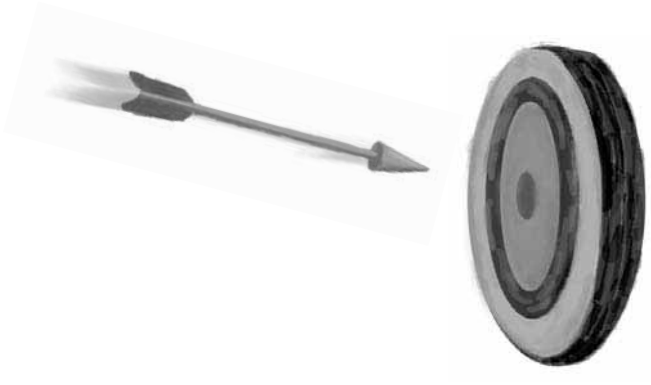

SECTION II

COMMITTEE REPORTS

Committee Members

Cookie Bible, Board President, NV, Area I, Chairperson*

Shelley Conroy, Board Member, VA, Area III*

Eileen Gloor, Associate Director, Nursing Education, IA, Area II*

Rose Kearney-Nunnery, Board President, SC, Area III*

Patricia Polansky, Executive Director, NJ, Area IV

Mary Smedley, Practice Consultant/Assistant Executive Director, WY, Area I*

Robin Vogt, Board Member, MO, Area II

**Denotes members who participated on the Education Standards Ad Hoc Group*

Consultant
Usrah Claar-Rice

Board Liaison
Deborah Burton, Board Member, OR, Area I, Director-at-Large

Staff
Donna Nowakowski, Associate Executive Director for Nursing Regulation

Renee Scaletta, Senior Coordinator

PR&E Subcommittee on Foreign Nurse Issues

Subcommittee Members
Patricia Polansky, Executive Director, NJ, Area IV, Chairperson

Usrah Claar-Rice, Nursing Education Consultant, CA-RN, Area I

Eileen Gloor, Associate Director, Nursing Education, IA, Area II*

Louise Shores, Education Consultant, OR, Area I

Board Liaison
Deborah Burton, Board Member, OR, Area I

Staff
Nancy Chornick, Director of Credentialing and Professional Development

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

Recommendations to the Delegate Assembly

Recommendation #1

Adopt the proposed 2002 Model Nursing Practice Act.

Rationale

The existing National Council Model Nursing Practice Act was last reviewed in 1993 and subsequently adopted in August 1994. The PR&E Committee determined in its initial meeting that the revisions of the Model Administrative Rules must be preceded by a revision of the Model Nursing Practice Act. The Board of Directors subsequently approved this implementation tactic for the progression of completion of both models. Upon analysis, the Model Nursing Practice Act was no longer relevant to state-of-the-art regulatory practice nor truly reflective of the practice of nurses in the current health care environment. Secondly, the 1994 Model did not sufficiently represent the differences in the practice of LPN/VNs, RNs and APRNs. Additionally, previous Delegate Assembly actions to adopt the Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements and the Nurse Licensure Compact were not reflected in the existing Model.

Recommendation #2

Adopt the proposed 2002 Model Administrative Rules, Chapter Five, Nursing Education.

Rationale

The existing National Council Model Administrative Rules were adopted in August 1994.

Background of the Practice, Regulation and Education Committee

The Board of Directors charged the PR&E Committee, assisted by the PR&E Subcommittee to Develop the Model Rules and Act, with the responsibility to review and revise as necessary the National Council's Model Nursing Practice Act and Model Nursing Administrative Rules for consideration by the 2002 Delegate Assembly.

Further, the Board charge to the PR&E Committee included that the committee recommend priority areas for revision of the model practice act and rules. In order to assure its completion, the Board of Directors appointed a special committee, the PR&E Subcommittee to Develop Model Rules to prepare the model under the direction of the PR&E Committee.

Background of the PR&E Subcommittee to Develop the Model Rules and Act

The subcommittee determined its best course was to revise the entire Model Nursing Practice Act as a prerequisite to any work on the Model Nursing Administrative Rules. The subcommittee requested and the PR&E Committee subsequently decided that the PR&E Committee would perform the work necessary to develop the model rules for the education program section of the existing

model this year. It was clear that the focus of the subcommittee on the revision of Model Nursing Practice Act would prevent the subcommittee from attending to any work on the Model Nursing Administrative Rules this year.

In approaching its work to revise the Model Nursing Practice Act, the subcommittee used a framework that had been developed by a previous National Council Model Rules Subcommittee. Before the subcommittee began the review of the current model, members identified their guiding principles and assumptions.

Guiding Principles

The primary purpose of the Model Nursing Practice Act and Model Nursing Administrative Rules is to promote public safety in a dynamic health care environment by supporting boards of nursing in their regulatory functions. A fundamental set of principles and a common core of nursing knowledge are shared by all nurses. The common core of nursing knowledge is based upon scientific principles, clinical skills, ethical values, legal parameters and strategies for the management of people and resources. The nurse is accountable for practicing within the legal, ethical and professional standards governing nursing.

Assumptions

Statutes and rules/regulations should be understandable and usable for nurses, employers, consumers and other interested parties. The nurse has frequent and sustained interactions with patients and families. In many situations, the nurse can be both the front and the last lines of defense against medical error. There is inherent value and worth in each nursing licensure level and each nursing education pathway. Each level of nursing licensure contributes to the provision of physical and psychosocial care as well as the management of the care of individuals and groups. Each should be respected for what it brings to the profession.

Nursing practice is the utilization of professional judgment in the application of nursing knowledge and skills to promote client outcomes. Recognition of both theoretical and experiential learning contributes to the evolution of nursing practice and is reflective of the professional expectations of life-long learning and ethical practice.

Supporting Data

1. Selected data elements from three NCSBN research studies:
   - Linking the NCLEX-RN® Examination in Practice: 2000 Practice Analysis of Newly Licensed Practical/Vocational Nurses in the United States.
   - July 2001 Newly Licensed Nurse Practice and Professional Issues Survey.
   - 2001 Employer Survey.
2. Consulted 13 NCSBN and other national publications and resources such as FARB Model Practice Act, various State Nursing Practice Acts, Council of State Governments Model Legislation, nursing and business literature (education, delegation, alternative programs).
3. Requested and considered direct feedback on existing language in the current model act and rules, and suggestions for revisions from relevant NCSBN committees and member program staff (discipline and non-discipline programs).

Scope of Practice Analysis

The most significant body of work completed in preparation for the model act revision process was a comprehensive analysis of critical elements of scopes of practice for nurses. In examining the scopes of practice, the subcommittee analyzed the critical elements of nursing scopes of practice, which include:

1. Advocacy
2. Assessment

Relationship to Strategic Plan

Strategic Initiative I – Nursing Competence: National Council will assist Member Boards in their role in the evaluation of nurse and nurse aide competence.

Outcome F: Research demonstrates relationships of various regulatory approaches to validate continued competence.

Strategic Initiative 2 – Regulatory Effectiveness: The National Council will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome C: Strategies assist Member Boards to respond effectively to critical issues and trends impacting nursing education.

Outcome E: Approaches and resources address issues related to assistive nursing personnel.

Outcome H: Resources and tools assist Member Boards to measure performance

Strategic Initiative 3 – Public Policy: The National Council will analyze the changing health care environment to develop state and national strategies to impact public policy and regulation effecting public protection.

Outcome A: National Council and Member Board leadership impacts national and state health care and regulatory policy.

Outcome C: National Council analysis of national and international trends impacting public protection is current and disseminated to Member Boards.

PR&E Subcommittee to Develop Model Act and Rules

Subcommittee Members
Barbara Newman, Director of Nursing Practice, MD, Area IV, Chairperson

Margarita Bautista-Gay, Executive Director, GU, Area I

Clara Dorris, Board Member, KY, Area III

Jacqueline Hightower, Executive Director, GA-PN, Area III

Gwelliam Hines, Board Member, DE, Area IV

Pamela Randolph, Nurse Practice Consultant, AZ, Area I

Cynthia VanWingerden, Nurse Consultant, VI, Area IV

Sandra Webb-Booker, Board Member, IL, Area II

Board Liaison
Myra Broadway, Executive Director, ME, Area IV

Staff
Vickie Sheets, Director for Practice and Regulation

3. Delegation/Assignment
4. Evaluation
5. Nursing Care Implementation
6. Nursing Care Planning
7. Supervision/Management
8. Teaching/Counseling

This analysis included identification of components and determination of what aspects of each component was done by RNs and/or LPN/VNs. The subcommittee also included a comparison of scopes of practice for licensed nurses and the role of nursing assistants (Attachment B). The subcommittee found the work very useful in preparation for revision of the model act and plans to use the detailed analysis when the model rules revision is undertaken next year. Input from the APRN Task Force was also useful in sections of the act pertaining to APRNs and will be essential in revision to the model rules in 2002-2003. The subcommittee also plans to develop an analysis of professional accountability (member of the profession) and develop a chapter on the role of unlicensed assistive and nursing assistive personnel.

Background of the PR&E Education Standards Ad Hoc Group

The PR&E Committee formed a subgroup of four committee members to revise the Nursing Administrative Rules, Chapter 5, Nursing Education Program Approval. The subgroup was well diversified and included members that represented nursing education program deans and faculty, nursing education and practice board staff and a board president. Using the Standards of Nursing Education revised and approved by the committee at its December 2001 meeting as the framework on which to build, the subgroup succeeded in revising the model education rules section.

At its April meeting, the full PR&E Committee revised the Standards of Nursing Education (Attachment F) and approved the 2002 Model Education Rules (with revisions) to be sent to the Board of Directors for its review and approval. The 10 Standards of Nursing Education provide a foundation for the rules and regulation as each section of the education program rules reference back to one or more standards. The proposed Model Rules address many critically important regulatory elements including:

1. Differences in board process related to education program approval vs. accreditation.
2. Reflects the educational environment as well as the practices of Member Boards.
3. Incorporates distance learning as an educational strategy.
4. Stressed the importance of evidenced-based outcomes for nursing program evaluation consistent with national and state approaches to educational standards that focus on improvement.
5. Incorporates language necessary for compact states.
6. Sets reasonable and relevant qualifications for program administrators and faculty, recognizing the need for possible alternative faculty in limited circumstances.
7. Distinguishes between several categories of educational program approval and separates that for new vs. existing programs.
8. Provides an appeal mechanism for programs denied approval in accordance with due process rights.

Background of the Subcommittee on Foreign Nurse Issues

At its January meeting, the Board of Directors approved a request from the PR&E Committee to appoint a Subcommittee on Foreign Nurse Issues. The subcommittee met three times and reviewed foreign nurse issues from a regulatory perspective. A grid was developed to identify priority foreign nurse issues, determine how the issues can be resolved and identify potential final products. (Fig. 1)
The subcommittee on Foreign Nurse Issues identified two additional foreign nurse issues not listed in Fig. 1: (1) English language skills/communication and (2) tracking and reporting of foreign nurses. The subcommittee felt that both of these issues are of equal importance to the issues of education, immigration/refugee status and initial licensure/endorsement. The English skills issue regarding foreign nurses is currently be explored by the National Council's Testing Services Department. The subcommittee met with the Director of Testing to discuss testing of foreign nurses in the United States and other countries and to ensure that its concerns were being addressed. Regarding the tracking and reporting of foreign nurse issues, it was determined that this issue would not be undertaken at this time due to absence of available mechanism to collect data.

The subcommittee recommended to the PR&E Committee that the term of the subcommittee be continued for one additional year to enable them to fully address the foreign nurse issues and produce the necessary member resources.

Meeting Dates

- November 15, 2001 (PR&E Subcommittee to Develop Model Rules teleconference call)
- November 19-20, 2001 (PR&E Committee)
- January 16-17, 2002 (PR&E Subcommittee to Develop Model Rules)
- February 14-15, 2002 (PR&E Committee)
- February 15, 2002 (PR&E Subcommittee on Foreign Nurse Issues)
- February 16-17, 2002 (PR&E Subcommittee to Develop Model Rules)
- April 4-5, 2002 (PR&E Subcommittee to Develop Model Rules)
- April 15, 2002 (PR&E Subcommittee on Foreign Nurse Issues)
- April 15-16, 2002 (PR&E Committee)

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Figure 1. Foreign Nurse Issues, Process and Outcomes

ISSUES	PROCESS	GUIDELINES FOR MEMBER BOARDS
1. Education • Equivalency • Remediation of gaps when they occur (e.g. education bridge courses) • Pre- & post-licensure in home country • Validation process • LPN and RN transcript evaluations	• Development of criteria • Evaluation of vendors • Data collection – survey Member Boards • Identification of existing bridge programs available to eligible NCLEX candidates (e.g., community colleges)	• Guidelines for Member Boards
2. Immigration/Refugee Status • Visa screens – ongoing changes • Equal standards used when addressing workforce issues • Student visas • Issues of immigration status and licensure • Requirements for Social Security Numbers • Inappropriate use of Tax Identification Numbers	• Survey Member Boards • Monitor changes in law • Access current legislative activity • Review immigration and naturalization laws	• Guideline Manual • Talking points directed to state and federal legislators for Member Boards
3. Initial Licensure/ Endorsement • Uniformity of approach/standards to be adopted by states and territories • Variety of state endorsement until licensure • Nursing programs developed to train foreign non-nurse health care providers	• Review available data: Profiles, current legislation, current legislation former foreign nurse committee materials • Survey Member Boards	• Position statement • Legislative language for Model Rules • Guidelines

- April 23, 2002 (PR&E Subcommittee to Develop Model Rules teleconference call)
- April 30, 2002 (PR&E Subcommittee on Foreign Nurse Issues)
- May 10, 2002 (PR&E Subcommittee to Develop Model Rules teleconference call)
- June 7, 2002 (PR&E Committee conference call)

Attachments

A. Proposed 2002 Model Nursing Practice Act for adoption
B. Proposed 2002 Model Nursing Practice Act for adoption with comparison with current Model Nursing Practice Act and rationale
C. Comparison of Scopes of Practice for licensed nurses and the role of nursing assistants
D. 2002 Model Nursing Administrative Rules
E. 2002 Model Nursing Administrative Rules with comparison and rationale
F. Revised Standards of Nursing Education
G. Revised Statement on Distance Education
H. Regulatory Priorities Survey Ranking

Highlights of FY02 Activities

- Recommended revisions to the Model Nursing Practice Act and Model Nursing Administration Rules, Chapter 5, to the Board of Directors for presentation to the 2002 Delegate Assembly.
- Developed and disseminated a distance education survey to obtain information about regulatory strategies and opinions of members regarding distance education.
- Developed, disseminated and analyzed results of a 2001 member regulatory survey and a follow-up 2002 survey of regulatory priorities spanning years 2002-2010.
- Prepared plans and curriculum outline for the November 2002 Patient Safety Summit to be held in conjunction with the Citizen Advocacy Center annual meeting.
- Discussed a strategy to address UAP issues in the committee's ongoing work.
- Conducted a brainstorming session to provide input to staff and the Board of Directors for tactic planning for 2003.
- Considered the report of the education consultant preceptorship/mentorship program conference call. The committee met with Anita Ristau regarding the Vermont Nurse Internship Coalition and discussed the need for reliable data regarding the impact of preceptorships on examination performance and competency.
- Reviewed and provided feedback to NCSBN research staff on all 2001 studies, discussed findings and recommended an information distribution strategy to the Board of Directors.

Future Activities

- Review results of NCSBN surveys and studies for emerging patterns and changes in nursing practice and education for implications to nursing regulation.
- Explore methods and develop resources to promote uniform scope-of-practice.
- Conduct a conference in collaboration with other regulatory groups to develop strategies for continued competence.
- Review results of Member Boards initiatives under the Citizen Advocacy Center Practice Remediation and Education Partnership.
- Recommend revisions to the Model Nursing Administrative Rules for consideration by the 2003 Delegate Assembly.
- Conduct a patient safety summit for regulators.
- Develop criteria for Member Boards using national accrediting agencies for the accreditation of nursing education programs.
- Explore evidence-based indicators of quality nursing education programs.
- Explore models for nurses' transition from education to practice.
- Design approaches and member resources to address issues related to assistive nursing personnel and conduct a UAP roundtable.
- Review applicable recommendations of the PERC action plan.
- Provide resource materials to Member Boards on the education, immigration and endorsement of foreign nurses.
- Stay informed on legislative and regulatory initiatives relative to nursing, health care professional shortages and environment of care issues as they impact public protection.

PR&E Committee: Attachment A

2002 Proposed Model Nursing Practice Act

Article I. Title and Purpose

Section 1. *Title of Act.* This Act shall be known and may be cited as *The [state] Nursing Practice Act*.

Section 2. *Description of Act.* An Act concerning the regulation of the practice of nursing; that creates and empowers the State Board of Nursing to regulate the practice of nursing and to enforce the provisions of this act.

Section 3. *Purpose.* The legislature finds that the practice of nursing is directly related to the public welfare of the citizens of the state and is subject to regulations and control in the public interest to assure that practitioners are qualified and competent. It is further declared that the practice of nursing, as defined in the Act, merits and deserves the confidence of the public and that only qualified persons be permitted to engage in the practice of nursing. The legislature recognizes that the practice of nursing is continually evolving and responding to changes within health care patterns and systems and recognizes the existence of overlapping functions within the practice of nursing and other providers of health care. This Act shall be liberally construed to carry out the objectives and purposes set forth in this Act.

Article II. Definitions and Scope

Section 1. *Practice of Nursing.* The *practice of nursing* means assisting individuals or groups to attain or maintain optimal health, implementing a strategy of care to accomplish defined goals, and evaluating responses to nursing care and treatment. Nursing practice includes both basic health care that helps individuals and groups of people cope with difficulties in daily living associated with their actual or potential health or illness status, and those nursing activities that require a substantial amount of scientific knowledge or technical skill. Nursing practice includes, but is not limited to:

1. Providing comfort and caring;
2. Providing attentive surveillance to monitor patient conditions and needs;
3. Promoting an environment conducive to well being;
4. Planning and implementing independent nursing strategies and prescribed treatment in the prevention and management of illness, injury, disability or achievement of a dignified death;
5. Promoting and supporting human functions and responses;
6. Providing health counseling and teaching; and
7. Collaborating on aspects of the health regimen; and
8. Advocating for the client.

Nursing is both an art and a scientific process founded on a professional body of knowledge; it is a learned profession based on an understanding of the human condition across the lifespan and the relationship of an individual with others and within the environment. Nursing is a dynamic discipline that is continually evolving to include more sophisticated knowledge, technologies, and patient care activities.

Section 2. *Registered Nurse.* Practice as a Registered Nurse means the full scope of nursing, with or without compensation or personal profit, and includes caring for all clients in all settings; and includes but is not limited to:

a. Providing comprehensive assessment of the health status of individuals, families, groups and communities.
b. Developing a comprehensive nursing plan that establishes nursing diagnoses; sets goals to meet identified health care needs; and prescribes nursing interventions.
c. Implementing nursing care through the execution of independent nursing strategies and prescribed medical regimen.
d. Managing nursing care through cohesive, coordinated care management within and across care settings.
e. Delegating and assigning nursing interventions to implement the plan of care.
f. Providing for the maintenance of safe and effective nursing care rendered directly or indirectly.
g. Promoting a safe and therapeutic environment.
h. Providing health teaching and counseling to promote, attain and maintain the optimum health level of individuals, and communities.
i. Advocating for individual clients, groups and communities by attaining and maintaining what is in the best interest of the individual client or group.
j. Evaluating responses to interventions and the effectiveness of the plan of care.
k. management of health care and the implementation of the total health care regimen.
l. Acquiring and applying critical new knowledge and technologies to practice domain.
m. Managing, supervising and evaluating the practice of nursing.
n. Teaching the theory and practice of nursing.
o. Participating in patient and health systems management.
p. Other acts that require education and training as prescribed by the Board. Additional nursing services shall be commensurate with the registered nurse's experience, continuing education and demonstrated competencies.

