a staff of a member board, and a past member of the NCSBN Board of Directors. Members are elected by ballot with a plurality vote.

The Leadership Succession Committee's function is to recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

COMMITTEES

Many of NCSBN's objectives are accomplished through the committee process. Every year, the committees report on their activities and make recommendations to the Board of Directors. At the present time, NCSBN has two standing committees: NCLEX Examinations and Finance. Subcommittees, such as the Item Review Subcommittee (Exam), may assist standing committees.

In addition to standing committees, special committees are appointed by the Board of Directors for a defined term to address special issues and concerns. NCSBN conducts an annual call for committee member nominations prior to the beginning of each fiscal year. Committees are governed by their specific charge and NCSBN policies and procedures. The appointment of committee chairs and committee members is a responsibility of the Board of Directors. Committee membership is extended to all current members and staff of Member Boards, consultants and external stakeholders.

In the appointment process, every effort is made to match the expertise of each individual with the charge of the committee. Also considered is balanced representation whenever possible, among areas, board members and board staff, registered and licensed practical/vocational nurses, and consumers. Nonmembers may be appointed to special committees to provide specialized expertise.. A Board of Director liaison and an NCSBN staff member are assigned to assist each committee. The respective roles of Board liaison, committee chair and committee staff are provided in NCSBN policy. Each work collaboratively to facilitate committee work and provide support and expertise to committee members to complete the charge. Neither the Board liaison nor the NCSBN staff are entitled to a vote, but respectively can advise the committee regarding the strategic or operational impact of decisions and recommendation.

Description of Standing Committees

NCLEX® EXAMINATION COMMITTEE

The NLCEX® Examination Committee comprises at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board of nursing. The committee chair shall have served as a member of the committee prior to being appointed as chair. The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce and deliver the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests enhancements, based on research that is important to the development of licensure examinations.

The Examination Committee advises the Board of Directors on matters related to the NCLEX® examination process, including psychometrics, item development, test security and administration and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation, oversight of test service transitions and preparation of written information about the examinations for Member Boards and other interested parties. The committee also regularly evaluates the licensure examinations by means of item analysis and test, and candidate statistics.

One of NCSBN's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is a key component of this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: 1) whether or not the examination actually measures competencies required for safe and effective job performance, and 2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation.

There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts, and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe and effective practice. The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills and abilities (KSA) statements or competency statements which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a passing standard to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected to recommend a series of passing standards for this process. Judges are trained in conceptualizing the minimally competent candidate (performing at the lowest acceptable level), and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in identification of a series of recommended passing standards. Taking these recommendations along with other data relevant to identification of the level of competence, the Board of Directors sets a passing standard that distinguishes between candidates who do and do not possess the essential competencies, thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes and utilizing item construction and test delivery processes based on sound psychometric principles constitute the best legal defense available for licensing examinations. For most of the possible challenges that a candidate might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

FINANCE COMMITTEE

The Finance Committee comprises at least four members and the treasurer, who serves as the chair. The Committee reviews the annual budget, monitors NCSBN investments, and facilitates the annual independent audit. The Committee recommends the budget to the Board of Directors and advises the Board of Directors on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. It also reviews financial status on a quarterly basis.

NCSBN STAFF

NCSBN staff members are hired by the chief executive officer. Their primary role is to implement the Delegate Assembly's and Board of Directors' policy directives and provide assistance to committees.