Each Registered Nurse is accountable to clients, employers, the nursing profession and the board for complying with the requirements of this Act and the quality of nursing care rendered; and for recognizing limits of knowledge and experience and planning for management of situations beyond the nurse's expertise.

Section 3. *Licensed Practical/Vocational Nurse*. Practice as a Licensed Practical/Vocational Nurse means a directed scope of nursing practice, with or without compensation or personal profit, under the supervision of the Registered Nurse, Advanced Practice Registered Nurse, licensed physician, or other health care provider authorized by the state to delegate health care activities and functions; and includes, but is not limited to:

a. Collecting data and conducting focused assessments of the health status of individuals and groups, and contributing to the comprehensive assessment of individuals, families and groups.
b. Planning nursing care during care episode for clients with stable conditions.
c. Participating in the development and modification of the comprehensive plan of care for all types of patients.
d. Implementing the appropriate aspects of the strategy of care within the LPN/VN scope of practice;
e. Participating in nursing care management through delegating, assigning and directing nursing interventions that may be performed by others, including other LPN/VNs, that do not conflict with the act.
f. Maintaining safe and effective nursing care rendered directly or indirectly.
g. Promoting a safe and therapeutic environment.
h. Participating in health teaching and counseling to promote, attain and maintain the optimum health level of individuals.

i. Serving as an advocate for the client by communicating and collaborating with other health service personnel.
j. Participating in the evaluation of client responses to interventions.
k. Communicating and collaborating with other health care professionals in the nursing practice management.
l. Contributing to patient and health systems management.
m. Other acts that require education and training as prescribed by the Board. Additional nursing services shall be commensurate with the licensed practical nurse's experience, continuing education and demonstrated competencies.

Each nurse is accountable to clients, employers, the nursing profession and the board for complying with the requirements of this Act and the quality of nursing care rendered; and for recognizing limits of knowledge and experience and planning for management of situations beyond the nurse's expertise.

Section 4. ***Advanced Practice Registered Nurse.*** Advanced Practice Registered Nursing by Nurse Practitioners, Registered Nurse Anesthetists, Nurse Midwives or Clinical Nurse Specialists is based on knowledge and skills acquired in basic nursing education; licensure as a Registered Nurse; graduation from or completion of a graduate level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate APRN specialty.

Practice as an Advanced Practice Registered Nurse means an expanded scope of nursing, with or without compensation or personal profit, and includes but is not limited to:
a. Assessing clients, synthesizing and analyzing data, and understanding and applying nursing principles at an advanced level.
b. Analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem and selecting appropriate treatment.
c. Making independent decisions in solving complex client care problems.
d. Developing a health regimen plan that establishes diagnoses, sets goals to meet identified health care needs, and prescribes a regimen of health care.
e. Performing acts of diagnosing, prescribing, administering and dispensing therapeutic measures, including legend drugs and controlled substances, within the advanced practice registered nurse's focus of practice.
f. Managing clients' physical and psychosocial health-illness status.
g. Providing for the maintenance of safe and effective nursing care rendered directly or indirectly.
h. Promoting a safe and therapeutic environment.
i. Providing expert guidance and teaching.
j. Participating in patient and health systems management.
k. Advocating for individual clients, groups and communities by attaining and maintaining what is in the best interest of the individual client or group.
l. Evaluating responses to interventions, the effectiveness of the plan of care and the health regimen.
m. Communicating and working effectively with clients, families and other members of the health care team.
n. Utilizing research skills and acquiring and applying critical new knowledge and technologies to practice domain.
o. Teaching the theory and practice of advance practice nursing.

Each advanced practice registered nurse is accountable to clients, employers, the nursing profession and the board for complying with the requirements of this Act and the quality of nursing care rendered; for recognizing limits of knowledge and experience, planning for management of situations beyond the nurse's expertise;

and for consulting with or referring clients to other health care providers as appropriate.

This act shall supersede all prior inconsistent statutes, rules or regulations regarding this subject.

Section 5. *Board.* "Board" means the (state) Board of Nursing.

Section 6. *Other Board.* "Other Board" means the comparable regulatory agency in any U.S. state, territory or the District of Columbia.

Section 7. *License.* "License" means a current document permitting the practice of nursing as a Registered Nurse, Licensed Practical/Vocational Nurse, or Advanced Practice Registered Nurse.

Section 8. *Other Definitions.*

a. Absolute discharge from sentence – Completion of any sentence including imprisonment, probation, parole, community supervision or any form of court supervision.
b. Assignment – Designating nursing activities to be performed by an individual consistent with his/her scope of practice (licensed person) or role description (unlicensed person).
c. Chief Administrative Nurse – The Registered Nurse who oversees the provision of nursing services in an organization, regardless of title.
d. Client – The individual, family, group or community receiving nursing care.
e. Compact – An interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of interstate concern.
f. Comprehensive assessment by the RN – Means an extensive data collection for patients, families, groups and communities addressing anticipated changes in patient conditions as well as emergent changes in a patient's health status; recognizing alterations to previous patient conditions; synthesizing the biological, psychological and social aspects of the patient's condition; evaluating the impact of nursing care; and using this broad and complete analysis to make independent decisions and nursing diagnoses; plan nursing interventions; evaluate need for different interventions; and the need to communicate and consult with other health team members.
g. Cooperation – Cooperate, assist or joint effort.
h. Delegation – Transferring to a competent individual the authority to perform a selected nursing task in a selected situation.
i. Emergency – Sudden state of danger, conflict, crisis, requiring immediate action.
j. Focused assessment by the LPN/VN – Means an appraisal of the patient's status and situation at hand, which includes comparing that appraisal to the patient's previous condition and identified problems; making preliminary decisions regarding the implementation of actions per the nursing care plan or protocol; and deciding who needs to be informed of this information and when.
k. Health Care Provider – An individual authorized (e.g., licensed or certified) to prescribe and/or administer various aspects of health care.
l. Health Care Regimen – Prescribed course of actions conducive to attaining and/or maintaining physical and mental well-being.
m. Licensure by Endorsement – Means the granting of authority to practice is based on an individual's licensure (having met comparable requirements) in another jurisdiction.
n. Licensure by Examination – Means the authority to practice is based on an assessment of minimum competency by such means as the boards shall determine.

o. Nurse Licensure Compact (NLC) – Is a compact between participating states to facilitate the regulation of nurses. The compact is adopted by each state legislature, and allows a nurse licensed in a compact state to practice under a multistate privilege in all other compact states.
p. Nurse Licensure Compact Administrators (NLCA) – Are the administrators of each compact state who are responsible for implementing and coordinating the NLC.
q. Person – Means an individual, corporation, partnership, association, unit of government or other legal entity.
r. Prescriptive Authority – Means the power to determine the need for drugs, immunizing agents, or devices; selecting the remedy; and writing a prescription to be filled by a licensed pharmacist.
s. Standards of Nursing Practice – Means those standards adopted by the Board that interpret legal definitions of practice.
t. Student Nurse – A person who is studying in an approved nursing education program.
u. Unauthorized Practice – Means the practice of Licensed Practical/Vocational Nursing, Registered Nursing or Advanced Practice Registered Nursing by any person who has not been authorized to practice nursing under the provision of this Act.

Article III. The Board of Nursing

Section 1. ***Membership; Appointment; Nominations; Term of Office; Removal; Vacancies; Qualifications; Immunity.***

a. The Board of Nursing shall consist of ( ) members to be appointed by the Governor ( ) days prior to the expiration of the term of office of a current member. Nominations for appointment may be made to the Governor by any interested individual, association, or any other entity, provided that such nominations be supported by a petition executed by no less than ( ) qualified voters in this State. These nominations shall not be binding upon the Governor.
b. The membership of the Board shall be at least ( ) members of Registered Nurses; at least ( ) members of Licensed Practical/Vocational Nurses; at least ( ) members of Advanced Practice Registered Nurses; and at least ( ) members representing the public.
    1. Each Registered Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as a Registered Nurse, and shall have no less than five (5) years of experience as a Registered Nurse, at least three (3) of which immediately preceded appointment.
    2. Each Licensed Practical/Vocational Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as a Licensed Practical/Vocational Nurse, and shall have no less than five (5) years of experience as a Licensed Practical/Vocational Nurse, at least three (3) of which immediately preceded appointment.
    3. Each Advanced Practice Registered Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as an Advanced Practice Registered Nurse, and shall have no less than five (5) years of experience as a Advanced Practice Registered Nurse, at least three (3) of which immediately preceded appointment.
    4. The representatives of the public shall be eligible voting residents of this

State who are knowledgeable in consumer health concerns, and shall not be associated with the provision of health care or be enrolled in any health-related education program.

5. Membership shall be restricted to no more than one (1) person who is associated with a particular agency, corporation other enterprise or subsidiary at one time.

c. Members of the Board shall be appointed for a term of ( ) years.
   1. The present members of the Board holding office under the provisions of the (Act being amended or repealed) shall serve as members for their respective terms.
   2. No member shall serve more than two (2) consecutive full terms. The completion of an unexpired portion of a full term shall not constitute a full term for purposes of this section. Any Board member initially appointed for less than a full term shall be eligible to serve two (2) additional terms.
   3. An appointee to a full term on the Board shall be appointed by the Governor before the expiration of the term of the member being succeeded and shall become a member of the Board on the first day following the appointment expiration date. Appointees to unexpired terms shall become members of the Board on the day following such appointment.
   4. Each term of office shall expire at midnight on the last day of the term of the appointment or at midnight on the date on which any vacancy occurs. If a replacement appointment has not been made, the term of the Member shall be extended until a replacement is made.
d. Any vacancy that occurs for any reason in the membership of the Board shall be filled by the Governor in the manner prescribed in the provisions of this article regarding appointments. Vacancies created by reason other than the expiration of a term shall be filled within ( ) days after such vacancy occurs. A person appointed to fill a vacancy shall serve for the un-expired portion of the term.
e. The governor may remove any member from the Board for neglect of any duty required by law or for incompetence or for unprofessional or dishonorable conduct. The general laws of this State controlling the removal of public officials from office shall be followed in dismissing Board members.
f. All members of the Board shall have immunity from individual civil liability while acting within the scope of the duties as Board members.
g. In the event that the entire Board, an individual member or staff is sued, the Attorney General shall appoint an attorney to represent the involved party.
h. Board meetings and hearings shall be open to the public. In accordance with the law, the Board may in its discretion conduct part of the meeting in executive session closed to the public.

Section 2. *Powers and Duties. The Board shall:*

a. Be responsible for interpretation and enforcement of the provisions of this Act. The Board shall have all of the duties, powers and authority specifically granted by and necessary to the enforcement of this Act, as well as other duties, powers and authority as it may be granted by appropriate status;
b. Be authorized to make, adopt, amend, repeal and enforce such administrative rules consistent with law as it deems necessary for the proper administration and enforcement of this Act and to protect the public health, safety and welfare.
c. Be authorized to make, adopt, amend, repeal and enforce such administrative rules consistent with the law as it deems necessary for the regulation of advanced nursing practice.
d. Further be authorized to do the following without limiting the foregoing:
   1. Develop standards for nursing education.

2. Shall enforce educational standards and rules set forth by the Board.
3. Require criminal background checks on applicants and licensees.
4. License qualified applicants for RN and LPN/VN licensure by examination or endorsement, and renew and reinstate licenses.
5. Regulate the advanced practice of nursing by Advanced Practice Registered Nurses.
6. Regulate the clinical support of nursing services by unlicensed assistive personnel regardless of title.
7. Maintain a record of all persons regulated by the Board.
8. Develop and enforce standards for nursing practice.
9. Develop rules to govern delegation by and to nurses.
10. Develop standards for maintaining competence of licensees continuing in or returning to practice.
11. Collect and analyze data regarding nursing education, nursing practice, and nursing resources.
12. Issue subpoenas in connection with investigations, inspections and hearings.
13. Access to records as reasonably requested by the Board to assist the Board in its investigation; the Board shall maintain any records obtained pursuant to this paragraph as confidential data.
14. Order licensees to submit to physical, mental health or chemical dependency evaluations for cause.
15. Cause prosecution of allegations of violations of this Act.
16. Conduct hearings, compel attendance of witnesses and administer oaths to persons giving testimony at hearings.
17. Close discipline sessions and hearings to the public.
18. Discipline licenses as needed.
19. Maintain membership in national organizations that develop and regulate the national licensure examinations and exclusively promote the improvement of the legal standards of the practice of nursing for the protection of the public health, safety and welfare.
20. Establish alternative programs for monitoring of nurses who voluntarily seek treatment for chemical dependency, mental health or physical health conditions that could lead to disciplinary action by the Board.
21. Regulate the manner in which nurses announce their practice to the public.
22. Issue a modified license to practice nursing to an individual to practice within a limited scope of practice or with accommodations or both, as specified by the Board.
23. Inform licensees on an established basis about changes in law and rules regarding nursing practice.
24. Maintain records of proceedings as required by the laws of this State.
25. Provide consultation, conduct conferences, forums, studies and research on nursing education and practice.
26. Appoint and employ a qualified Registered Nurse to serve as Executive Officer and approve such additional staff positions as may be necessary, in the opinion of the Board, to administer and enforce the provisions of the Act.
27. Delegate to the Executive Officer those activities that expedite the functions of the Board.
28. Develop disaster preparedness plan.
29. Employ professional and support staff, investigators and legal counsel and other personnel necessary for the Board to carry out its functions.
30. Require such surety bonds as are deemed necessary.
31. Determine and collect reasonable fees.

32. Receive and expend funds in addition to appropriations from this State, provided such funds are received and expended for the pursuit of the authorized objectives of the Board of Nursing; such funds are maintained in a separate account; and periodic reports of the receipt and expenditures of such funds are submitted to the Governor.
33. Adopt a seal that shall be in the care of the Executive Director and shall be affixed only in such a manner as prescribed by the Board.

This Act shall not be construed to require the Board of Nursing to report violations of the provisions of the Act whenever, in the Board's opinion, the public interest will be served adequately by a suitable written notice of warning.

Section 3. *Executive Director.* The Executive Director shall be responsible for:
a. the performance of administrative responsibilities of the Board;
b. employment of personnel needed to carry out the functions of the Board; and
c. the performance of any other duties as the board may direct.

Section 4. *Compensation.* Each member of the Board shall receive, as compensation, a reasonable sum for each day the member is engaged in performance of official duties of the Board and reimbursement for all expenses incurred in connection with the discharge of such official duties.

Article IV. Administrative Procedures Act – Application

The state Administrative Procedures Act is hereby expressly adopted and incorporated herein as if all the provisions of such Act were included in this Act.

Article V. Licensure

Section 1. *Requirements.* Each applicant who successfully meet the requirements of this section shall be entitled to licensure as a Registered Nurse or Licensed Practice/Vocational Nurse, whichever is applicable as follows:
a. Licensure by Examination. An applicant for licensure by examination to practice as a Registered Nurse or Licensed Practical/Vocational Nurse shall:
    1. Submit a completed application and fees as established by the Board;
    2. Be a graduate of a board-approved nursing education program or a program that meets criteria comparable to those established by the Board in its rules.
    3. Be proficient in English language as set forth in the board rules;
    4. Pass an examination authorized by the Board;
    5. Have committed no acts or omissions which are grounds for disciplinary action as set forth in Article IX, Section 2, of this Act, or, if such acts have been committed and would be grounds for disciplinary action, the Board has found after investigation that sufficient restitution has been made;
    6. If convicted of one or more felonies, has received an absolute discharge from the sentences for all felony convictions ( ) years prior to the date of filing an application pursuant to this chapter; and
    7. Meet other criteria established by the Board.
b. Licensure by Endorsement. An applicant for licensure by endorsement to practice as a Registered Nurse or Licensed Practical/Vocational Nurse shall:
    1. Submit a completed application and fees as established by the Board.
    2. Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for disciplinary action as set forth in Article IX, Section 2, of this Act, the Board has found after investigation that sufficient restitution has been made.

3. Be a graduate of a Board-approved nursing education program which meets criteria comparable to those established by this Board and which prepares for the level of licensure being sought.
4. Pass an examination authorized by the Board.
5. Be proficient in English language as set forth in the Board rules.
6. Submit verification of licensure status directly from the U.S. jurisdiction of licensure by examination, Nursys™ *[or the Coordinated Licensure Information System]*.
7. Meet continued competency requirements as stated in Article V, Section 3(b), and as set forth in board rules.
8. If convicted of one or more felonies, has received an absolute discharge from the sentences for all felony convictions five or more years prior to the date of filing an application pursuant to this chapter.
9. Meet other criteria established by the Board.

c. Initial Licensure for Advanced Practice Registered Nurse. An application for initial licensure as an Advanced Practice Registered Nurse shall:
   1. Be licensed as a Registered Nurse (unencumbered).
   2. Be a graduate from or have completed a graduate level APRN program accredited by a national accrediting body.
   3. Be currently certified by a national certifying body in the APRN specialty appropriate to educational preparation.
   4. Submit a completed written application and appropriate fees as established by the Board.
   5. Provide evidence as required by the Board in its Rules.
   6. Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for discipline under Article IX, Section 2, of this Act, the Board has found after investigation that sufficient restitution has been made.

d. The Board may issue a license by endorsement to practice as an Advanced Practice Registered Nurse under the laws of another state and, in the opinion of the Board the applicant meets the qualifications for licensure in this jurisdiction.

e. Temporary Permits
   1. Applicants for Endorsement. The Board may issue, upon the request of an applicant, a temporary permit to practice nursing at the same level of licensure to an individual currently licensed in another jurisdiction of the United States who submits an application in accord with the rules of the Board.
   2. Individuals Previously Licensed to Practice Nursing Enrolled in Refresher Courses. The Board may issue a temporary permit to provide direct patient care as part of a nursing refresher course, as permitted in Board rules.

f. The Board may issue, upon request of the applicant, a temporary permit to practice advanced practice nursing to an applicant authorized to practice at that level in a U.S. jurisdiction who submits an application in accord with the rules of the Board.

Section 2. *Examinations*.

a. The Board shall authorize the administration of the examination to applicants for licensure as Registered Nurses or Licensed Practical/Vocational Nurses.

b. The Board may employ, contract and cooperate with any entity in the preparation and process for determining results of a uniform licensure examination. When such an examination is utilized, access to questions and answers shall be restricted by the Board.

c. The Board shall determine whether a licensure examination may be repeated, the frequency of reexamination and any requisite education prior to reexamination.

Section 3. *Renewal of Licenses.*
a. Licenses issued under this Act shall be renewed every ( ) years according to a schedule established by the Board.
b. An applicant for licensure renewal shall submit a verified statement that indicates whether the applicant has been convicted of a felony, and if convicted of one or more felonies, indicates the date of absolute discharge from the sentences for all felony convictions.
c1. A renewal license shall be issued to a Registered Nurse or Licensed Practical/Vocational Nurse who remits the required fee and satisfactorily completes any other requirements established by the Board as set forth in rules.
c2. A renewal license shall be issued to an Advanced Practice Registered Nurse who maintains national certification in the appropriate APRN specialty through an ongoing certification maintenance program of a nationally recognized certifying body, [or for applicants for whom no recognized certification is available must participate in a competence maintenance program] remits the required fee, and satisfactorily completes any other requirements established by the Board as set forth in rules.
d. Failure to renew the license shall result in forfeiture of the right to practice nursing in this State.

Section 4. *Reinstatement of Licenses.*
a. A licensee whose license has lapsed by failure to renew may apply for reinstatement according to the rules established by the Board. Upon satisfaction of the requirements for reinstatement, the Board shall issue a renewal of license.
b. A licensee whose license has been suspended, revoked or otherwise removed shall comply with all requirements set forth in the Board's discipline order.

Section 5. *Modified License.* The Board may consider issuing a modified license to an individual who has successfully completed a board approved nursing program and who is able to practice without compromise to the public safety within a modified scope of practice or with accommodations or both as specified by the Board.

Section 6. *Duties of Licensees.* The nurse shall comply with the provisions of this act. The burden of responsibility is on the licensee to know and practice according to the laws and regulations of the state.
a. In response to Board inquiries, provide relevant and truthful personal, professional or demographic information requested by the board to perform its duties in regulating and controlling nursing practice in order to protect the public health, safety and welfare. Failure to provide the requested information may result in non-renewal of the license to practice nursing and/or licensure disciplinary action.
b. Submit to a physical or mental evaluation by a designated ( ) when directed in writing by the Board for cause. If requested by the licensee, the licensee may also designate a ( ) for an independent medical examination. Refusal or failure of a licensee to complete such examinations shall constitute an admission of any allegations relating to such condition. All objections shall be waived as to the admissibility of the examining ( ) testimony or examination reports on the grounds that they constitute privileged communication. The medical testimony or examinations reports shall not be used against a Registered Nurse, Licensed Practical/Vocational Nurse or Advance Practice Registered Nurse in

another proceeding and shall be confidential. At reasonable intervals, a Registered Nurse, Licensed Practical/Vocational Nurse or Advance Practice Registered Nurse shall be afforded the opportunity to demonstrate competence to resume the practice of nursing with reasonable skill and safety to patients.

c. Report to the Board those acts or omissions which are violations of the Act or grounds for disciplinary action as set forth in Articles VIII and IX of this Act.

Article VI. Titles and Abbreviations

Section 1. Only those persons who hold a license to practice nursing in this state shall have the right to use the following title abbreviations:

a. Title: "Registered Nurse" and the abbreviation "RN."
b. Title: "Licensed Practical/Vocational Nurse" and the abbreviation "LPN/VN."
c. Title: "Advanced Practice Registered Nurse" and the abbreviation "APRN."

Section 2. Any person who has been approved as an applicant for licensure by endorsement and has been granted a temporary permit shall the right to use the title ( ) and abbreviations ( ) designated by the state.

Article VII. Approval of Nursing Education Programs.

Section 1. *Approval Standards.* The Board shall, by administrative rules, set standards for the establishment and outcomes of nursing education programs, including clinical learning experiences and approve such programs that meet the requirements of the Act and the Board administrative rules.

Section 2. *Initial Approval Required.* An educational institution that seeks to provide a diploma, degree or certificate in nursing to students in this jurisdiction shall apply to the Board and submit evidence that its nursing program(s) meets or will meet the standards established by the Board. If, upon review, the Board determines that the program(s) meets established standards, it shall grant approval.

Section 3. *Provisional or Interim Approval of New Programs.* Provisional approval of new programs may be granted contingent upon conditions set forth by the Board in administrative rules.

Section 4. *Continuing Approval of Nursing Programs.* The Board shall periodically review educational nursing programs and require nursing education programs to submit evidence of compliance with standards and administrative rules. If upon review of such evidence the Board determines that the program(s) meets the established standards, it shall grant continued approval. The board will publish a list of approved programs.

Section 5. *Denial or Withdrawal of Approval.* The Board may deny or withdraw approval or take such action as deemed necessary when nursing education programs fail to meet the standards established by the Board, provided that all such actions shall be in accordance with this State's Administrative Procedures Act and/or the Administrative Rules of the Board. A process of appeal and reinstatement shall be delineated in Board rules.

Section 6. *Reinstatement of Approval.* The Board shall reinstate approval of a nursing education program upon submission of satisfactory evidence that its program meets the standards established by the Board.

Article VIII. Violations and Penalties

Section 1. *Violations.*
Every employer of a licensed nurse and every person acting as an agent for such a nurse in obtaining employment, shall verify the current status of the licensee's authorization to practice within the provisions of this chapter. As used in this section, the term "agent" includes, but is not limited to, a nurses registry.

No person shall:
a. Engage in the practice of nursing as defined in the Act without a valid, current license, except as otherwise permitted under this Act.
b. Practice nursing under cover of any diploma, license or record illegally or fraudulently obtained, signed or issued unlawfully or under fraudulent representation.
c. Practice nursing during the time a license is suspended, revoked, surrendered, inactive or lapsed.
d. Use any words, abbreviations, figures, letters, title, sign, card or device tending to imply that he or she is a Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse unless such person is duly licensed so to practice under the provisions of this Act.
e. Fraudulently obtain or furnish a license by or for money or any other thing of value.
f. Knowingly employ unlicensed persons in the practice of nursing.
g. Fail to report information relating to violations of this Act.
h. Conduct a program for the preparation for licensure under this chapter unless the program has been approved by the Board.
i. Conducting courses or providing consultation that conflict with the scope and standards of practice set forth in this Act and in rules of the board.
j. Otherwise violate, or aid or abet another person to violate any provision of this Act.

Section 2. *Penalties.* Violation of any provision of this article shall constitute a misdemeanor or felony as defined by rule.

Section 3. *Criminal Prosecution.* Nothing in this Act shall be construed as a bar to criminal prosecution for violation of the provisions of this Act.

Section 4. *Civil Penalties.* The Board may, in addition to any other sanctions herein provided, impose on any person violating a provision of this Act or Administrative Rules of the Board, a civil penalty not to exceed ($) for each count or separate offense.

Article IX. Discipline and Proceedings

Section 1. *Authority.* For any one or combination of the grounds set forth below, the Board of Nursing shall have the power to:
a. Refuse to issue or renew a license;
b. Limit a license;
c. Suspend a license:
d. Revoke a license;
e. Place a license on probation;
f. Reprimand or otherwise discipline a licensee;
g. Impose a civil penalty not exceeding $10,000 for each separate violation;
h. Impose fines of up to ($); or
i. Take any other action justified by the facts in the case.

Section 2. *Grounds for Discipline*. The Board may discipline a licensee or applicant for any or a combination of the following grounds [as defined by regulations adopted by the Board]:

a. Failure to Meet Requirements.
b. Failure to demonstrate the qualifications or satisfy the requirements for licensure contained in Article V. In the case of a person applying for a license, the burden of proof is upon the applicant to demonstrate the qualifications or satisfactions of the requirements.
c. Criminal Convictions.
d. Conviction by a court or entry of a plea of *nolo contendere* to a crime in any jurisdiction that relates adversely to the practice of nursing or to the ability to practice nursing.
e. Fraud and/or Deceit.
f. Employment of fraud or deceit in procuring or attempting to procure a license to practice nursing in filing any reports or completing patient records, signing any report or records in the nurse's capacity as a Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse or in submitting any information or record to the Board.
g. Action in Another Jurisdiction.
h. License to practice nursing or another health care profession has been denied, revoked, suspended, restricted or otherwise disciplined in this or any other state.
i. Unsafe Practice/Unprofessional Practice.
    1. Failure or inability to perform professional, practical nursing or advanced practice nursing, as defined in Article II, with reasonable skill and safety.
    2. Unprofessional conduct, including a departure from or failure to conform to Board standards of professional or practical nursing,
    3. Failure of to supervise or the performance of acts by any individual working at the nurse's direction.
    4. Failure of a chief administrative nurse to provide oversight of the nursing organization and nursing services of a health care delivery system.
    5. Failure to practice within a modified scope of practice or with the required accommodations, as specified by the Board in granting a modified license;
    6. Conduct or any nursing practice that may create unnecessary danger to a patient's life, health or safety. Actual injury to a patient need not be established.
j. Inability to Practice Safely.
k. Demonstration of actual or potential inability to practice nursing with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as a result of any mental or physical conditions.
l. Unethical Conduct.
m. Behavior, likely to deceive, defraud, or harm the public, or demonstration of a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established.
n. Misconduct.
    1. Failure to cooperate with a lawful investigation conducted by the Board.
    2. Use of excessive force upon or mistreatment or abuse of any patient. "Excessive force" means force clearly greater than what would normally be applied in similar clinical situations.
    3. Engagement in sexual conduct with a patient, or conduct that may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient.
o. Drug Diversion – Diversion or attempts to divert drugs or controlled substances.

p. Failure to Comply with Alternative Program Requirements – Failure to comply with terms of alternative program agreement.
q. Other Drug Related.
   1. Intemperate use of alcohol or drugs that the Board determines endangers or could endanger a patient.
   2. Use of any controlled substance or any dangerous drug or dangerous device or alcoholic beverages, to an extent or in a matter dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
r. Unlawful Practice
   1. Has knowingly aided, assisted, advised, or allowed an unlicensed person to engage in the unlawful practice of professional or practical nursing.
   2. Has violated a rule adopted by the Board, an order of the Board, or a state or federal law relating to the practice of professional or practical nursing, or a state or federal narcotics or controlled substance law.
   3. Has practiced beyond the scope of practice as stated in this Act.

Section 4. *Procedure*. The Board shall establish a disciplinary process based on the Administrative Procedure Act of the State of ( ).

Section 5. *Immunity.* Any member of the Board or staff and any person reporting to the Board of Nursing under oath and in good faith information relating to alleged incidents of negligence or malpractice or the qualifications, fitness or character of a person licensed or applying for a license to practice nursing shall not be subject to a civil action for damages as a result of report such information.

The immunity provided by this section shall extend to the members of any professional review committee and witnesses appearing before the committee authorized by the Board to act pursuant to this section.

Article X. Emergency Relief

Section 1. *Summary Suspension*.
a. Authority. The Board is authorized to temporarily suspend the license of a nurse without a hearing if:
   1. the Board finds that there is probable cause to believe that the nurse has violated a statute or rule that the Board is empowered to enforce; and
   2. continued practice by the nurse would create imminent and serious risk of harm to others.
b. Duration. The suspension shall remain in effect until the Board issues a stay of suspension or a final order in the matter after a hearing or upon agreement between the Board and licensee.
c. Hearing. The Board shall schedule a disciplinary hearing to be held under the Administrative Procedures Act, to begin no later than ( ) days after the issuance of the summary suspension order. The licensee shall receive at least ( ) days notice of the hearing.

Section 2. *Automatic Suspension*.
Unless the Board orders otherwise, a license to practice professional or practical nursing is automatically suspended if:
a. A guardian of a nurse is appointed by order of a court under sections (reference to state law governing);
b. The nurse is committed by order of a court under (reference to state law governing); or
c. The nurse is determined to be mentally incompetent, mentally ill, chemically

dependent, or a person dangerous to the public by a court of competent jurisdiction within or without this state.

The license remains suspended until the nurse is restored to capacity by a court, and upon petition by the nurse, the suspension is terminated by the board after a hearing or upon agreement between the Board and the nurse.

Section 3. *Injunctive Relief.*

a. Authority. The Board or any prosecuting officer upon a proper showing of the facts is authorized to petition a court of competent jurisdiction for an injunction to enjoin:
   1. Any person who is practicing nursing within the meaning of this Act from practicing without a valid license, unless exempted under Article XII.
   2. Any person, firm, corporation, institution or association from employing any person who is not licensed to practice nursing under this Act or exempted under Article XII.
   3. Any person, firm, corporation, institution or association from operating a school of nursing without approval.
   4. Any person whose license has been suspended or revoked from practicing as an RN, LPN/VN or APRN.

   Such acts are declared to be a public nuisance and pose a risk of harm to the public health and safety.

b. The court may without notice or bond, enjoin such acts and practice. A copy of the complaint shall be served on the defendant and the proceedings thereafter shall be conducted as in other civil cases. In case of violation of an injunction issued under this section, the court, or any judge thereof, may summarily try and punish the offender for contempt of court.

Section 4. *Preservation of other Remedies.* The emergency proceedings herein described shall be in addition to, not in lieu of, all penalties and other remedies provided by law.

Article XI. Reporting Required

Section 1. *Affected parties.*

a. Hospitals, nursing homes and other employers of Registered Nurses, Licensed Practical/Vocational Nurses **or Advanced Practice Registered Nurses** shall report to the Board the names of those licensees whose employment has been terminated voluntarily or involuntarily, or who has resigned in order avoid termination for any reasons stipulated in Article IX, Section 1.
b. Certifying nursing organizations shall report to the Board the names of Registered Nurses, Licensed Practical/Vocational Nurses **or Advanced Practice Registered Nurses** who have been denied certification or re-certification for failure to meet certification standards.

Section 2. *Court Order.* The Board may seek an order from a proper court of competent jurisdiction for a report from any of the parties stipulated in Section 1 of this Article if one is not forthcoming voluntarily.

Section 3. *Penalty.* The Board may seek a citation for civil contempt if a court order for a report is not obeyed by any of the parties stipulated in Section 1 of this Article.

Section 4. *Immunity.*

a. Any organization or person reporting, in good faith, information to the Board

under this Article shall be immune from civil action as provided in Article IX, Section 4.

b. A physician or other licensed health care professional who, at the request of the Board, examines a nurse, shall be immune from suit for damages by the nurse examined if the examining physician or examining health care professional conducted the examination and made findings or diagnoses in good faith.

Article XII. Exemptions

No provisions of this Act shall be construed to prohibit:

a. The practice of nursing that is an integral part of a program by students enrolled in Board approved nursing education programs.
b. An individual engaged in an internship, residency or other supervised study/practice opportunity as defined by rules of the Boards.
c. The rendering of assistance by anyone in the case of an emergency or disaster.
d. The practice of any currently licensed Registered Nurses, Licensed Practical/Vocational Nurses or Advanced Practice Registered Nurses licensed in another state in the provision of nursing care in the case of emergency or disaster.
e. The incidental and gratuitous care of the sick by members of the family, friends or companions; or household aides at the discretion of a person needing such care who resides independently outside any hospital, nursing or health care facility, or other similar institutional setting.
f. Caring for the sick in accordance with tenets or practices of any church or religious denomination which teaches reliance upon spiritual means for healing.
g. The practice of any currently licensed Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse of another state who is employed by the United States government, or any bureau, division or agency thereof; while in the discharge of official duties.
h. The practice of any currently licensed Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse who is employed by an individual, agency or corporation located in another State and whose employment responsibilities include transporting patients into, out of or through this State. Such exemptions shall be limited to a period not to exceed ( ) hours for each transport.
i. The practice of any Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse currently licensed in another state who is in this state on a non-routine basis for a period not to exceed [ ] days to:
   - Provide care to a patient being transported into, out of, or through this state;
   - Provide professional nursing consulting services;
   - Attend or present a continuing nursing education program
   - Provide other short-term non-clinical nursing services.
j. The practice of any other occupation or profession licensed under the laws of this state, provided that such care does not constitute the practice of nursing within the meaning of this Act.

Article XIII. Revenue, Fees

Section 1. *Revenue.* The Board is authorized to establish, appropriate fees for licensure by examination, reexamination, endorsement and such other fees and fines as the Board determines necessary.

Section 2. ***Disposition of Fees.*** All fees collected by the Board shall be administered according to the established fiscal policies of this State in such manner as to implement adequately the provisions of this Act.

Section 3. ***Disposition of Fines.*** All fines collected shall be used by and at the discretion of the Board for designated projects as established in the fiscal policy of this state.

Article XIV. Implementation

Section 1. ***Effective Date.*** This Act shall take effect (date).

Section 2. ***Persons Licensed Under a Previous Law.***

a. Any person holding a license to practice nursing as a Registered Nurse in this State that is valid on (effective date) shall be deemed to be licensed as a Registered Nurse under the provisions of this Act and shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.
b. Any person holding a license to practice nursing as a Licensed Practical/Vocational Nurse in this State that is valid on (effective date) shall be deemed to be licensed as a Licensed Practical/Vocational Nurse under the provisions of this Act and shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.
c. Any person eligible for reinstatement of a license as a Registered Nurse or Licensed Practical/Vocational Nurse, respectively, under provisions under the conditions and standards prescribed in the Act by applying for reinstatement according to rules established by the Board of Nursing. Application for such reinstatement must be made within ( ) months of the effective date of this Act.
d. Any person holding a lapsed license to practice nursing as a Registered Nurse or Licensed Practical/Vocational Nurse in this State on (effective date), because of failure to renew, may become licensed as a Registered Nurse or as a Licensed Practical/Vocational Nurse, respectively, under the provisions of this Act by applying for reinstatement according to rules established by the Board of Nursing. Application for such reinstatement must be made within ( ) months of the effective date of this Act.
e. New applicants for Advanced Practice Registered Nurse as of (effective date of statute) shall meet requirements set forth in administrative rules. Any individual authorized to practice in an advanced role prior to (effective date) may apply for licensure on the basis of the individual's prior education and practice as set forth in administrative rule.
f. Those so licensed under the provisions of Article XIV, Section 2 (a) through (e) above, shall be eligible for renewal of such license under the conditions and standards prescribed by this Act.

Section 3. ***Severability.*** The provisions of this Act are severable. If any provision of this Act is declared unconstitutional, illegal or invalid, the constitutionality, legality and validity of the remaining portions of this Act shall be unaffected and shall remain in full force and effect.

Section 4. ***Repeal.*** The laws specified below are repealed except with respect to rights and duties that have matured, penalties that were incurred and proceedings that were begun before the effective date of this Act. (List statutes to be repealed; for example, the current nursing practice act or appropriate sections).