GENERAL DELEGATE ASSEMBLY INFORMATION

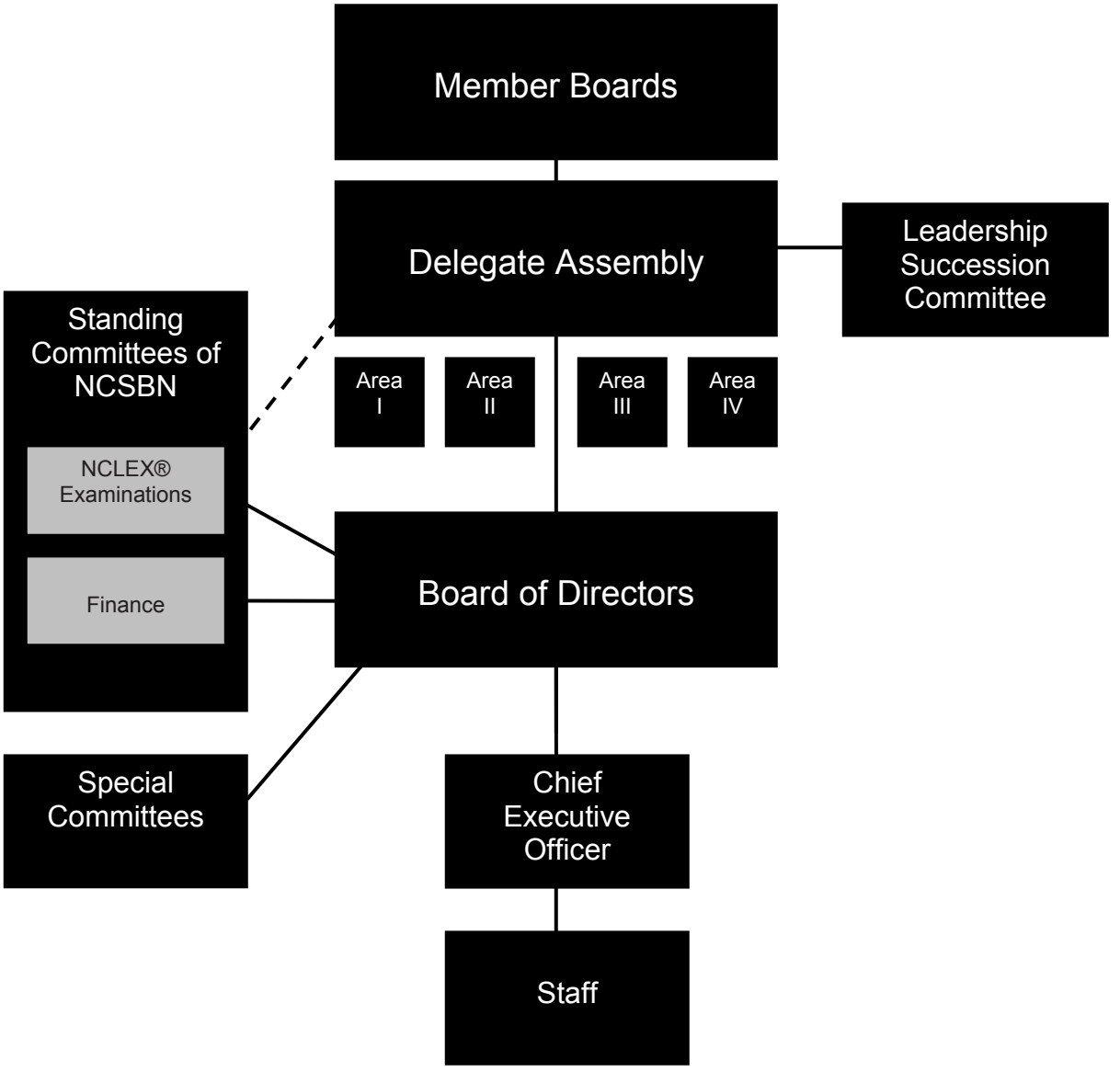
The business agenda of the Delegate Assembly is prepared and approved by the Board of Directors. At least 45 days prior to the Annual Meeting, Member Boards are sent the recommendations to be considered by the Delegate Assembly. A Business Book is provided to all Annual Meeting registrants which contains the agenda, reports requiring Delegate Assembly action, reports of the Board of Directors, reports of special and standing committees, and strategic initiatives and objectives.

Prior to the annual session of the Delegate Assembly, the president appoints the credentials, resolutions, and elections committees, as well as the Committee to Approve Minutes. The president may also appoint a timekeeper, a parliamentarian and pages.

The function of the Credentials Committee is to provide delegates with identification bearing the number of votes to which the delegate is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and the Leadership Succession Committee. The Elections Committee conducts all elections that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits, and evaluates all others in terms of their relationship to NCSBN's mission and fiscal impact to the organization. At a time designated by the president, it reports to the Delegate Assembly.

The parliamentarian keeps minutes of the Delegate Assembly. These minutes are then reviewed, corrected as necessary and approved by the Committee to Approve Minutes, which includes the chief executive officer who serves as corporate secretary.