PR&E: Attachment B

NCSBN 2002 Proposed Revisions to the 1994 Model Nursing Practice Act

Coding Key:
New Language

CURRENT MODEL ACT	PROPOSED REVISIONS	NOTES/COMMENTS
Article I. Title and Purpose	**Article I. Title and Purpose**	
Section 1. *Title of Act.* This Act shall be known and may be cited as "The (state) Nursing Practice Act."	**Section 1. *Title of Act.*** This Act shall be known and may be cited as The [state] Nursing Practice Act.	
Section 2. *Description of Act.* An Act to provide for the regulation of the practice of nursing, a practice affecting the public health, safety and welfare; to provide for a State Board of Nursing; and to define the powers and duties of that Board, including licensure of practitioners of nursing, establishment of standards for nursing practice and nursing education programs, adoption of administrative rules to implement this Act, and prescription of penalties for violation of the provisions of this Act.	**Section 2. *Description of Act.*** An Act **concerning** the regulation of the practice of nursing; **that creates and empowers the State Board of Nursing to regulate the practice of nursing and to enforce** the provisions of this act.	The language was changed to concisely describe the Act as authorizing the regulation of nursing and creating the board to enforce the act.
Section 3. *Purpose.* The legislature finds that the practice of nursing by competent persons is necessary for the protection of the public health, safety and welfare; and further finds that three levels of practice within the profession should be regulated and controlled in the public interest. Therefore, it is the legislative purpose of this Act to promote, preserve and protect the public health, safety and welfare by and through the effective control and regulation of nursing education and practice, and to ensure that any person practicing or offering to practice nursing, as defined in the Act, or using the title of Registered Nurse, Licensed Practical/ Vocational Nurse, or Advanced Practice Registered Nurse in the categories of Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Nurse Practitioner or Clinical Nurse Specialist after the effective date of this Act within this state shall before entering upon such practice or using such title, be licensed as hereinafter provided. Boards of Nursing shall adopt regulations to identify those essential elements of practice necessary to protect the public.	**Section 3. *Purpose.*** The legislature finds that the practice of nursing **is directly related to** the public welfare **of the citizens of the state and is subject to regulations** and control in the public interest **to assure that practitioners are qualified and competent. It is further declared that the practice of nursing,** as defined in the Act, **merits and deserves the confidence of the public and that only qualified persons be permitted to engage in the practice of nursing. The legislature recognizes that the practice of nursing is continually evolving and responding to changes within health care patterns and systems and recognizes the existence of overlapping functions within the practice of nursing and other providers of health care. This Act shall be liberally construed to carry out the objectives and purposes set forth in this Act.**	The purpose was streamlined, and care was taken not to duplicate the description of the act section 2 above. A statement was added "to be liberally construed," providing legislative direction that the language of the act be read broadly. (Sections taken from the Federation of Associations of Regulatory Board Model Practice Act.) This purpose statement emphasizes that nursing is an evolving profession and acknowledges overlapping functions with other health care providers.

Article II. Definitions and Scope	Article II. Definitions and Scope	
Section 1. ***Practice of Nursing.*** The "practice of nursing" means assisting individuals or groups to maintain or attain optimal health, implementing a strategy of care to accomplish defined goals, and evaluating responses to care and treatment. This practice includes, but is not limited to, initiating and maintaining comfort measures, promoting and supporting human functions and responses, establishing an environment conducive to well being, providing health counseling and teaching, and collaborating on certain aspects of the health regimen. This practice is based on understanding of the human condition across the lifespan and the relationship of the individual within the environment.	**Section 1.** ***Practice of Nursing.*** The practice of nursing means assisting individuals or groups to attain or maintain optimal health, implementing a strategy of care to accomplish defined goals, and evaluating responses to nursing care and treatment. **Nursing practice includes both basic health care that helps both individuals and groups of people cope with difficulties in daily living associated with their actual or potential health or illness status, and those nursing activities that require a substantial amount of scientific knowledge or technical skill.** Nursing practice includes, but is not limited to: 1. **Providing** comfort **and caring**; 2. **Providing attentive surveillance to monitor patient conditions and needs;** 3. **Promoting an environment conducive to well being;** 4. **Planning and implementing independent nursing strategies and prescribed treatment in the prevention and management of illness, injury, disability or achievement of a dignified death;** 5. Promoting and supporting human functions and responses; 6. Providing health counseling and teaching; **and** 7. Collaborating on aspects of the health regimen; **and** 8. **Advocating for the client.** **Nursing is both an art and a scientific process founded on a professional body of knowledge; a learned profession** based on an understanding of the human condition across the lifespan and the relationship of an individual with **others and within** the environment. **Nursing is a dynamic discipline that is continually evolving to include more sophisticated knowledge, technologies, and patient care activities.**	This definition is a combined definition from many state statutes. It includes all the previous elements, adds patient advocacy and is presented in a numbered format for easier reading.
Section 2. ***Registered Nurse.*** The practice of nursing as a Registered Nurse means the practice of the full scope of nursing which includes but is not limited to: (a) assessing the health status of individuals and groups; (b) establishing a nursing diagnosis; (c) establishing goals to meet identified health care needs: (d) planning a strategy of care;	**Section 2.** ***Registered Nurse.*** Practice as a Registered Nurse means the full scope of nursing, **with or without compensation or personal profit, incorporates caring for all clients in all settings, and includes but is not limited to:** (a) **Providing comprehensive assessment** of the health status of individuals, **families,** groups **and communities.** (b) **Developing a comprehensive nursing plan that** estab-	The stem of this definition was rephrased, elements were added and reordered. Most elements were retained with rewording. The reader is referred to Section 8 below which includes a definition of "comprehensive assessment." Content areas are listed in the same order for RN, LPN/VN and APRN scopes, to facilitate comparison and

(e) prescribing nursing interventions to implement the strategy of care; (f) implementing the strategy of care; (g) delegating nursing interventions to qualified others as provided in this Act; (h) providing for the maintenance of safe and effective nursing care rendered directly or by others; (i) evaluating responses to interventions; (j) teaching the theory and practice of nursing; (k) managing and supervising the practice of nursing; and (l) collaborating with other health care professionals in the management of health care.	lishes nursing diagnoses; sets goals to meet identified health care needs; and prescribes nursing interventions. (c) Implementing **nursing care through the execution of independent nursing strategies and prescribed medical regimen.** (d) **Managing nursing care through cohesive, coordinated care management within and across care settings.** (e) Delegating **and assigning** nursing interventions **to implement the plan of care.** (f) Providing for the maintenance of safe and effective nursing care rendered directly or **indirectly.** (g) **Promoting a safe and therapeutic environment.** (h) **Providing health teaching and counseling to promote, attain and maintain the optimum health level of individuals, and communities.** (i) **Advocating for individual clients, groups and communities by attaining and maintaining what is in the best interest of the individual client or group.** (j) Evaluating responses to interventions **and the effectiveness of the plan of care.** (k) **Communicating and** collaborating with other health care professionals in the management of health care **and the implementation of the total health care regimen.** (l) **Acquiring and applying critical new knowledge and technologies to practice domain.** (m) Managing, supervising **and evaluating** the practice of nursing. (n) Teaching the theory and practice of nursing. (o) **Participating in patient and health systems management.** (p) **Other acts that require education and training as prescribed by the Board. Additional nursing services shall be commensurate with the registered nurse's experience, continuing education and demonstrated competencies.** **Each Registered Nurse is accountable to clients, employers, the nursing profession and the board for complying with the requirements of this Act and the quality of nursing care rendered; and for recognizing limits of knowledge and experience and planning for management of situations beyond the nurse's expertise.**	differentiation. (o) The subcommittee recommended to include "shaping health policy," but it was concluded that it was not unique to the scope of nursing practice.

Section 3. ***Licensed Practical/Vocational Nurse.*** The practice of nursing as a Licensed Practical/Vocational Nurse means a directed scope of nursing practice which includes, but is not limited to: (a) contributing to the assessment of the health status of individuals and groups; (b) participating in the development and modification of the strategy of care; (c) implementing the appropriate aspects of the strategy of care as defined by the Board; (d) maintaining safe and effective nursing care rendered directly or indirectly; (e) participating in the evaluation of responses to interventions; and (f) delegating nursing interventions to qualified others as provided in the Act The Licensed Practical/ Vocational Nurse practices under the direction of the Registered Nurse, Advanced Practice Registered Nurse, licensed physician, or dentist in the performance of activities delegated by that health care professional.	**Section 3.** ***Licensed Practical/Vocational Nurse.*** Practice as a Licensed Practical/Vocational Nurse means a directed scope of nursing practice, **with or without compensation or personal profit, under the supervision of the Registered Nurse, Advanced Practice Registered Nurse, licensed physician, or other health care provider authorized by the state to delegate health care activities and functions;** and includes, but is not limited to: (a) **Collecting data and conducting focused assessments of the health status of individuals and groups,** and contributing to the **comprehensive** assessment of individuals, **families** and groups. (b) **Planning nursing care during care episode for clients with stable conditions.** (c) Participating in the development and modification of the **comprehensive plan** of care for **all types of patients.** (d) Implementing the appropriate aspects of the strategy of care **within the LPN/VN scope of practice;** (e) **Participating in nursing care management through delegating, assigning and directing nursing interventions that may be performed by others, including other LPN/VNs, that do not conflict with the act.** (f) **Maintaining safe and effective nursing care rendered directly or indirectly.** (g) **Promoting a safe and therapeutic environment.** (h) **Participating in health teaching and counseling to promote, attain and maintain the optimum health level of individuals.** (i) **Serving as an advocate for the client by communicating and collaborating with other health service personnel.** (j) Participating in the evaluation of client responses to interventions; (k) **Communicating and collaborating with other health care professionals in the nursing practice management.** (l) **Contributing to patient and health systems management.** (m) **Other acts that require education and training as prescribed by the Board. Additional nursing services shall be commensurate with the licensed practical nurse's experience, continuing education and demonstrated competencies.**	Revisions to the LPN/VN scope of practice are based on analysis of findings of the most recent LPN job analysis. This remains a directed scope of practice. Note that content areas are listed in same order for RN, LPN/VN and APRN scopes, to facilitate comparison. The first step in the nursing process, assessment, is the basis for nursing decisions and interventions. The subcommittee believes that the first step is implemented in much the same way across jurisdictions, but that it is described and discussed differently. All nurses assess, but with differences in the breadth, depth and comprehensiveness of the assessments conducted by the three levels of nurses. The term “focused assessment” is used to differentiate the LPN/VNs role and the term "comprehensive assessment" is used to describe the role of the RN (see definitions in Section 9 below). An alternative option for boards that prefer more precision regarding assessment is to describe what is expected of the level of licensee for the assessment process. See definitions of focused assessment and comprehensive assessment. (l) The subcommittee recommended to include “shaping health policy”, but it was concluded that it was not unique to the scope of nursing practice.

	Each nurse is accountable to clients, employers, the nursing profession and the board for complying with the requirements of this Act and the quality of nursing care rendered; and for recognizing limits of knowledge and experience and planning for management of situations beyond the nurse's expertise.	
Section 4. *Advanced Practice Registered Nurse.* Advanced Practice Registered Nursing by Nurse Practitioners, Certified Registered Nurse Anesthetists, Certified Nurse Midwives or Clinical Nurse Specialists, is based on knowledge and skills acquired in basic nursing education; licensure as a Registered Nurse; and a graduate degree with a major in nursing or a graduate degree with a concentration in the advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions, and management of health care. Advanced Practice Registered Nursing includes but is not limited to: (a) assessing clients, synthesizing and analyzing data, and understanding and applying nursing principles at an advanced level; (b) providing expert guidance and teaching; (c) working effectively with clients, families and other members of the health care team; (d) managing clients' physical and psycho-social health-illness state; (e) utilizing research skills; (f) analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem and selecting appropriate treatment; (g) making independent decisions in solving complex client care problems; (h) performing acts of diagnosing, prescribing, administering and dispensing therapeutic measures, including legend drugs and controlled substances, within the scope of practice; and(i) recognizing limits of knowledge and experience, planning for situations beyond expertise, and consulting with or referring clients to other health care providers as appropriate.This act shall supersede all prior inconsistent	**Section 4. *Advanced Practice Registered Nurse.*** Advanced Practice Registered Nursing by Nurse Practitioners, Registered Nurse Anesthetists, Nurse Midwives or Clinical Nurse Specialists, is based on knowledge and skills acquired in basic nursing education; licensure as a Registered Nurse; graduation from or completion of a graduate level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate APRN specialty. Practice as an Advanced Practice Registered Nurse **means an expanded scope of nursing, with or without compensation or personal profit, and** includes but is not limited to: (a) Assessing clients, synthesizing and analyzing data, and understanding and applying nursing principles at an advanced level. (b) Analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem and selecting appropriate treatment. (c) Making independent decisions in solving complex client care problems. (d) **Developing a health regimen plan that establishes diagnoses; sets goals to meet identified health care needs; and prescribe a regimen of health care.** (e) Performing acts of diagnosing, prescribing, administering and dispensing therapeutic measures, including legend drugs and controlled substances, **within the advanced practice registered nurse's focus of practice.** (f) Managing clients' physical and psychosocial health-illness status. (g) **Providing for the maintenance of safe and effective nursing care rendered directly or indirectly.** (h) **Promoting a safe and therapeutic environment.**	"Certified" was removed from Nurse Anesthetist and Nurse Midwives to be consistent with the Uniform Advanced Practice Registered Nurse Licensure/ Authority to Practice Requirements. Several elements addressed in the RN and LPN/VN scopes were refined to identify the advanced practice registered nursing role with those topics. Content areas are listed in same order for RN, LPN/VN and APRN scopes, to facilitate comparison. (d) Health regimen includes the prescribed course of actions conducive to attaining and/or maintaining physical and mental well-being.

statutes, rules or regulations regarding this subject.	(i) Providing expert guidance and teaching. (j) **Participating in patient and health systems management.** (k) **Advocating for individual clients, groups and communities by attaining and maintaining what is in the best interest of the individual client or group.** (l) **Evaluating responses to interventions, the effectiveness of the plan of care and the health regimen.** (m) **Communicating and working effectively with clients, families and other members of the health care team.** (n) Utilizing research skills **and acquiring and applying critical new knowledge and technologies to practice domain.** (o) **Teaching the theory and practice of advance practice nursing.** **Each advanced practice registered nurse is accountable to clients, employers, the nursing profession and the board for complying with the requirements of this Act and the quality of nursing care rendered;** and for recognizing limits of knowledge and experience, planning for management of situations beyond the nurse's expertise; and consulting with or referring clients to other health care providers as appropriate. **This act shall supersede all prior inconsistent statutes, rules or regulations regarding this subject.**	(j) The subcommittee recommended to include "shaping health policy," but it was concluded that it was not unique to the scope of nursing practice.
Section 5. *Prescriptive Authority.* An Advanced Practice Registered Nurse is authorized to prescribe and dispense drugs for administration to and use by other persons within the scope of practice defined by rules adopted by the Board. This act shall supersede all prior inconsistent statutes, rules or regulations regarding nurse prescriptive authority.		Section 4(e) on page 6 includes the act of prescribing, so the separate section on prescriptive authority was eliminated. There was mixed feedback on this provision, one commenter thought it useful because not all APRNs have prescriptive authority. Others thought it calls unnecessary attention to prescriptive authority and is not needed. Some states may wish to include a separate section for prescriptive authority because that was how the authority was negotiated. For purposes of a Model, however, it is better positioned in the scope of APRN practice. The language regarding this act superseding all prior inconsistent statutes, etc. was retained at the end of the APRN definition.

Section 6. *Board.* "Board" means the (state) Board of Nursing.	**Section 5. *Board.*** "Board" means the (state) Board of Nursing.	
Section 7. *Other Board.* "Other Board means the comparable regulatory agency in any U.S. state or territory.	**Section 6. *Other Board.*** "Other Board" means the comparable regulatory agency in any U.S. state, territory **or District of Columbia.**	
Section 8. *License.* "License" means a current document permitting the practice of nursing as a Registered Nurse, Licensed Practical/Vocational Nurse, or Advanced Practice Registered Nurse.	**Section 7. *License.*** "License" means a current document permitting the practice of nursing as a Registered Nurse, Licensed Practical/Vocational Nurse, or Advanced Practice Registered Nurse.	
	Section 8. *Other Definitions.* **(a) Absolute discharge from sentence. Completion of any sentence including imprisonment, probation, parole, community supervision or any form of court supervision.**	Source: Arizona Statutes.
	(b) Assignment. Designating nursing activities to be performed by an individual consistent with his/her scope of practice (licensed person) or role description (unlicensed person).	Source: *Role Development: Critical Components of Delegation Curriculum Outline*, NCSBN, 1997.
	(c) Chief Administrative Nurse. The Registered Nurse who oversees the provision of nursing services in an organization, regardless of title.	
	(d) Client. The individual, family, group or community receiving nursing care.	
	(e) Compact. An interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of interstate concern.	Source: *Black's Law Dictionary* (5th Ed.). St. Paul, MN: West Publishing, Co. (p.736).
	(f) Comprehensive assessment by the RN. Means an extensive data collection for patients, families, groups and communities addressing anticipated changes in patient conditions as well as emergent changes in a patient's health status; recognizing alterations to previous patient conditions; synthesizing the biological, psychological and social aspects of the patient's condition; evaluating the impact of nursing care; and using this broad and complete	See Article II, Section 2(a). This definition describes a broader assessment, in breadth and depth, and how it is used.

	analysis to make independent decisions and nursing diagnoses; plan nursing interventions; evaluate need for different interventions; and the need to communicate and consult with other health team members.	
	(g) Cooperation. Cooperate, assist, or joint effort.	
	(h) Delegation. Transferring to a competent individual the authority to perform a selected nursing task in a selected situation.	Source: *Role Development: Critical Components of Delegation Curriculum Outline*, NCSBN, 1997.
	(i) Emergency. Sudden state of danger, conflict, crisis, requiring immediate action.	
	(j) Focused assessment by the LP/VN. Means an appraisal of the patient's status and situation at hand, which includes comparing that appraisal to the patient's previous condition and identified problems; making preliminary decisions regarding the implementation of actions per the nursing care plan or protocol; and deciding who needs to be informed of this information and when.	See Article II, Section 3(a). This definition describes collection of data and analysis limited to the situation at hand and how it is used.
	(k) Health Care Provider. An individual authorized (e.g., licensed or certified) to prescribe and/or administer various aspects of health care.	
	(l) Health Care Regimen. Prescribed course of actions conducive to attaining and/or maintaining physical and mental well-being.	See Article II, Section 4(a).
	(m) Licensure by Endorsement. Means the granting of authority to practice is based on an individual's licensure (having met comparable requirements) in another jurisdiction.	
	(n) Licensure by Examination. Means the authority to practice is based on an assessment of minimum competency by such means as the boards shall determine.	
	(o) Nurse Licensure Compact (NLC). Is a compact between participating states to facilitate the regulation of nurses. The compact is adopted by each state legislature, and allows a nurse licensed in a compact state to practice under a multistate privilege in all other compact states.	Source: The Nurse Licensure Compact.

	(p) Nurse Licensure Compact Administrators (NLCA.)Are the administrators of each compact state who are responsible for implementing and coordinating the NLC.	Source: The Nurse Licensure Compact.
	(q) Person. Means an individual, corporation, partnership, association, unit of government or other legal entity.	
	(r) Prescriptive Authority. Means the power to determine the need for drugs, immunizing agents, or devices; selecting the remedy; and writing a prescription to be filled by a licensed pharmacist.	
	(s) Standards of Nursing Practice. Means those standards adopted by the Board that interpret legal definitions of practice.	
	(t) Student Nurse. A person who is studying in an approved nursing education program.	This definition is intended to describe students at all levels of nursing education.
	(u) Unauthorized practice. Means the practice of Licensed Practical /Vocational Nursing, Registered Nursing or Advanced Practice Registered Nursing by any person who has not been authorized to practice nursing under the provision of this Act.	
Article III. The Board of Nursing	Article III. The Board of Nursing	
Section 1. *Membership; Appointment; Nominations; Term of Office; Removal; Vacancies; Qualifications; Immunity.* (a) The Board of Nursing shall consist of ( ) members to be appointed by the Governor ( ) days prior to the expiration of the term of office of a current member. Nominations for appointment may be made to the Governor by any interested individual, association, or any other entity, provided that such nominations be supported by a petition executed by no less than ( ) qualified voters in this State. These nominations shall not be binding upon the Governor.	Section 1. *Membership; Appointment; Nominations; Term of Office; Removal; Vacancies; Qualifications; Immunity.* (a) The Board of Nursing shall consist of ( ) members to be appointed by the Governor ( ) days prior to the expiration of the term of office of a current member. Nominations for appointment may be made to the Governor by any interested individual, association, or any other entity, provided that such nominations be supported by a petition executed by no less than ( ) qualified voters in this State. These nominations shall not be binding upon the Governor.	

(b) The membership of the Board shall be at least ( ) members of Registered Nurses; at least ( ) members of Licensed Practical/Vocational Nurses; at least ( ) members of Advanced Practice Registered Nurses; and at least ( ) members representing the public.	(b) The membership of the Board shall be at least ( ) members of Registered Nurses; at least ( ) members of Licensed Practical/Vocational Nurses; at least ( ) members of Advanced Practice Registered Nurses; and at least ( ) members representing the public.	
Each Registered Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as a Registered Nurse, and shall have no less than five (5) years of experience as a Registered Nurse, at least three (3) of which immediately preceded appointment.	(1) Each Registered Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as a Registered Nurse, and shall have no less than five (5) years of experience as a Registered Nurse, at least three (3) of which immediately preceded appointment.	
Each Licensed Practical/Vocational Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing, and shall have no less than five (5) years of experience as a Licensed Practical/Vocational Nurse, at least three (3) of which immediately preceded appointment.	(2) Each Licensed Practical/Vocational Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing **as a Licensed Practical/Vocational Nurse,** and shall have no less than five (5) years of experience as a Licensed Practical/Vocational Nurse, at least three (3) of which immediately preceded appointment.	The rationale for this addition was to make these provisions consistent with (1), requiring the nursing experience to be in the type of nursing the individual is representing.
Each Advanced Practice Registered Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing, and shall have no less than five (5) years of experience as a Advanced Practice Registered Nurse, at least three (3) of which immediately preceded appointment.	(3) Each Advanced Practice Registered Nurse member shall be an eligible voting resident in this State, licensed in good standing under the provisions of this chapter, currently engaged in the practice of nursing as an Advanced Practice Registered Nurse, and shall have no less than five (5) years of experience **as an Advanced Practice Registered Nurse,** at least three (3) of which immediately preceded appointment.	The rationale for this addition was to make these provisions consistent with (1), requiring the nursing experience to be in the type of nursing the individual is representing.
The representative of the public shall be eligible voting residents of this State who are knowledgeable in consumer health concerns, and shall neither be, nor ever have been, associated with the provision of health care or be enrolled in any health-related education program.	(4) The representatives of the public shall be eligible voting residents of this State who are knowledgeable in consumer health concerns, and shall not be associated with the provision of health care or be enrolled in any health-related education program.	
Membership shall be restricted to no more than one (1) person who is associated with a particular agency, corporation other enterprise or subsidiary at one time.	(5) Membership shall be restricted to no more than one (1) person who is associated with a particular agency, corporation other enterprise or subsidiary at one time.	

(c) Members of the Board shall be appointed for a term of ( ) years.	(c) Members of the Board shall be appointed for a term of ( ) years.	
The present members of the Board holding office under the provisions of the (Act being amended or repealed) shall serve as members for their respective terms.	(1) The present members of the Board holding office under the provisions of the (Act being amended or repealed) shall serve as members for their respective terms.	
No member shall serve more than two (2) consecutive full terms. The completion of an un-expired portion of a full term shall not constitute a full term for purposes of this section. Any Board member initially appointed for less than a full term shall be eligible to serve two (2) additional terms.	(2) No member shall serve more than two (2) consecutive full terms. The completion of an un-expired portion of a full term shall not constitute a full term for purposes of this section. Any Board member initially appointed for less than a full term shall be eligible to serve two (2) additional terms.	
An appointee to a full term on the Board shall be appointed by the Governor before the expiration of the term of the member being succeeded and shall become a member of the Board on the first day following the appointment expiration date. Appointees to un-expired terms shall become members of the Board on the day following such appointment.	(3) An appointee to a full term on the Board shall be appointed by the Governor before the expiration of the term of the member being succeeded and shall become a member of the Board on the first day following the appointment expiration date. Appointees to un-expired terms shall become members of the Board on the day following such appointment.	
Each term of office shall expire at midnight on the last day of the term of the appointment or at midnight on the date on which any vacancy occurs. If a replacement appointment has not been made, the term of the Member shall be extended until a replacement is made.	(4) Each term of office shall expire at midnight on the last day of the term of the appointment or at midnight on the date on which any vacancy occurs. If a replacement appointment has not been made, the term of the Member shall be extended until a replacement is made.	
(d) Any vacancy that occurs for any reason in the membership of the Board shall be filled by the Governor in the manner prescribed in the provisions of this article regarding appointments. Vacancies created by reason other than the expiration of a term shall be filled within ( ) days after such vacancy occurs. A person appointed to fill a vacancy shall serve for the unexpired portion of the term.	(d) Any vacancy that occurs for any reason in the membership of the Board shall be filled by the Governor in the manner prescribed in the provisions of this article regarding appointments. Vacancies created by reason other than the expiration of a term shall be filled within ( ) days after such vacancy occurs. A person appointed to fill a vacancy shall serve for the un-expired portion of the term.	
(e) The governor may remove any member from the Board for neglect of any duty required by law or for incompetency or for unprofessional or dishonorable con-	(e) The governor may remove any member from the Board for neglect of any duty required by law or for incompetence or for unprofessional or dishonorable con-	

duct.The general laws of this State controlling the removal of public officials from office shall be followed in dismissing Board members.	duct. The general laws of this State controlling the removal of public officials from office shall be followed in dismissing Board members.	
(f) All members of the Board shall have immunity from individual civil liability while acting within the scope of the duties as Board members.	(f) All members of the Board shall have immunity from individual civil liability while acting within the scope of the duties as Board members.	
(g) In the event that the entire Board, an individual member or staff is sued, the Attorney General shall appoint an attorney to represent the involved party.	(g) In the event that the entire Board, an individual member or staff is sued, the Attorney General shall appoint an attorney to represent the involved party.	
(h) Board meetings and hearing shall be open to the public. In accordance with the law, the Board may in its discretion conduct part of the meeting in executive session closed to the public.	(h) Board meetings and hearings shall be open to the public. In accordance with the law, the Board may in its discretion conduct part of the meeting in executive session closed to the public.	
Section 2. *Powers and Duties.* The Board shall:	**Section 2. *Powers and Duties.*** The Board shall:	
(a) be responsible for enforcement of the provisions of this Act. The Board shall have all of the duties, powers and authority specifically granted by and necessary to the enforcement of this Act, including subpoena power, as well as such other duties, powers and authority as it may be granted by appropriate status;	a) Be responsible for **interpretation and** enforcement of the provisions of this Act. The Board shall have all of the duties, powers and authority specifically granted by and necessary to the enforcement of this Act, as well as other duties, powers and authority as it may be granted by appropriate status;	This addition was to articulate a role for the Board of Nursing in ascertaining the sense and meaning of the subject matter.
(b) be authorized to make, adopt, amend, repeal and enforce such administrative rules consistent with law as it deems necessary for the proper administration and enforcement of this Act and to protect the public health, safety and welfare;	(b) Be authorized to make, adopt, amend, repeal and enforce such administrative rules consistent with law as it deems necessary for the proper administration and enforcement of this Act and to protect the public health, safety and welfare.	
(c) be authorized to make, adopt, amend, repeal and enforce such administrative rules consistent with law as it deems necessary for the regulation of advanced nursing practice;	(c) Be authorized to make, adopt, amend, repeal and enforce such administrative rules consistent with the law as it deems necessary for the regulation of advanced nursing practice.	
(d) further be authorized to do the following without limiting the foregoing: (1) develop and enforce qualifications for licensure; (2) develop and enforce standards for nursing practice and nursing education;	(d) Further be authorized to do the following without limiting the foregoing: (1) Develop standards for nursing education (2) Shall enforce educational standards and rules set forth by the Board. (3) **Require criminal background checks on appli-**	Concepts regarding standards development are not new. Education standards, practice standards and enforcement are presented here as stand-alone elements.

(3) license qualified applicants by examination or endorsement, and renew and reinstate licenses; (4) develop standards for maintaining competence of licensees continuing in or returning to practice; (5) collect and analyze data regarding nursing education, nursing practice, and nursing resources; (6) discipline licenses as needed; (7) regulate the manner in which nurses announce their practice to the public; (8) issue a special license to practice nursing to an individual to practice within a modified scope of practice or with accommodations or both, as specified by the Board, (9) inform licensees on an established basis about changes in law and rules regarding nursing practice; (10) maintain records of proceedings as required by the laws of this State; (11) provide consultation, conduct conferences, forums, studies and research on nursing education and practice; (12) appoint and employ a qualified Registered Nurse to serve as Executive Director and approve such additional staff positions as may be necessary, in the opinion of the Board, to administer and enforce the provisions of the Act; (13) maintain membership in national organizations that develop and regulate the national nursing licensure examinations and exclusively promote the improvement of the legal standards of the practice of nursing for the protection of the public health, safety and welfare; (14) require such surety bonds as are deemed necessary; (15) determine and collect reasonable fees; (16) receive and expend funds in addition to appropriations from this State, provided such funds are received and expended for the pursuit of the authorized objectives of the Board of Nursing; such funds are maintained in a separate account; and periodic reports of the receipt and expenditures of such funds are submitted to the Governor; and (17) adopt a seal which shall be in the care of the Executive Director and shall be affixed only in such a manner as prescribed by the Board.	**cants and licensees.** (4) License qualified applicants for RN and LPN/VN licensure by examination or endorsement, and renew and reinstate licenses. (5) **Regulate the advanced practice of nursing by Advanced Practice Registered Nurses.** (6) **Regulate the clinical support of nursing services by unlicensed assistive personnel regardless of title.** (7) **Maintain a record of all persons regulated by the Board.** (8) Develop and enforce standards for nursing practice. (9) **Develop rules to govern delegation by and to nurses.** (10) Develop standards for maintaining competence of licensees continuing in or returning to practice. (11) Collect and analyze data regarding nursing education, nursing practice, and nursing resources. (12) **Issue subpoenas in connection with investigations, inspections and hearings.** (13) **Access to records as reasonably requested by the board to assist the Board in its investigation; the Board shall maintain any records obtained pursuant to this paragraph as confidential data.** (14) **Order licensees to submit to physical, mental health or chemical dependency evaluations for cause.** (15) **Cause prosecution of allegations of violations of this Act.** **(16) Conduct hearings, compel attendance of witnesses and administer oaths to persons giving testimony at hearings.** **(17) Close discipline sessions and hearings to the public.** (18) Discipline licenses as needed. (19) Maintain membership in national organizations that develop and regulate the national licensure examinations and exclusively promote the improvement of the legal standards of the practice of nursing for the protection of the public health, safety and welfare. (20) **Establish alternative programs for monitoring of nurses who voluntarily seek treatment for chemical dependency, mental health or physical health condi-**	(3) Provides clear authority to the board to require criminal background checks (specifics to be elaborated in rule). (5) and (6) provide clear authority to have the authority to develop chapters in the Model Nursing Administrative Rules to develop chapters on APRN and nursing assistive personnel. (12)–(17) Discipline authority language is strengthened. (17) The opportunity for boards to incorporate this element will depend on the data practices, privacy and open meeting provisions in their states. The intent in providing this option is in anticipation of protecting the privacy of patient witnesses. (20) Provides clear authority for boards to use alternative programs to monitor nurses in recovery or with health conditions that could impact the ability to practice safely.

This Act shall not be construed to require the Board of Nursing to report violations of the provisions of the Act whenever, in the Board's opinion, the public interest will be served adequately by a suitable written notice of warning.	**tions that could lead to disciplinary action by the Board.** (21) Regulate the manner in which nurses announce their practice to the public. (22) **Issue a modified license to practice nursing to an individual to practice within a limited scope of practice or with accommodations or both, as specified by the Board.** (23) Inform licensees on an established basis about changes in law and rules regarding nursing practice. (24) Maintain records of proceedings as required by the laws of this State. (25) Provide consultation, conduct conferences, forums, studies and research on nursing education and practice. (26) Appoint and employ a qualified Registered Nurse to serve as Executive Officer and approve such additional staff positions as may be necessary, in the opinion of the Board, to administer and enforce the provisions of the Act. (27) **Delegate to the Executive Officer those activities that expedite the functions of the Board.** (28) **Develop disaster preparedness plan.** (29) **Employ professional and support staff, investigators and legal counsel and other personnel necessary for the Board to carry out its functions.** (30) Require such surety bonds as are deemed necessary. (31) Determine and collect reasonable fees. (32) Receive and expend funds in addition to appropriations from this State, provided such funds are received and expended for the pursuit of the authorized objectives of the Board of Nursing; such funds are maintained in a separate account; and periodic reports of the receipt and expenditures of such funds are submitted to the Governor. (33) Adopt a seal that shall be in the care of the Executive Director and shall be affixed only in such a manner as prescribed by the Board. This Act shall not be construed to require the Board of Nursing to report violations of the provisions of the Act whenever, in the Board's opinion, the public interest will be served adequately by a suitable written notice of warning.	(22) This power continues the concept (current model (8) of a non-disciplinary process for nurses with disabilities, renaming it a modified license. (26) Some boards may not require that the chief executive be a Registered Nurse, such as with some umbrella boards. (29) The need for a disaster preparedness plan refers to both national emergencies and local disasters that affect a board's functioning (e.g., immediate need to bring in nurses or loss of records due to fire or flood).

Section 3. *Executive Director.* The Executive Director shall be responsible for: (a) the performance of administrative responsibilities of the Board; (b) employment of personnel needed to carry out the functions of the Board; and (c) the performance of any other duties as the board may direct.	**Section 3. *Executive Director.*** The Executive Director shall be responsible for: (a) the performance of administrative responsibilities of the Board; (b) employment of personnel needed to carry out the functions of the Board; and (c) the performance of any other duties as the board may direct.	
Section 4. *Compensation.* Each member of the Board shall receive, as compensation, a reasonable sum for each day the member is engaged in performance of official duties of the Board and reimbursement for all expenses incurred in connection with the discharge of such official duties.	**Section 4. Compensation.** Each member of the Board shall receive, as compensation, a reasonable sum for each day the member is engaged in performance of official duties of the Board and reimbursement for all expenses incurred in connection with the discharge of such official duties.	
Article IV. Administrative Procedures Act - Application. The state Administrative Procedures Act is hereby expressly adopted and incorporated herein as if all the provisions of such Act were included in this Act.	**Article IV. Administrative Procedures Act – Application.** The state Administrative Procedures Act is hereby expressly adopted and incorporated herein as if all the provisions of such Act were included in this Act.	
Article V. Licensure.	**Article V. Licensure.**	
Section 1. *Requirements.* Each applicant who successfully meet the requirements of this section shall be entitled to licensure as a Registered Nurse or Licensed Practice/Vocational Nurse, whichever is applicable as follows: (a) Licensure by Examination. An applicant for licensure by examination to practice as a Registered Nurse or Licensed Practical/Vocational Nurse shall: (1) submit a completed written application and fees as established by the Board; (2) be a graduate of an approved nursing education program which meets criteria similar to and not less stringent than those established by the Board and which prepares for the level of licensure being sought;	**Section 1. *Requirements.*** Each applicant who successfully meet the requirements of this section shall be entitled to licensure as a Registered Nurse or Licensed Practice/Vocational Nurse, whichever is applicable as follows: (a) Licensure by Examination. An applicant for licensure by examination to practice as a Registered Nurse or Licensed Practical/Vocational Nurse shall: (1) Submit a **completed application** and fees as established by the Board; (2) Be a graduate of a board-approved nursing education program or a program that meets criteria comparable to those established by the Board in its rules.	(1) Allows for electronic applications. (2) "Board-approved" clarifies that the approval is provided or recognized by a board of nursing in a U.S. jurisdiction rather than a foreign entity if not in the definition; "comparable" is the term used by many academic evaluation services.

(3) be proficient in English language if a graduate of a foreign nursing educational program; (4) pass an examination authorized by the Board; (5) have committed no acts or omissions which are grounds for disciplinary action as set forth in Article IX, Section 2, of this Act, or, if such acts have been committed and would be grounds for disciplinary action if the Board has found after investigation that sufficient restitution has been made; and (6) meet other criteria established by the Board.	(3) Be proficient in English language **as set forth in the board rules;** (4) Pass an examination authorized by the Board; (5) Have committed no acts or omissions which are grounds for disciplinary action as set forth in Article IX, Section 2, of this Act, or, if such acts have been committed and would be grounds for disciplinary action, the Board has found after investigation that sufficient restitution has been made; (6) **If convicted of one or more felonies, has received an absolute discharge from the sentences for all felony convictions ( ) years prior to the date of filing an application pursuant to this chapter; and** (7) Meet other criteria established by the Board.	(3) Addresses English proficiency for graduates of programs in U.S. jurisdictions when English is not the first language. (7) Source: Arizona statute §32-1632. Included in requirements for licensure as part of applicant's burden to demonstrate that these requirements are met. This approach provides protection to the public (as the most recidivism occurs in the first years after a criminal conviction) but also leaves the opportunity for an individual to still apply for licensure after a criminal conviction.
(b) Licensure by Endorsement. An applicant for licensure by endorsement to practice as a Registered Nurse or Licensed Practical/Vocational Nurse shall: (1) submit a completed written applications and f ees as established by the Board; (2) have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for disciplinary action as set forth in Article IX, Section 2, of this Act, the Board has found after investigation that sufficient restitution has been made; (3) be a graduate of an approved nursing education program which meets criteria similar to and not less stringent than those established by this Board and which prepares for the level of licensure being sought; (4) submit verification of licensure status directly from the jurisdiction of licensure by examination; (5) submit verification of licensure status directly	(b) Licensure by Endorsement. An applicant for licensure by endorsement to practice as a Registered Nurse or Licensed Practical/Vocational Nurse shall: (1) Submit a completed application and fees as established by the Board. (2) Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for disciplinary action as set forth in Article IX, Section 2, of this Act, the Board has found after investigation that sufficient restitution has been made. (3) Be a graduate of a board-approved nursing edu cation program which meets criteria comparable to those established by this Board and which prepares for the level of licensure being sought. (4) **Pass an examination authorized by the Board.** (5) **Be proficient in English language as set forth in the board rules.** (6) Submit verification of licensure status directly	Allows for electronic application. (6) Clarifies where jurisdiction is located if not in the def-

from the jurisdiction of licensure by examination; (6) meet continued competency requirements as stated in Article V, Section 3(b); and (7) meet other criteria established by the Board.	from the U.S. jurisdiction of licensure by examination, **Nur*sys* [or the Coordinated Licensure Information System].** (7) Meet continued competency requirements as stated in Article V, Section 3(b) **and as set forth in board rules;** (8) **If convicted of one or more felonies, has received an absolute discharge from the sentences for all felony convictions five or more years prior to the date of filing an application pursuant to this chapter; and** (9) Meet other criteria established by the Board.	inition: update to address Nursys and the Nurse Licensure Compact. (8) Source: Arizona statute §32-1632, as above, this provision is included in requirements for licensure as part of applicant's burden to demonstrate that these requirements are met.
(c) Initial Licensure for Advanced Practice Registered Nurse. An application for initial licensure as an Advanced Practice Registered Nurse shall: (1) be currently licensed as a Registered Nurse in (this jurisdiction); (2) submit a completed written application and appropriate fees as established by the Board; (3) provide evidence of successful completion of a graduate degree with a major in nursing or a graduate degree with a concentration in the advanced nursing practice category; and (4) have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for discipline under Article IX, Section 2, of this Act, the Board has found after investigation that sufficient restitution has been made.	(c) Initial Licensure for Advanced Practice Registered Nurse. An application for initial licensure as an Advanced Practice Registered Nurse shall: (1) Be licensed as a Registered Nurse (unencumbered) (2) Be a graduate from or have completed a gradu ate level APRN program accredited by a national accrediting body. (3) Be currently certified by a national certifying body in the APRN specialty appropriate to educational preparation. (4) Submit a completed written application and appropriate fees as established by the Board; (5) **Provide evidence as required by the Board in its Rules;** (6) Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction or, if such acts have been committed and would be grounds for discipline under Article IX, Section 2, of this Act, the Board has found after investigation that sufficient restitution has been made.	(2) This requirement is recommended for implementation by 2003. (3) Source: NCSBN Uniform Core Licensure Requirements (2000).Provides authority for Board to use Rules to delineate detailed requirements regarding educational requirements and national certification requirements, provides Board flexibility to change the rules if needed to reflect current advanced practice environment.
(d) the Board may issue a license by endorsement to practice as an Advanced Practice Registered Nurse under the laws of another state and, in the opinion of the Board the applicant meets the qualifications for licensure in this jurisdiction.	(d) The Board may issue a license by endorsement to practice as an Advanced Practice Registered Nurse under the laws of another state and, in the opinion of the Board the applicant meets the qualifications for licensure in this jurisdiction.	
(e) Temporary Permits. (1) Applicants for Endorsement. The Board may issue, upon the request of an applicant, a tem-	(e) Temporary Permits (1) Applicants for Endorsement. The Board may issue, upon the request of an applicant, a tem-	Clarifies level of permit.