NCSBN Organizational Chart



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;
- who's 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 nonpharmacologic 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).

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 (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

References

1. American Academy of Nurse Practitioners website. *About AANP*. Retrieved 2 March 2009, from http://www.aanp.org/AANPCMS2/AboutAANP/
2. American Association of Colleges of Nursing website. *About AACN*. Retrieved 2 March 2009, from http://www.aacn.nche.edu/ContactUs/index.htm
3. American Association of Critical Care Nurses website. *AACN fact sheet*. Retrieved 2 March 2009, from http://classic.aacn.org/AACN/mrkt.nsf/vwdoc/CNFactSheet?opendocument
4. American Association of Nurse Anesthetists website. *About AANA*. Retrieved 2 June 2010, from http://www.aana.com/about.aspx?=46
5. American College of Nurse-Midwives website. *About us*. Retrieved 2 March 2009, from http://www.midwife.org/about.cfm
6. American Dental Association website. *ADA mission & values*. Retrieved 2 March 2009, from http://www.ada.org/ada/about/mission/index.asp
7. American Dietetic Association website. Retrieved 2 March 2009, from http://www.eatright.org
8. AILA.org website. *About AILA*. Retrieved 2 March 2009, from http://www.aila.org/content/default.aspx?docid=1021
9. American Medical Association website. *Our mission*. Retrieved 2 March 2009, from http://www.ama-assn.org/ama/pub/about-ama/our-mission.shtml

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)
The 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 40,000 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 mis-

sion 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 3.1 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 health care 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 more than 7,000 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. Since 2001, ANSR has worked to change public policy 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 operates. 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 of APRN certification programs regarding their certification examination. Contains information such as accreditation status, credential granted, exceptions and pass rates.

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.

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 website. *About us.* Retrieved 2 March 2009, from http://www.amcbmidwife.org/c/104/about-us
11. ANA Nursing World website. *About the ANA.* Retrieved 2 June 2010, from http://www.nursingworld.org/FunctionalMenuCategories/AboutANA.aspx
12. American Nurses Credentialing Center website. Retrieved 2 March 2009, from http://www.nursecredentialing.org/
13. Hospitalconnect.com: AONE website. *Welcome to AONE.* Retrieved 2 June 2010, from http://www.aone.org/aone/about/home.html
14. AWHONN: Association of Women's Health, Obstetric and Neonatal Nurses website. *Health policy & legislation.* Retrieved 2 June 2010, from http://www.awhonn.org/awhonn/content.do?name=05_ealthPolicyLegislation%2F5E1_ANSR.htm
15. EEOC U.S. Equal Employment Opportunity Commission website. *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.

APRN ListServ
Open to board members, executive officers of boards of nursing and staff who work with APRN issues. Used for discussion of APRN regulatory issues.

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
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 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 exam. The CPR reflects candidate performance on various aspects of the NCLEX exam 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 accreditation supports and encourages

16. Institute for Credentialing Excellence website. *NOCA's Basic Guide to Credentialing Terminology*. Retrieved 2 June 2010, from http://www.credentialingexcellence.org/portals/0/nocasbasicguidetocredentialingterminology.pdf
17. *All Nursing Schools website. Become a certified nurse-midwife.* Retrieved 2 March 2009, from http://www.allnursingschools.com/faqs/cnm.php
18. American Association of Nurse Anesthetists website. (n.d.) *Questions and Answers: A Career in Nurse Anesthesia.* Retrieved 2 June 2010, from http://www.aana.com/qualifications.aspx
19. Citizen Advocacy Center website. *About us.* Retrieved 2 March 2009, from http://www.citizenadvocacycenter.org/about.html

continuing self-assessment by nursing education programs and the continuing growth and improvement of collegiate professional education.[20]

CGFNS (Commission on Graduates of Foreign Nursing Schools) International
An immigration-neutral nonprofit 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. Available online at www.ncsbn.org/149.htm.

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 an active project of NCSBN, this project provided a framework for the licensed nurse to document learning needs, learning plans and goals/objectives, strategies for development and evaluation of the achievements of goals/objectives. It is an expected activity of all licensed nurses to reflect upon lifelong learning activities and their application to daily practice. The profile was, in essence, the application of the nursing process to one's own competence, professional development and accountability.