porary permit to practice nursing to an individual currently licensed as a Registered Nurse in another jurisdiction of the United States who submits a written application in accord with the rules of the Board. (2) Post-basic Nursing Students. The Board may issue a temporary permit to practice nursing as part of a formal nursing education program and under direct supervision by a Registered Nurse licensed in this jurisdiction. This permit may be issued to an individual licensed to practice nursing in another country or in another jurisdiction who submits a written application in accord with the rules of the Board. (3) Nurse Refresher Course Students. The board may issue a temporary permit to practice nursing as part of a nursing refreshed course, under the direct supervision of a nursing instructor licensed to practice as a Registered Nurse in this jurisdiction. This permit may be issued to an individual who is seeking reinstatement of licensure, or is meeting continued competence requirements to apply for licensure by endorsement.	porary permit to practice nursing **at the same level of licensure** to an individual currently licensed in another jurisdiction of the United States who submits an application in accord with the rules of the Board. (2) **Individuals Previously Licensed to Practice Nursing Enrolled in Refresher Courses.** The board may issue a temporary permit to **provide direct patient care** as part of a nursing refresher course, **as permitted in Board rules.**	(2) Existing model term "Post-basic" may be confusing in light of new educational programs, so this type of permit was deleted. See exemptions in Article XII for provision to allow practice by graduate student. (2) Also allows temporary permit to complete nursing refresher course.
(f) The Board may issue, upon request of the applicant, a temporary permit to practice advanced practice nursing to an applicant who submits a written application in accord with the rules of the Board.	(f) The Board may issue, upon request of the applicant, a temporary permit to practice advanced practice nursing to an applicant **authorized to practice at that level in a U.S. jurisdiction** who submits **an application** in accord with the rules of the Board.	Clarifies level of previous licensure and advanced practice registration.
Section 2. *Examinations.*	Section 2. *Examinations.*	
(a) The Board shall authorize the administration of the examination to applicants for licensure as Registered Nurses or Licensed Practical/Vocational Nurses.	(a) The Board shall authorize the administration of the examination to applicants for licensure as Registered Nurses or Licensed Practical/Vocational Nurses.	
(b) The Board may employ, contract and cooperate with any organization in the preparation and grading of an appropriate nationally uniform examination, but shall retain sole discretion and responsibility for determining	(b) The Board may employ, contract and cooperate with **any entity in the preparation and process for determining results of a uniform licensure examination.** When such an examination is utilized, access to questions and answers	Allows for potential development of an international examination. Promotes uniformity of the passing standard.

the standard for the successful completion of such an examination. When such an examination is utilized, access to questions and answers shall be restricted by the Board. The Board shall determine whether an examination may be repeated, the frequency of reexamination and any requisite further education.	shall be restricted by the Board. (c) The Board shall determine whether a **licensure** examination may be repeated, the frequency of reexamination and any requisite education prior to reexamination.	Technical change.
Section 3. *Renewal of Licenses.*	**Section 3. *Renewal of Licenses.***	
(a) Licenses issued under this Act shall be renewed every ( ) years according to a schedule established by the Board.	(a) Licenses issued under this Act shall be renewed every ( ) years according to a schedule established by the Board. (b) **An applicant for licensure renewal shall submit a verified statement that indicates whether the applicant has been convicted of a felony, and if convicted of one or more felonies, indicates the date of absolute discharge from the sentences for all felony convictions;**	Source: Arizona Statute §32-1642.
(b) A renewal license shall be issued to a Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse who remits the required fee and satisfactorily completes any other requirements established by the Board as set forth in rules.	(c) (1) A renewal license shall be issued to a Registered Nurse or Licensed Practical/ Vocational Nurse who remits the required fee and satisfactorily completes any other requirements established by the Board as set forth in rules. (c) **(2) A renewal license shall be issued to an Advanced Practice Registered Nurse who maintains national certification in the appropriate APRN specialty through an ongoing certification maintenance program of a nationally recognized certifying body, [or for applicants for whom no recognized certification is available must participate in a competence maintenance program] remits the required fee, and satisfactorily completes any other requirements established by the Board as set forth in rules.**	Language inserted to conform to the Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements.
(c) Failure to renew the license shall result in forfeiture of the right to practice nursing in this State.	(d) Failure to renew the license shall result in forfeiture of the right to practice nursing in this State.	
Section 4. *Reinstatement of Lapsed Licenses.* A licensee whose license has lapsed by failure to renew may apply for reinstatement according to the rules established by the Board. Upon satisfaction of the requirements for reinstatement, the Board shall issue a renewal of license.	**Section 4. *Reinstatement of Licenses.*** (a) A licensee whose license has lapsed by failure to renew may apply for reinstatement according to the rules established by the Board. Upon satisfaction of the requirements for reinstatement, the Board shall issue a	

	renewal of license. (b) **A licensee whose license has been suspended, revoked or otherwise removed shall comply with all requirements set forth in the Board's discipline order.**	Addition suggested by Disciplinary Curriculum Advisory Panel.
Section 5. *Special License.* The Board may issue a special license to an individual who is unable to practice the full scope of nursing safely, but who is able to practice safely within a modified scope of practice or with accommodations or both as specified by the Board.	**Section 5. *Modified License.*** The Board may **consider** issuing a **modified** license to an individual who **has successfully completed a board approved nursing program and who is able to practice without compromise to the public** safety within a modified scope of practice or with accommodations or both as specified by the Board.	Intended as a non-disciplinary approach for nurses who have serious disabilities and to conform to the Americans with Disabilities Act. Reflects a need for boards to work with educators to promote notice to students that ability to practice safely is a consideration at time of licensure.
Section 6. *Duties of Licensees.* Each licensee shall:	**Section 6. *Duties of Licensees.* The nurse shall comply with the provisions of this act. The burden of responsibility is on the licensee to know and practice according to the laws and regulations of the state.**	This added language is especially important In light of the Nurse Licensure Compact, that the burden is on the nurse to know the laws and rules that govern practice.
(a) In response to Board inquiries, provide relevant and truthful personal, professional or demographic information requested by the board to perform its duties in regulating and controlling nursing practice in order to protect the public health, safety and welfare. Failure to provide the requested information may result in non-renewal of the license to practice nursing and/or licensure disciplinary action.	(a) In response to Board inquiries, provide relevant and truthful personal, professional or demographic information requested by the board to perform its duties in regulating and controlling nursing practice in order to protect the public health, safety and welfare. Failure to provide the requested information may result in non-renewal of the license to practice nursing and/or licensure disciplinary action.	
(b) Submit to a physical or mental evaluation by a designated ( ) when directed in writing by the Board for cause. If requested by the licensee, the licensee may also designate a ( ) for an independent medical examination. Refusal or failure of a licensee to complete such examinations shall constitute an admission of any allegations relating to such condition. All objections shall be waived as to the admissibility of the examining ( ) testimony or examination reports on the grounds that they constitute privileged communication. The medical testimony or examinations reports shall not be used against a Registered Nurse, Licensed Practical/Vocational Nurse or Advance Practice Registered Nurse in another proceeding and shall be confidential. At reasonable intervals, a Registered Nurse, Licensed Practical/Vocational Nurse or Advance Practice Registered Nurse shall be afforded the opportunity to demonstrate competence to resume the practice of nursing with reasonable skill and safety to	(b) Submit to a physical or mental evaluation by a designated ( ) when directed in writing by the Board for cause. If requested by the licensee, the licensee may also designate a ( ) for an independent medical examination. Refusal or failure of a licensee to complete such examinations shall constitute an admission of any allegations relating to such condition. All objections shall be waived as to the admissibility of the examining ( ) testimony or examination reports on the grounds that they constitute privileged communication. The medical testimony or examinations reports shall not be used against a Registered Nurse, Licensed Practical/Vocational Nurse or Advance Practice Registered Nurse in another proceeding and shall be confidential. At reasonable intervals, a Registered Nurse, Licensed Practical/Vocational Nurse or Advance Practice Registered Nurse shall be afforded the opportunity to demonstrate competence to resume the practice of nursing with reasonable skill and safety to	

patients.	patients.	
(c) Report to the Board those acts or omissions which are violations of the Act or grounds for disciplinary action as set forth in Articles VIII and IX of this Act.	(c) Report to the Board those acts or omissions which are violations of the Act or grounds for disciplinary action as set forth in Articles VIII and IX of this Act.	
Article VI. Titles and Abbreviations.	**Article VI. Titles and Abbreviations.**	
Section 1. Only those persons who hold a license to practice nursing in this state shall have the right to use the following title abbreviations:	**Section 1.** Only those persons who hold a license to practice nursing in this state shall have the right to use the following title abbreviations:	
(a) Title: "Registered Nurse" and the abbreviation "RN.""	(a) Title: "Registered Nurse" and the abbreviation "RN."	
(b) Title: "Licensed Practical/Vocational Nurse" and the abbreviation "LPN/VN."	(b) Title: "Licensed Practical/Vocational Nurse" and the abbreviation "LPN/VN."	
(c) Title: "Advanced Practice Registered Nurse" and the abbreviation "APRN."	(c) Title: "Advanced Practice Registered Nurse" and the abbreviation "APRN."	In some jurisdictions, APRNs use a term other than APRN.
Section 2. Any person who has been approved as an applicant for licensure by endorsement and has been granted a temporary permit shall the right to use the title ( ) and abbreviations ( ) designated by the state.	**Section 2.** Any person who has been approved as an applicant for licensure by endorsement and has been granted a temporary permit shall the right to use the title ( ) and abbreviations ( ) designated by the state.	
Article VII. Approval of Nursing Education Programs.	**Article VII. Approval of Nursing Education Programs.**	
Section 1. *Approval Standards.* The Board shall, by administrative rules, set standards for the establishment and conduct of nursing education programs, including all clinical facilities used for learning experiences and shall survey and approve such programs that meet the requirements of the Act and the Board administrative rules.	**Section 1. *Approval Standards.*** The Board shall, by administrative rules, set standards for the establishment **and outcomes of nursing education programs,** including clinical **learning experiences and approve such programs** that meet the requirements of the Act and the Board administrative rules.	Clarifies that standards are set for the learning experiences rather than the facilities in which they occur; allows the Board discretion in defining how approval may be granted if surveys are not conducted.
Section 2. *Approval Required.* An educational institution within this State shall apply to the Board and submit evidence that its nursing program is able to meet the standards established by the Board. If, upon investigation, the Board finds that the program meets the established standards for nursing education programs, it shall approve the applicant program.	**Section 2. *Initial Approval Required.*** An educational institution **that seeks to provide a diploma, degree or certificate in nursing to students in this** jurisdiction shall apply to the Board and submit evidence that its nursing program**(s) meets or will meet the standards established by the Board. If, upon review, the Board determines that the program(s) meets established standards, it shall grant approval.** Section 3. ***Provisional or Interim Approval of New***	Distinguishes initial approval from continuing approval; provides for public protection (students and patients) when out-of-state/country distance learning programs bring learning experiences into the jurisdiction - this is a substantive change. Expands terminology and authority to regulate post-licensure programs leading to advanced nursing practice. Conforms to current practice of many boards.

	Programs. **Provisional approval of new programs may be granted contingent upon conditions set forth by the Board in administrative rules.**	
Section 3. ***Periodic Evaluation of Nursing Programs.*** The Board shall periodically reevaluate approved nursing education programs and shall publish a list of approved programs.	**Section 4.** ***Continuing Approval of Nursing Programs.*** The Board shall periodically **review educational nursing programs and require nursing education programs to submit evidence of compliance with standards and administrative rules. If upon review of such evidence the board determines that the program(s) meets the established standards, it shall grant continued approval.** The board will publish a list of approved programs.	Allows for state differences regarding process for determining continuing approval.
Section 4. ***Denial or Withdrawal of Approval.*** The Board may deny or withdraw approval or take such action as deemed necessary when nursing education programs fail to meet the standards established by the Board, provided that all such actions shall be in accordance with this State's Administrative Procedures Act and/or the Administrative Rules of the Board. A process of appeal and reinstatement shall be delineated in Board rules.	**Section 5.** ***Denial or Withdrawal of Approval.*** The Board may deny or withdraw approval or take such action as deemed necessary when nursing education programs fail to meet the standards established by the Board, provided that all such actions shall be in accordance with this State's Administrative Procedures Act and/or the Administrative Rules of the Board. A process of appeal and reinstatement shall be delineated in Board rules.	
Section 5. ***Reinstatement of Approval.*** The Board shall reinstate approval of a nursing education program upon submission of satisfactory evidence that its program meets the standards established by the Board	**Section 6.** ***Reinstatement of Approval.*** The Board shall reinstate approval of a nursing education program upon submission of satisfactory evidence that its program meets the standards established by the Board.	
Article VIII. Violations and Penalties.	**Article VIII. Violations and Penalties.**	
Section 1. ***Violations.*** No person shall:	**Section 1.** ***Violations.*** **Every employer of a licensed nurse and every person acting as an agent for such a nurse in obtaining employment, shall verify the current status of the licensee's authorization to practice within the provisions of this chapter. As used in this section, the term "agent" includes, but is not limited to, a nurses registry.** No person shall:	Added for nurses practicing on a privilege under the Nurse Licensure Compact.
(a) engage in the practice of nursing as defined in the Act without a valid, current license, except as otherwise permitted under this Act;	(a) Engage in the practice of nursing as defined in the Act without a valid, current license, except as otherwise permitted under this Act.	
(b) practice nursing under cover of any diploma, license or record illegally or fraudulently obtained, signed or issued unlawfully or under fraudulent representation;	(b) Practice nursing under cover of any diploma, license or record illegally or fraudulently obtained, signed or issued unlawfully or under fraudulent representation.	

(c) practice nursing during the time a license is suspended, revoked, surrendered, inactive or lapsed;	(c) Practice nursing during the time a license is suspended, revoked, surrendered, inactive or lapsed.	
(d) use any words, abbreviations, figures, letters, title, sign, card or device tending to imply that he or she is a Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse unless such person is duly licensed so to practice under the provisions of this Act;	(d) Use any words, abbreviations, figures, letters, title, sign, card or device tending to imply that he or she is a Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse unless such person is duly licensed so to practice under the provisions of this Act.	
(e) fraudulently obtain or furnish a license by or for money or any other thing of value;	(e) Fraudulently obtain or furnish a license by or for money or any other thing of value.	
(f) knowingly employ unlicensed persons in the practice of nursing;	(f) Knowingly employ unlicensed persons in the practice of nursing.	
(g) fail to report information relating to violations of this Act;	(g) Fail to report information relating to violations of this Act.	
(h) conduct a program for the preparation for licensure under this chapter unless the program has been approved by the Board;	(h) Conduct a program for the preparation for licensure under this chapter unless the program has been approved by the Board (i) Conducting courses or providing consultation that conflict with the scope and standards of practice set forth in this Act and in rules of the board.	This section was added to address workshops or consultation that promote activities either beyond the scope of practice or in conflict with the board's standards of practice.
(i) otherwise violate, or aid or abet another person to violate any provision of this Act.	(j) Otherwise violate, or aid or abet another person to violate any provision of this Act.	
Section 2. *Penalties.* Initial violation of any provision of this article shall constitute a misdemeanor, and each subsequent violation shall constitute a felony.	**Section 2. *Penalties.*** **Violation of any provision of this article shall constitute a misdemeanor or felony as defined by rule.**	This section was changed to make any violation a felony.
Section 3. *Criminal Prosecution.* Nothing in this Act shall be construed as a bar to criminal prosecution for violation of the provisions of this Act.	**Section 3. *Criminal Prosecution.*** Nothing in this Act shall be construed as a bar to criminal prosecution for violation of the provisions of this Act.	
Section 4. *Civil Penalties.* The Board may, in addition to any other sanctions herein provided, impose on any person violating a provision of this Act or Administrative Rules of the Board, a civil penalty not to exceed ($) for	**Section 4. *Civil Penalties.*** The Board may, in addition to any other sanctions herein provided, impose on any person violating a provision of this Act or Administrative Rules of the Board, a civil penalty not to exceed ($) for	

each count or separate offense.	each count or separate offense.	
Article IX. Discipline and Proceedings.	**Article IX. Discipline and Proceedings**	
Section 1. *Authority.* The Board of Nursing shall have the power to refuse to issue or renew a license; to limit, suspend or revoke a license; or place on probation or reprimand or otherwise discipline a licensee for any one or combination of the grounds set forth below. Fines of up to ($) may be imposed.	**Section 1. *Authority.*** For any one or combination of the grounds set forth below, the Board of Nursing shall have the power to: (a) Refuse to issue or renew a license; (b) Limit a license; (c) Suspend a license: (d) Revoke a license; (e) Place a license on probation; (f) Reprimand or otherwise discipline a licensee; (g) **Impose a civil penalty not exceeding $10,000 for each separate violation** (h) Impose fines of up to ($); or (i) **Take any other action justified by the facts in the case.**	This section was reformatted to view the remedy options more easily. The rationale for large civil penalty: the amount of the civil penalty to be fixed as to deprive the nurse of any economic advantage gained by reason of the violation charged, to reimburse the board the cost of counsel, investigation, and proceeding and to discourage repeated violations. The other action provision gives the board flexibility to be creative with remedy provisions (e.g., require community service or remuneration to a patient).
Section 2. *Grounds.* The Board may discipline a licensee or applicant for any or a combination of the following grounds:	**Section 2. *Grounds for Discipline.*** The Board may discipline a licensee or applicant for any or a combination of the following grounds **[as defined by regulations adopted by the Board].**	(i) Will be described further in rule. The current Model Act includes a very detailed list of discipline grounds. Two possible approaches to discipline grounds in Nursing Practice Acts are identified: <u>Approach One - Broad Grounds Categories</u> Details would be promulgated in rules/regulations. <u>Approach Two - Detailed Grounds</u> The detailed language is included as part of the Nursing Practice Act. There are advantages to both approaches. Having broad ground category with detail in rules/regulations provides more flexibility for the board to modify the grounds as needed. Having detailed grounds in the Act is more likely to provide clear notice to nurses as to the types of conduct subject to board action. Boards using the broad category approach could use the heading language for each group of grounds in their act, and the details in their rules. The boards using the detailed grounds could use all or selected parts of the detailed language in their law.

(a) has failed to demonstrate the qualifications or satisfy the requirements for licensure contained in Article V. In the case of a person applying for a license, the burden of proof is upon the applicant to demonstrate the qualifications or satisfactions of the requirements;	(a) **Failure to Meet Requirements.** Failure to demonstrate the qualifications or satisfy the requirements for licensure contained in Article V. In the case of a person applying for a license, the burden of proof is upon the applicant to demonstrate the qualifications or satisfactions of the requirements;	In the work to develop this section, the statutes of many boards were reviewed. Some optional language identified is included in the comment section to serve as an additional resource.
(b) has been convicted by a court or has entered a plea of nolo contendere to a crime in any jurisdiction that relates adversely to the practice of nursing or to the ability to practice nursing;	(b) **Criminal Convictions.** Conviction by a court or entry of a plea of nolo contendere to a crime in any jurisdiction that relates adversely to the practice of nursing or to the ability to practice nursing;	
(c) has employed fraud or deceit in procuring or attempting to procure a license to practice nursing in filing any reports or completing patient records, signing any report or records in the nurse's capacity as a Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse or in submitting any information or record to the Board.	(c) **Fraud and/or Deceit.** Employment of fraud or deceit in procuring or attempting to procure a license to practice nursing in filing any reports or completing patient records, signing any report or records in the nurse's capacity as a Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse or in submitting any information or record to the Board.	OTHER LANGUAGE OPTIONS: • Violating the security of examination materials… • Violating the standard of test administration. • Impersonating an examinee or permitting an impersonator to take the examination on one's own behalf. • Providing false, incomplete or misleading information on an application for licensure • Providing false, incomplete or misleading information on an application for nursing employment • Repeating willful ordering or performing demonstrably unnecessary laboratory tests or studies • Administering without clinical justification, treatment which is demonstrably unnecessary and/or contrary to recognized standards of the practice of nursing as interpreted by the Board. • Failing to obtain consultations or perform referrals when failing to do so is not consistent with the standard of the profession • Committing a fraudulent insurance act • Committing fraud in presentation as to own skill or ability. • Engaging in false, misleading, improbable or deceptive advertising statements. • Impersonating another certified or licensed practitioner, or permitting or allowing another person to use his or her certificate or license for the purpose of nursing the sick or afflicted. • Engaging in conduct likely to deceive, defraud or

		endanger a patient or the general public.
(d) has had a license to practice nursing or to practice in another health care discipline denied, revoked, suspended or otherwise restricted in this or any other state;	(d) **Action in Another Jurisdiction.** License to practice nursing or another health care profession has been denied, revoked, suspended, restricted or otherwise disciplined in this or any other state.	OTHER LANGUAGE OPTIONS: • A certified copy of the order of suspension or revocation shall be prima facie evidence of such suspension or revocation. • Has been disciplined by another state, territory, or country based upon an act or omission that is defined substantially the same as a ground for discipline pursuant to this subsection.
	(e) **Unsafe Practice/Unprofessional Practice** (1) Failure or inability to perform professional, practical nursing or advanced practice nursing, as defined in Article II, with reasonable skill and safety. (2) Unprofessional conduct, including a departure from or failure to conform to Board standards of professional or practical nursing, (3) Failure of to supervise or the performance of acts by any individual working at the nurse's direction. (4) Failure of a chief administrative nurse to pro vide oversight of the nursing organization and nursing services of a health care delivery system. (5) Failure to practice within a modified scope of practice or with the required accommodations, as specified by the Board in granting a modified license; (6) Conduct or any nursing practice that may create unnecessary danger to a patient's life, health or safety. Actual injury to a patient need not be established.	The two categories, unsafe practice and unprofessional practice were collapsed because both dealt with safety issues. OTHER LANGUAGE OPTIONS: • Acting in a willful, negligent [or reckless] manner inconsistent with the health or safety of persons under his/her care. • Engaging in intentional or negligent [or reckless] conduct resulting in a serious harm or significant risk to the health or safety of a client or in injury to a client • Being guilty of willful or repeated departure from or the failure to conform to the minimum standard of acceptable and prevailing practice of nursing; however actual injury to a patient need not be established. • Failing to care adequately for a patient or to conform to the minimum standards of acceptable professional nursing practice in a manner that, in the board's opinion, exposes a patient or other person [co-worker] unnecessarily to risk or harm. • Failing to protect patients, except in emergency life threatening situation where it is not feasible, by complying with Centers for Disease Control's guidelines on universal precautions. • Demonstrating professional incompetency • Engaging in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed. • Engaging in repeated malpractice, which may be evidences by claims of malpractice settled against the nurse. • Exhibiting unprofessional conduct as defined by regu-

		lations adopted by the Board. • Engaging in any unprofessional conduct as identified by the board in its rule. • Performing an act that is beyond the licensee's knowledge and skills. • Failing to supervise:- - Delegating [assigning or directing] nursing acts or responsibilities to an individual that the licensee knows or has reason to know lacks the ability or knowledge to perform- - Delegating nursing acts or responsibilities that the licensee knows or has reason to know should only be performed by a [licensed] nurse. • Directing (when acting as a supervisor), another nurse to delegate a nursing task to an individual that the nurse reasonably believes lacks the knowledge and skills to perform the task, or the patient's condition does not allow delegation of the nursing task [action].
(e) has failed or is unable to perform professional or practical nursing, as defined in Article II, with reasonable skill and safety, including failure of the professional nurse to supervise or the Licensed Practice/Vocational Nurse to monitor the performance of acts by any individual working at the nurse's direction or the failure of a professional nurse in a chief administrative nurse role to provide supervision of the nursing organization of a health care delivery system.		
(f) has failed to practice within the modified scope of practice or with the required accommodations, as specified by the Board in granting a special license;		This ground is included in the new section (e).This ground is included in the new section (f).
(g) has engaged in unprofessional conduct including, but not limited to, a departure from or failure to conform to Board standards of professional or practical nursing, or any nursing practice that may create unnecessary danger to a patient's life, health or safety. Actual injury to a patient need not be established.		This ground is included in the new section (e).
(h) has demonstrated actual or potential inability to practice nursing with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals, or any	(f) **Inability to Practice Safely.** Demonstration of actual or potential inability to practice nursing with reasonable skill and safety to patients by rea-	OTHER LANGUAGE OPTIONS Engaging in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a

other material, or as a result of any mental or physical conditions;	son of illness, use of alcohol, drugs, chemicals, or any other material, or as a result of any mental or physical conditions.	client or patient or the general public. • Having a physical, mental or emotional disability that renders the licensee unable to perform nursing services or duties with reasonable care and safety. • Practicing or attempting to practice nursing while afflicted with physical or mental illness, deterioration, or disability that interferes with the individual's performance of nursing functions • Having a lack of fitness to practice because of a mental or physical health condition that could result in injury to a patient or the public, • Having been adjudicated as mentally incompetent§
(i) conduct likely to deceived, defrauds, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established;	(g) Unethical Conduct. Behavior, likely to deceive, defraud, or harm the public, or demonstration of a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established.	OTHER LANGUAGE OPTIONS • Exiting undue influence, fraud, sexual conduct, fraudulent billing practices, including violation federal Medicare and Medicaid laws or state medical assistance laws.§ Engaging in conduct that violates the professional code of conduct • Engaging in conduct that fails to maintain the professional boundaries of a therapeutic relationship. • Falsifying or makes grossly incorrect, inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to controlled substances.
(j) has engaged in sexual conduct with a patient, or conduct that may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;	(h) **Misconduct** **(1) Failure to cooperate with a lawful investigation conducted by the Board** **(2) Use of excessive force upon or mistreatment or abuse of any patient. "Excessive force" means force clearly greater than what would normally be applied in similar clinical situations.** (3) Engagement in sexual conduct with a patient, or conduct that may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient.	
(k) has diverted or attempted to divert drugs or controlled substances;	(i) **Drug Diversion.** Diversion or attempts to divert drugs or controlled substances; **(j) Failure to Comply with Alternative Program Requirements. Failure to comply with terms of alternative program agreement.**	Specific ground for failure to comply with terms of agreement with Alternatives to Discipline Program. By adding this ground, the problem of investigation if a nurse has

		been in a program for some time, relapses and is referred to the board for possible disciplinary action, is addressed.
	(k) Other Drug Related **(1) Intemperate use of alcohol or drugs that the board determines endangers or could endanger a patient.** **(2) Use of any controlled substance or any dangerous drug or dangerous device or alcoholic beverages, to an extent or in a matter dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.**	
(l) has knowingly aided, assisted, advised, or allowed an unlicensed person to engage in the unlawful practice of professional or practical nursing; or	(l) **Unlawful Practice.** Has knowingly aided, assisted, advised, or allowed an unlicensed person to engage in the unlawful practice of professional or practical nursing. Has violated a rule adopted by the Board, an order of the Board, or a state or federal law relating to the practice of professional or practical nursing, or a state or federal narcotics or controlled substance law. **Has practiced beyond the scope of practice as stated in this Act.**	Makes not completing/complying with a Board Order a ground for discipline in itself without maintaining an evidence trail. Also addresses failure to complete with other laws and rules/regulations. Moved from section 3 in current model and expanded to include all licensure levels.
(m) has violated a rule adopted by the Board, an order of the Board, or a state or federal law relating to the practice of professional or practical nursing, or a state or federal narcotics or controlled substance law.		See unlawful practice section (l) above.
Section 3. *Additional Ground.* The Board may take disciplinary action against an Advanced Practice Registered Nurse who has practiced beyond the scope of the advanced practice registered nurse category.		This ground is incorporated into Article IX, Section 2(e).
Section 4. *Procedure.* The Board shall establish a disciplinary process based on the Administrative Procedure Act of the State of ( ).	**Section 4. *Procedure.*** The Board shall establish a disciplinary process based on the Administrative Procedure Act of the State of ( ).	
Section 5. *Immunity.* Any member of the Board or staff and any person reporting to the Board of Nursing under	**Section 5. *Immunity.*** Any member of the Board or staff and any person reporting to the Board of Nursing under	

oath and in good faith information relating to alleged incidents of negligence or malpractice or the qualifications, fitness or character of a person licensed or applying for a license to practice nursing shall not be subject to a civil action for damages as a result of report such information. The immunity provided by this section shall extend to the members of any professional review committee and witnesses appearing before the committee authorized by the Board to act pursuant to this section.	oath and in good faith information relating to alleged incidents of negligence or malpractice or the qualifications, fitness or character of a person licensed or applying for a license to practice nursing shall not be subject to a civil action for damages as a result of report such information. The immunity provided by this section shall extend to the members of any professional review committee and witnesses appearing before the committee authorized by the Board to act pursuant to this section.	
Article X. Emergency Relief.	**Article X. Emergency Relief.**	
Section 1. *Temporary Suspension.*	**Section 1. *Summary Suspension.***	Title changed to reflect common terminology.
(a) Authority. The Board is authorized to temporarily suspend the license of a nurse without a hearing if: (1) the Board finds that there is probable cause to believe that the nurse has violated a statute or rule that the Board is empowered to enforce; and (2) continued practice by the nurse would create imminent and serious risk of harm to others	(a) Authority. The Board is authorized to temporarily suspend the license of a nurse without a hearing if: (1) the Board finds that there is probable cause to believe that the nurse has violated a statute or rule that the Board is empowered to enforce; and (2) continued practice by the nurse would create imminent and serious risk of harm to others	
(b) Duration. The suspension shall remain in effect until the Board issues a stay of suspension or a final order in the matter after a hearing or upon agreement between the Board and licensee.	(b) Duration. The suspension shall remain in effect until the Board issues a stay of suspension or a final order in the matter after a hearing or upon agreement between the Board and licensee.	
(c) Hearing. The Board shall schedule a disciplinary hearing to be held under the Administrative Procedures Act, to begin no later than ( ) days after the issuance of the summary suspension order. The licensee shall receive at least ( ) days notice of the hearing.	(c) Hearing. The Board shall schedule a disciplinary hearing to be held under the Administrative Procedures Act, to begin no later than ( ) days after the issuance of the summary suspension order. The licensee shall receive at least ( ) days notice of the hearing. **Section 2. *Automatic Suspension.*** **Unless the board orders otherwise, a license to practice professional or practical nursing is automatically suspended if:** **(1) A guardian of a nurse is appointed by order of a court under sections (reference to state law governing);(** **2) The nurse is committed by order of a court under**	Allows a board to act on a previous court action without additional proceedings. Example: a nurse who is determined by a court of competent jurisdiction to be dangerous to the public because of serious mental disorder.

	(reference to state law governing); or **(3) The nurse is determined to be mentally incompetent, mentally ill, chemically dependent, or a person dangerous to the public by a court of competent jurisdiction within or without this state.** **The license remains suspended until the nurse is restored to capacity by a court, and upon petition by the nurse, the suspension is terminated by the board after a hearing or upon agreement between the board and the nurse.**	Another option is to consider automatic suspension for specified, very serious criminal convictions.
Section 2. *Injunctive Relief.* (a) Authority. The Board is authorized to petition in its own name to a proper court of competent jurisdiction for an injunction to enjoin: (1) any person who is practicing nursing within the meaning of this Act from practicing without a valid license, unless exempted under Article XII; (2) any person, firm, corporation, institution or association from employing any person who is not licensed to practice nursing under this Act or exempted under Article XII; or (3) any person, firm, corporation, institution or association from operating a school of nursing without approval.	Section 3. *Injunctive Relief.* (a) Authority. The Board **or any prosecuting officer upon a proper showing of the** facts is authorized to petition a court of competent jurisdiction for an injunction to enjoin: (1) Any person who is practicing nursing within the meaning of this Act from practicing without a valid license, unless exempted under Article XII. (2) Any person, firm, corporation, institution or association from employing any person who is not licensed to practice nursing under this Act or exempted under Article XII. (3) Any person, firm, corporation, institution or association from operating a school of nursing without approval. **(4) Any person whose license has been suspended or revoked from practicing as an RN, LPN/VN or APRN.** **Such acts are declared to be a public nuisance and pose a risk of harm to the public health and safety.**	Authority broadened to allow a prosecuting attorney to also petition for injunctive relief related to nursing practice. A public nuisance is defined by Black's Law Dictionary (5th Ed.). St. Paul, MN: West Publishing, Co. as a condition dangerous to health...an unreasonable interference with a right common to the general public. Sometimes prosecutors are not interested in pursuing nursing violations. It is hoped that this language would carry additional weight with prosecutors and courts.
(b) Procedure. Upon filing of a verified petition in such court, the court, or any judge thereof, if satisfied that a violation described in Sections 2(a) has occurred, may issue an injunction without notice or bond, enjoining the defendant from further violating this provision. A copy of the complaints shall be served on the defendant and	**(b) The court may without notice or bond, enjoin such acts and practice. A copy of the complaint shall be served on the defendant and the proceedings thereafter shall be conducted as in other civil cases. In case of violation of an injunction issued under this section, the court, or any judge thereof, may summarily try and punish the offender**	Language streamlined, builds on previous section.

the proceedings thereafter shall be conducted as in other civil cases. In case of violation of an injunction issued under this section, the court, or any judge thereof, may summarily try and punish the offender of contempt of court.	**for contempt of court.**	
Section 3. *Preservation of other Remedies.* The emergency proceedings herein described shall be in addition to, not in lieu of, all penalties and other remedies provided by law.	**Section 4. *Preservation of other Remedies.*** The emergency proceedings herein described shall be in addition to, not in lieu of, all penalties and other remedies provided by law.	
Article XI. Reporting Required.	**Article XI. Reporting Required.**	
Section 1. *Affected parties.*	**Section 1. *Affected parties.***	
(a) Hospitals, nursing homes and other employers of Registered Nurses, Licensed Practical/Vocational Nurses or **Advanced Practice Registered Nurses** shall report to the Board the names of those licensees whose employment has been terminated voluntarily or involuntarily for any reasons stipulated in Article IX, Section 1.	(a) Hospitals, nursing homes and other employers of Registered Nurses, Licensed Practical/Vocational Nurses or **Advanced Practice Registered Nurses** shall report to the Board the names of those licensees whose employment has been terminated voluntarily or involuntarily, or who has resigned in order avoid termination for any reasons stipulated in Article IX, Section 1.	Also consider criminal convictions, malpractice payments reporting as options.
(b) Nursing organizations shall report to the Board the names of Registered Nurses, Licensed Practical/Vocational Nurses **or Advanced Practice Registered Nurses** who have been investigated and found to be a threat to the public health, safety and welfare for any of the reasons stipulated I Article IX, Section 2.	(b) **Certifying** nursing organizations shall report to the Board the names of Registered Nurses, Licensed Practical/Vocational Nurses **or Advanced Practice Registered Nurses** who have been denied certification or re-certification for failure to meet certification standards.	Specifies that certifying reports should be made by nursing organizations that provide additional professional credentials for nurses.
Section 2. *Court Order.* The Board may seek an order from a proper court of competent jurisdiction for a report from any of the parties stipulated in Section 1 of this Article if one is not forthcoming voluntarily.	**Section 2. *Court Order.*** The Board may seek an order from a proper court of competent jurisdiction for a report from any of the parties stipulated in Section 1 of this Article if one is not forthcoming voluntarily.	
Section 3. *Penalty.* The Board may seek a citation for civil contempt if a court order for a report is not obeyed by any of the parties stipulated in Section 1 of this Article.	**Section 3. *Penalty.*** The Board may seek a citation for civil contempt if a court order for a report is not obeyed by any of the parties stipulated in Section 1 of this Article.	
Section 4. *Immunity.* Any organization or person reporting, in good faith, information to the Board under this Article shall be immune from civil action as provided in Article IX, Section 4.	**Section 4. *Immunity.*** (a) Any organization or person reporting, in good faith, information to the Board under this Article shall be immune from civil action as provided in Article IX, Section 4.	