Continuing Education Unit (CEU)
Represents 10 contact hours in a formal education program.

Continuous Quality Improvement Survey (CQI)
Results of this annual survey sent to Member Boards are analyzed for program and service improvements.

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 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 for the certification of registered nurse anesthetists who meet all the criteria for entry into practice as a certified nurse anesthetist (CRNA). CCNA is also responsible for the development and administration of the National Certification Examination (NCE).[22]

Council on Licensure, Enforcement and Regulation (CLEAR)
An organization of regulatory boards and agencies.

20. American Association of Colleges of Nursing (AACN) website. *CCNE accreditation.* Retrieved 2 March 2009, from http://www.aacn.nche.edu/Accreditation/
21. CGFNS International website. *Who we are/what we do.* Retrieved 2 March 2009, from www.cgfns.org/sections/about/
22. National Board on Certification & Recertification of Nurse Anesthetists website. Retrieved 2 June 2010, from www.nbcrna.com/certification.html

D

Delegate Assembly (DA)
The membership body of NCSBN comprised of 60 Member Boards. It provides direction through adoption of the mission and strategic initiatives; approves all new memberships; approves the substance of all NCLEX exam contracts between the NCSBN and Member Boards; adopts test plans to be used for the development of the NCLEX exam; and establishes the fee for the NCLEX exam. 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 authority to a competent individual to perform a selected nursing task in a selected situation. A 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-American).

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 Medication Aide Programs
An annual publication available on the NCSBN website with contact information for states that offer medication aide programs.

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 Nur*sys*®, which continues to provide tracking of disciplinary data reported by boards of nursing.

Discipline
The actions taken, as well as the process used, to investigate and resolve complaints received by boards of nursing regarding the practice and/or conduct of licensed nurses. Boards follow their jurisdiction's Administrative Procedures Act, as well as the State Nurse Practice Act and Nursing Administrative Rules/Regulations in providing due process (i.e., the procedural safeguards for the nurse of receiving notice, having an opportunity to respond to allegations and having a fair and objective decision maker) in the enforcement of nursing laws and rules.

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 a speaker dialogue with 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 board 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 small file that is stored as encrypted information on one's computer so that others are not able to read it.

English as a Second Language (ESL)
NCSBN asks NCLEX candidates to 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 a 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
Comprises of executive officers of all boards of nursing or board staff members 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 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 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 U.S. Department of Health & 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 HRSA for the reporting of final adverse actions against health care providers, suppliers or practitioners, as required by HIPAA.

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 HIPDB.

HIPDB Webinars
A series of conference calls, with documents available online, that are held to support the transition to reporting nurse disciplinary actions to 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 website.

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, 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 IRE 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 en-

23. Institute of Medicine of the National Academies website. Retrieved 2 March 2009, from http://www.iom.edu/CMS/3239.aspx

sure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce.[24]

24. International Council of Nurses website. *About ICN*. Retrieved 2 March 2009, from http://www.icn.ch/abouticn.htm

International Scheduling Fee
The charge associated with scheduling an NCLEX exam 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 is held every spring and 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, NNAAP and MACE exams.

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, NCLEX-PN, NNAAP and MACE exams. Item reviewers must meet specific criteria in order to participate on a panel.

Item Writers
Individuals who write items for the NCLEX-RN, NCLEX-PN, NNAAP and MACE exams. 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 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 (KSAs)
The attributes required to perform a job, 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 biannual publication sent to all nursing programs and boards of nursing, updating educators on NCSBN initiatives relevant to nursing education.

Leadership Succession Committee (LSC)
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 to 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 LSC.

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.

25. The Joint Commission website. *About us*. Retrieved 2 March 2009, from http://www.jointcommission.org/AboutUs/
26. U.S. Office of Personnel Management Website. *Policies and instructions*. Retrieved 2 June 2010, from http://www.opm.gov/qualifications/policy/Terms.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

Master Pool Items
NCLEX operational items. The bank of test items from which examinations are developed.

Medication Aide Certification Exam (MACE®)
The medication aide certification examination owned by NCSBN and administered by Pearson Vue.

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 website.

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 website.

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 website.

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 Clinical Nurse Specialists (NACNS)
Enhances and promotes the unique, high value contribution of the clinical nurse specialist to the health and well-being of individuals, families, groups and communities, and to promote and advance the practice of nursing.[28]

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.[29]

National Black Nurses Association (NBNA)
Provides a forum for collective action by African American nurses to investigate, define and determine the health care needs of African-Americans and implement change; and to make health care available to African-Americans and other minorities.[30]

National Certification Corporation (NCC)
A nonprofit association that provides a national credentialing program for nurses, physicians and other licensed health care personnel who 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.[31]

National Conference of State Legislatures (NCSL)
A bipartisan organization that serves the legislators and staff of the 50 states and 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 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.[33]

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 nonprofit organization whose membership comprises boards of nursing in the 50 states, the District of Columbia and four U.S. territories – American Samoa, Guam, Northern Marina Islands and the Virgin Islands. There are also four associate members. 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.

27. National Association for Practical Nurse Education and Services, Inc. (NAPNEP) website. *About us.* Retrieved 2 June 2010, from http://www.napnes.org/about/index.htm
28. National Association of Clinical Nurse Specialists website. Retrieved 25 August 2009, from http://www.nacns.org/
29. National Association of Hispanic Nurses website. Retrieved 3 March 2009, from http://www.thehispanicnurses.org/
30. National Black Nurses Association, Inc. (NBNA) website. *Who we are.* Retrieved 2 March 2009, from http://www.nbna.org/index.php?option=com_content&view=article&id=44&Itemid=60
31. The National Coordinating Council for Medication Error Reporting and Prevention website. *About NCC MERP.* Retrieved 2 June 2010, from http://www.nccwebsite/org/about-ncc.aspx
32. National Certification Corporation website. *What is NCC?* Retrieved 2 March 2009, from http://www.nccnet.org/public/pages/index.cfm?pageid=61
33. National Conference of State Legislatures (NCSL) website. *Mission.* Retrieved 2 June 2010, from http://www.ncsl.org/AboutUs/tabid/305/Defualt.aspx

34. The National Federation of Licensed Practical Nurses, Inc. website. *All About NFLPN*. Retrieved 2 March 2009, from http://www.nflpn.org/allabout-nflpn.htm
35. National League for Nursing (NLN) website. *National League for Nursing Bylaws*. Retrieved 2 March 2009, from http://www.nln.org/aboutnln/Bylaws/index.htm
36. National League for Nursing Accrediting Commission, Inc. (NLNAC) website. *About NLNAC*. Retrieved 2 March 2009, from http://www.nlnac.org/About NLNAC/whatsnew.htm
37. National Student Nurses Association website. Retrieved 2 June 2010, from www.nsna.org

National Federation of Licensed Practical Nurses (NFLPN)
A professional organization for LPNs, LVNs and practical/vocational nursing students in the U.S.[34]

National Institute of Nursing Research (NINR)
Part of the National Institutes of Health; works toward 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 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.[35]

National League for Nursing Accrediting Commission (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.[36]

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 5). Proposed rules to implement section 1921 were published in March 2006 and final rules were published in January 2010.

National Provider Identifier (NPI)
Planned to be a new, unique eight-character alpha-numeric identifier. Created in response to the posting of rules in the Federal Register on May 7, 1998, which proposed a standard for a national health care provider identifier and requirements for its use by health plans, health care clearinghouses and health care providers.

National Student Nurses Association (NSNA)
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.[37]

NCLEX® Administration Website
Allows Member Boards to process and manage NCLEX candidate records. Member Boards use the site to perform tasks such as 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, information 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 website 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 exams and enlightens them about the development and administration of the NCLEX-RN® and NCLEX-PN® Examinations. The intended audience is nursing regulators, nursing educators and other stakeholders.

NCLEX® Item Review Subcommittee
An NCSBN committee that assists the NCLEX® Examination Committee with item review.

NCLEX® Member Board Manual
Provides all the information Member Board staff need to know regarding the NCLEX exam and the NCLEX process. The manual is intended for use by Member Board staff and is located on the members-only side of the NCSBN website. It is updated as changes occur to the NCLEX program.

NCLEX® Program Reports
Published twice a year for subscribing schools of nursing, reports provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX exam. Included in the reports: information about a given program's performance by the NCLEX test plan dimensions and content areas, and data regarding the program's rank at both national and state levels.

NCLEX® Quarterly Reports
Reports that summarize the performance of all first-time candidates educated in a given jurisdiction and tested in a given quarter, and the national group of candidates. They also provide a summary of the preceding three quarters' passing rates.

NCLEX® Quick Results Service
Candidates in select jurisdictions may access their "unofficial" results via the NCLEX® Candidate Web site or through the NCLEX® Quick Results Line. "Unofficial" results are available two business days after taking the test. There is a charge for the service.

NCLEX® Regional Workshop
A one-day 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.

NCLEX® Registration Methods
Method(s) by which NCLEX candidates register for the NCLEX through the 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.

NCSBN Board of Directors (BOD)
Administrative body of NCSBN, consisting of 11 elected officers whose authority is to transact the business and bylaws of the affairs of NCSBN. The BOD 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. Visit 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
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 Website
The private side of NCSBN's website, which provides access to nonpublic NCSBN documents, meeting minutes and works in progress. Accessible only by a preassigned password.

NCSBN Public Website
NCSBN's public website (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 who 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 BOD development.

Nonlicensure Participating Board of Nursing
A board of nursing that is not supplying license information on a regular basis. However, nonparticipating 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.
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 by special request, for licensure, discipline and other board staff, for the purpose of learning how to use Nursys.

O

Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)
Contains requirements for nurse aide training and competency evaluation.

Online Nur*sys*® Verification Request Application
The electronic application that a nurse completes to request verification of existing licenses from participating boards of nursing in Nur*sys*.

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 exam, 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 (PPCs)
Pearson Professional Centers are testing locations where candidates take the NCLEX exams.
See Pearson Professional Testing entry.

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 for the administration of the NCLEX, NNAAP and MACE exams.

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 which 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
Bimonthly calls intended for executive officers (and/or their designated policy contact on staff) and Member Board presidents 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®, and NNAAP™ & MACE™ Examinations departments 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 BOD in the enforcement of all policies and regulations relating to NCSBN and performs all other duties normally incumbent upon the BOD 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, NNAAP and MACE exams for gathering statistics. Pretest items are not used in determining the pass/fail result.

Privilege to Practice
This refers to the multistate licensure privilege, which is the authority to practice nursing in any compact state that is not the state of residency. Additional license is not granted for this authority.
See also Nurse Licensure Compact entry.

Professional Accountability and Legal Liability for Nurses
Online course offered through NCSBN Learning Extension for practicing nurses. Learners earn 5.4 contact hours for completing the course.

Professional Boundaries
The space between the nurse's power and the client's vulnerability—the power of the nurse comes from the professional position and access to private knowledge about the client. Establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the client's needs. Complimentary professional boundaries materials are available from NCSBN.

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 exam, the "decision consistency statistic" is the preferred statistic for assessing reliability. NCSBN uses the Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of the National Nurse Aide Assessment Program (NNAAP).

Resolutions Committee
Comprised of at least four members generally representing each of the four NCSBN geographical areas and includes one member of the Finance Committee. Reviews, evaluates and reports to the Delegate Assembly all resolutions and motions submitted by Member Boards. The committee is governed by the operational policies and procedures, the standing rules and the bylaws.

Resource Manual for International Nurses
User-friendly resource on the members-only NCSBN website, 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 exam.

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, NCLEX-PN, NNAAP and MACE exams 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.

38. U.S. Department of Education website. *An overview of the U.S. department of education.* Retrieved 3 June 2010, from www2.ed.gov/about/overview/focus/what.htm/#whatis
39. U.S. Department of Health & Human Services website. *HHS: what we do.* Retrieved 2 March 2009, from http://www.hhs.gov/about/whatwedo.html/
40. Homeland Security Web site. *Department subcomponents and agencies.* Retrieved 2 March 2009, from http://www.dhs.gov/xabout/structure/
41. U.S. Drug Enforecement Administration website. *DEA mission statement.* Retrieved 2 March 2009, from http://www.dhs.gov/xabout/structure/

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.[38]

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.[39]

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."[40]

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 nonenforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.[41]

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 CGFNS; however, the NCLEX exams may be 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, discuss issues or 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 and Medication Aide
Workshop presented by NCSBN each year to provide current information on regulatory issues with unlicensed nursing personnel and to provide a forum for boards of nursing and other interested stakeholders to discuss emerging issues and to network.