	(b) A physician or other licensed health care professional who, at the request of the board, examines a nurse, shall be immune from suit for damages by the nurse examined if the examining physician or examining health care professional conducted the examination and made findings or diagnoses in good faith.	Added to provide specific protection for those health care professionals who provide reports regarding nurses to the board for use in licensing decisions.
Article XII. Exemptions. No provisions of this Act shall be construed to prohibit: (a) the practice of nursing that is an integral part of a program by students enrolled in Board approved nursing education programs;	**Article XII. Exemptions.** No provisions of this Act shall be construed to prohibit: (a) The practice of nursing that is an integral part of a program by students enrolled in Board approved nursing education programs. (b) An individual engaged in an internship, residency or other supervised study/practice opportunity as defined by rules of the Boards.	Included to provide the opportunity for participating in these special programs without the requirement of licensure. May include graduate students, foreign students, residency, internship or preceptor programs.
(b) the rendering of assistance by anyone in the case of an emergency or disaster;	(c) The rendering of assistance by anyone in the case of an emergency or disaster.	
(c) the practice of any currently licensed Registered Nurses, Licensed Practical/Vocational Nurses **or Advanced Practice Registered Nurses** licensed in another state in the provision of nursing care in the case of emergency or disaster;	(d) The practice of any currently licensed Registered Nurses, Licensed Practical/Vocational Nurses or Advanced Practice Registered Nurses licensed in another state in the provision of nursing care in the case of emergency or disaster.	
(d) the incidental care of the sick by members of the family, friends, domestic servants or persons primarily hired as housekeepers, provided that such care does not constitute the practice of nursing within the meaning of this Act;	(e) The incidental **and gratuitous** care of the sick by members of the family, friends **or companions; or household aides at the direction of a person needing such care who resides independently outside any hospital, nursing or health care facility, or other similar institutional setting.**	
(e) caring for the sick in accordance with tenets or practices of any church or religious denomination which teaches reliance upon spiritual means for healing;	(f) Caring for the sick in accordance with tenets or practices of any church or religious denomination which teaches reliance upon spiritual means for healing	
(f) the practice of any currently licensed Registered Nurse, Licensed Practical/Vocational Nurse **or Advanced Practice Registered Nurse** of another state who is employed by the United States government, or any	(g) The practice of any currently licensed Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse of another state who is employed by the United States government, or any	

bureau, division or agency thereof; while in the discharge of official duties;	bureau, division or agency thereof; while in the discharge of official duties.	
(g) the practice of any currently licensed Registered Nurse, Licensed Practical/Vocational Nurse **or Advanced Practice Registered Nurse** who is employed by an individual, agency or corporation located in another State and whose employment responsibilities include transporting patients into, out of or through this State. Such exemptions shall be limited to a period not to exceed ( ) hours for each transport.	(h) The practice of any currently licensed Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse who is employed by an individual, agency or corporation located in another State and whose employment responsibilities include transporting patients into, out of or through this State. Such exemptions shall be limited to a period not to exceed ( ) hours for each transport.	
(h) the practice of any currently licensed Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse who provides or attends educational programs or provides consultative services within this state for a period not to exceed ( ) days. Neither the education nor the consultation may include the provision of patient care, the direction of patient care, of the affecting of patient care policies.	(i) **The practice of any** Registered Nurse, Licensed Practical/Vocational Nurse or Advanced Practice Registered Nurse **currently licensed in another state who is in this state on a non-routine** basis for a period not to exceed [ ] days **to:** **• Provide care to a patient being transported into, out of, or through this state;-** • Provide **professional nursing** consulting services;- • Attend or **present a continuing nursing** education program- **• Provide other short-term non-clinical nursing services.**	Combined (h), (j) and (k)
(i) the establishment of an independent practice by one or more licensed nurses for the purpose of rendering to patients nursing services within the scope of their educational preparation and the scope of the license to practice nursing.		
(j) the practice of any other occupation or profession licensed under the laws of this state, provided that such care does not constitute the practice of nursing within the meaning of this Act;	(j) The practice of any other occupation or profession licensed under the laws of this state, provided that such care does not constitute the practice of nursing within the meaning of this Act;	
(k) the practice of nursing as a Registered Nurse by a person currently licensed in another state who is visiting this state as a non-resident, in order to provide specific, non-clinical, short-term, time-limited services, including but not limited to, consultation, accreditation site visits, and participation in continuing education programs; or		
(l) the practice of nursing by a Registered Nurse, Licensed Practical/Vocational Nurse **or Advanced Practice**		

Registered Nurse currently licensed in another jurisdiction whose employment by a resident of that jurisdiction requires the nurse to accompany and care for that resident while in this State.		
Article XIII. Revenue, Fees.	**Article XIII. Revenue, Fees.**	
Section 1. *Revenue.* The Board is authorized to establish, appropriate fees for licensure by examination, reexamination, endorsement and such other fees and fines as the Board determines necessary.	**Section 1. *Revenue.*** The Board is authorized to establish, appropriate fees for licensure by examination, reexamination, endorsement and such other fees and fines as the Board determines necessary.	
Section 2. *Disposition of Fees.* All fees collected by the Board shall be administered according to the established fiscal policies of this State in such manner as to implement adequately the provisions of this Act.	**Section 2. *Disposition of Fees.*** All fees collected by the Board shall be administered according to the established fiscal policies of this State in such manner as to implement adequately the provisions of this Act.	
Section 3. *Disposition of Fines.* All fines collected shall be used by and at the discretion of the Board for designated projects as established in the fiscal policy of this state.	**Section 3. *Disposition of Fines.*** All fines collected shall be used by and at the discretion of the Board for designated projects as established in the fiscal policy of this state.	
Article XIV. Implementation.	**Article XIV. Implementation.**	
Section 1. *Effective Date.* This Act shall take effect (date).	**Section 1. *Effective Date.*** This Act shall take effect (date).	
Section 2. *Persons Licensed Under a Previous Law.*	**Section 2. *Persons Licensed Under a Previous Law.***	
(a) any person holding a license to practice nursing as a Registered Nurse in this State that is valid on (effective date) shall be deemed to be licensed as a Registered Nurse under the provisions of this Act and shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.	(a) any person holding a license to practice nursing as a Registered Nurse in this State that is valid on (effective date) shall be deemed to be licensed as a Registered Nurse under the provisions of this Act and shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.	
(b) any person holding a license to practice nursing as a Licensed Practical/Vocational Nurse in this State that is valid on (effective date) shall be deemed to be licensed as a Licensed Practical/Vocational Nurse under the provisions of this Act and shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.	(b) any person holding a license to practice nursing as a Licensed Practical/Vocational Nurse in this State that is valid on (effective date) shall be deemed to be licensed as a Licensed Practical/Vocational Nurse under the provisions of this Act and shall be eligible for renewal of such license under the conditions and standards prescribed in this Act.	

(c) Any person eligible for reinstatement of a license as a Registered Nurse or Licensed Practical/Vocational Nurse, respectively, under provisions under the conditions and standards prescribed in the Act.	(c) Any person eligible for reinstatement of a license as a Registered Nurse or Licensed Practical/Vocational Nurse, respectively, under provisions under the conditions and standards prescribed in the Act **by applying for reinstatement according to rules established by the Board of Nursing. Application for such reinstatement must be made within ( ) months of the effective date of this Act.**	Conforms to Section 2(d).
(d) Any person holding a lapsed license to practice nursing as a Registered Nurse or Licensed Practical/Vocational Nurse in this State on (effective date), because of failure to renew, may become licensed as a Registered Nurse or as a Licensed Practical/Vocational Nurse, respectively, under the provisions of this Act by applying for reinstatement according to rules established by the Board of Nursing. Application for such reinstatement must be made within ( ) months of the effective date of this Act.	(d) Any person holding a lapsed license to practice nursing as a Registered Nurse or Licensed Practical/Vocational Nurse in this State on (effective date), because of failure to renew, may become licensed as a Registered Nurse or as a Licensed Practical/Vocational Nurse, respectively, under the provisions of this Act by applying for reinstatement according to rules established by the Board of Nursing. Application for such reinstatement must be made within ( ) months of the effective date of this Act.	
(e) New applicants for Advanced Practice Registered Nurse as of (effective date of statute) shall meet requirements set forth in administrative rules. Any individual authorized to practice in a an advanced role prior to (effective date) may apply for licensure on the basis of the individual's prior education and practice as set forth in administrative rule.	(e) New applicants for Advanced Practice Registered Nurse as of (effective date of statute) shall meet requirements set forth in administrative rules. Any individual authorized to practice in a an advanced role prior to (effective date) may apply for licensure on the basis of the individual's prior education and practice as set forth in administrative rule.	
(f) Those so licensed under the provisions of Article XIV, Section 2 (a) through (e) above, shall be eligible for renewal of such license under the conditions and standards prescribed by this Act.	(f) Those so licensed under the provisions of Article XIV, Section 2 (a) through (e) above, shall be eligible for renewal of such license under the conditions and standards prescribed by this Act.	
Section 3. Severability. The provisions of this Act are severable. If any provision of this Act is declared unconstitutional, illegal or invalid, the constitutionality, legality and validity of the remaining portions of this Act shall be unaffected and shall remain in full force and effect.	**Section 3. *Severability.*** The provisions of this Act are severable. If any provision of this Act is declared unconstitutional, illegal or invalid, the constitutionality, legality and validity of the remaining portions of this Act shall be unaffected and shall remain in full force and effect.	
Section 4. *Repeal.* The laws specified below are repealed except with respect to rights and duties that have matured, penalties that were incurred and proceedings that were begun before the effective date of this Act. (List statutes to be repealed; for example, the current nursing practice act or appropriate sections).	**Section 4. *Repeal.*** The laws specified below are repealed except with respect to rights and duties that have matured, penalties that were incurred and proceedings that were begun before the effective date of this Act. (List statutes to be repealed; for example, the current nursing practice act or appropriate sections).	Nurse Licensure Compact language and model enabling language will be provided as optional language if Model Act is adopted.

PR&E: Attachment C

Comparison of Scopes of Practice

Role of Unlicensed Assistive Personnel	Section 3. Licensed Practical/Vocational Nurse	Section 2. Registered Nurse	Section 4. Advanced Practice Registered Nurse
Unlicensed assistive personnel, who include nursing assistants, nurse aides, medication aides and numerous over titles, provide assistance in the provision of nursing care, working under the supervision of the licensed nurse or other authorized licensed health care provider. The role of unlicensed assistive personnel may include:	Practice as a Licensed Practical/ Vocational Nurse means a directed scope of nursing practice, with or without compensation or personal profit, under the supervision of the Registered Nurse, Advanced Practice Registered Nurse, licensed physician, or other health care provider authorized by the state to delegate health care activities and functions; and includes, but is not limited to:	Practice as a Registered Nurse means the full scope of nursing, with or without compensation or personal profit, and includes caring for all clients in all settings; and includes but is not limited to:	Advanced Practice Registered Nursing by Nurse Practitioners, Certified Registered Nurse Anesthetists, Certified Nurse Midwives or Clinical Nurse Specialists, is based on knowledge and skills acquired in basic nursing education; licensure as a Registered Nurse; and a graduate degree with a major in nursing or a graduate degree with a concentration in the advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions, and management of health care. Practice as an Advanced Practice Registered Nurse means an expanded scope of nursing, with or without compensation or personal profit, and includes but is not limited to:
(a) Collecting routine data as directed for patients with stable, unchanging and/or predictable recurring conditions. (b) Recognizing significant alterations to assigned patient's normal baseline as described by the nurse.	(a) Collecting focused data and assessment of the health status of individuals and groups. (b) Contributing to the comprehensive assessment of the health status of individuals, families and groups.	(a) Providing comprehensive assessment of the health status of individuals, families, groups and communities.	(a) Assessing clients, synthesizing and analyzing data, and understanding and applying nursing principles at an advanced level. (b) Analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem and

			selecting appropriate treatment.
(c) Recognizing alterations to parameters provided by nurse. (d) Alerting licensed nurse of alterations in patient conditions in timely manner. (e) Reporting on patient status. (f) Suggesting care plan elements based on expressed client wishes concerning basic needs. (g) Providing feedback to the licensed nurse as to the workability of the plan of care.	(c) Planning nursing care during care episode for clients with stable conditions. (d) Participating in the development and modification of the comprehensive plan of care for all types of patients.	(b) Developing a comprehensive nursing plan that establishes nursing diagnoses; sets goals to meet identified health care needs; and prescribes nursing interventions.	(c) Making independent decisions in solving complex client care problems. (d) Developing a plan of expanded nursing care that establishes diagnoses; sets goals to meet identified health care needs; and prescribe a regimen of health care.
(h) Implementing assigned interventions in support of basic client care, based on education, demonstrated competency and specified supervision. (i) Performing assigned or delegated interventions with supervision. (j) Recording care on appropriate document. (k) Keeping licensed nurse informed as to patient progress in goal achievement.	(e) Implementing the appropriate aspects of the strategy of care within the LPN scope of practice. (f) Participating in nursing care management through delegating, assigning and directing nursing interventions that may be performed by others, including other LPN/VNs, that do not conflict with the act.	(c) Implementing nursing care through the execution of independent nursing strategies and prescribed medical regimen. (d) Managing nursing care through cohesive, coordinated care management within and across care settings. (e) Delegating and assigning nursing interventions to implement the plan of care.	
(m) Recognizing need for and requests assistance when NA is: - Unsure about a client situation - Does not know how to do an activity - Client circumstances have changed - Working in a new area or with a different kind of			(e) Performing acts of diagnosing, prescribing, administering and dispensing therapeutic measures, including legend drugs and controlled substances, within the advanced practice registered nurse's focus of practice. (f) Managing clients' physical and psychosocial health-illness status.

client. (n) Provides information regarding completion of tasks and patient outcomes.	(g) Maintaining safe and effective nursing care rendered directly or indirectly.	(f) Providing for the maintenance of safe and effective nursing care rendered directly or indirectly.	(g) Providing for the maintenance of safe and effective nursing care rendered directly or indirectly.
(o) Promoting a safe and therapeutic environment. (p) Recognizing client request for information and reports to nurse.	(h) Promoting a safe and therapeutic environment. (i) Participating in health teaching and counseling to promote, attain and maintain the optimum health level of individuals.	(g) Promoting a safe and therapeutic environment. (h) Providing health teaching and counseling to promote, attain and maintain the optimum health level of individuals, and communities.	(h) Promoting a safe and therapeutic environment. (i) Providing expert guidance and teaching.
(q) Sharing information with nurses regarding client response to teaching provided by nurse. (r) Respecting right of clients to an explanation of care provided by NA. (s) Providing information related to performance of basic care measures.	(j) Serving as an advocate for the client by communicating and collaborating with other health service personnel. (k) Participating in the evaluation of client responses to interventions.	(i) Advocating for individual clients, groups and communities by attaining and maintaining what is in the best interest of the individual client or group. (j) Evaluating responses to interventions and the effectiveness of the plan of care.	(j) Advocating for individual clients, groups and communities by attaining and maintaining what is in the best interest of the individual client or group. (o) Evaluating responses to interventions and the effectiveness of the health regimen and plan of care.
(t) Sharing information regarding client responses to care interventions.	(l) Communicating and collaborating with other health care professionals in the nursing practice management. (m) Other acts that require education and training as prescribed by the Board. Additional nursing services shall be commensurate with the licensed practical nurse's experience, continuing education and demonstrated competencies.	(k) Communicating and collaborating with other health care professionals in the management of health care and the implementation of the total health care regimen. (l) Acquiring and applying critical new knowledge and technologies to practice domain. (m) Managing, supervising and evaluating the practice of nursing. (n) Teaching the theory and practice of nursing.	(k) Communicating and working effectively with clients, families and other members of the health care team. (p) Utilizing research skills and acquiring and applying critical new knowledge and technologies to practice domain. (q) Teaching the theory and practice of advance practice nursing.

The UAP is responsible for completing the assigned activities and reporting to the nurse.	Each nurse is accountable to clients, employers, the nursing profession and the board for complying with the requirements of this Act and the quality of nursing care rendered and for recognizing limits of knowledge and experience and planning for management of situations beyond the nurse's expertise.	Each Registered Nurse is accountable to clients, employers, the nursing profession and the board for complying with the requirements of this Act and the quality of nursing care rendered; and for recognizing limits of knowledge and experience and planning for management of situations beyond the nurse's expertise.	Each advanced practice registered nurse is accountable to clients, employers, the nursing profession and the board for complying with the requirements of this Act and the quality of nursing care rendered; and for recognizing limits of knowledge and experience, planning for management of situations beyond the nurse's expertise; and consulting with or referring clients to other

PR&E: Attachment D

NCSBN 2002 Proposed Model Nursing Administrative Rules, Chapter 5 – Nursing Education

A. Purpose of Standards.

1. To ensure that graduates of nursing education programs are prepared for safe and effective nursing practice.
2. To provide criteria for the development, evaluation, and improvement of new and established nursing education programs.
3. To assure candidates are educationally prepared for licensure and recognition at the appropriate level.

B. Standards of Nursing Education.

1. The purpose and outcomes of the nursing program shall be consistent with the Nursing Practice Act and board-promulgated administrative rules, regulations, and other relevant state statutes.
2. The purpose and outcomes of the nursing program shall be consistent with generally accepted standards of nursing practice appropriate for graduates of the type of nursing program offered.
3. The input of consumers shall be considered in developing and evaluating the purpose and outcomes of the program.
4. The nursing program shall implement a comprehensive, systematic plan for ongoing evaluation that is based on program outcomes and incorporates continuous improvement.
5. Faculty and students shall participate in program planning, implementation, evaluation, and continuous improvement.
6. The curriculum shall provide diverse learning experiences consistent with program outcomes.
7. The fiscal, human, physical and learning resources are adequate to support program processes and outcomes.
8. The nursing program administrator shall be a professionally and academically qualified registered nurse with institutional authority and administrative responsibility for the program.
9. Professionally and academically qualified nurse faculty is sufficient in number and expertise to accomplish program outcomes and quality improvement.
10. Program information communicated by the nursing program shall be fair, accurate, inclusive, consistent, and readily available to the public.

C. Models for Implementing Standards.

The evaluation model for achievement of these standards is determined by each individual jurisdiction, and may be met by state approval and/or through accreditation by a recognized national, regional, or state accreditation body.

D. Required Components for Nursing Education Programs.

1. The organization and administration of the nursing education program shall be consistent with the law governing the practice of nursing.

2. Administrator Qualifications

a. The administrator of the nursing education program shall be a Registered Nurse, licensed or privileged to practice in this state, with the additional education and experience necessary to direct the program preparing graduates for the safe and effective practice of nursing. The administrator is accountable for the administration, planning, implementation and evaluation of the nursing education program.

b. In a program preparing for Practical/Vocational Nurse licensure:
   (1) Minimum of a baccalaureate degree with a major in nursing;
   (2) Educational preparation or experience in teaching, curriculum development and administration, including at least two years of clinical experience; and
   (3) A current knowledge of nursing practice at the practical/vocational level.

c. In a program preparing for Registered Nurse licensure:
   (1) Minimum of a master's degree with a major in nursing;
   (2) Educational preparation or experience in teaching, curriculum development and administration, including at least two years of clinical experience; and
   (3) A current knowledge of professional nursing practice.

3. Faculty

a. There shall be sufficient a number of qualified faculty to meet the objectives and purposes of the nursing education program.

b. Qualifications:
   (1) nursing faculty who teach in a program leading to licensure as a Practical/Vocational Nurse shall:
      (a) Be currently licensed or privileged to practice as a Registered Nurse in this state;
      (b) Have a minimum of a baccalaureate degree with a major in nursing; and
      (c) Have () years of clinical experience.
   (2) Nursing faculty who teach in programs leading to licensure as a Registered Nurse shall:
      (a) Be currently licensed or privileged to practice as a Registered Nurse in this state;
      (b) Have a minimum of a master's degree in nursing with a major in nursing; and
      (c) Have () years of clinical experience.

4. Adjunct Clinical Faculty

a. Faculty employed solely to supervise clinical nursing experiences of students shall meet all the qualifications above with the exception of education level.

5. Interdisciplinary Faculty

a. Faculty who teach non-clinical nursing courses, e.g., issues and trends, nursing law and ethics, pharmacology, nutrition, research, management and statistics, shall have advanced preparation appropriate to these areas of content.

6. Preceptors

a. Clinical preceptors may be used to enhance clinical learning experiences, after a student has received clinical and didactic instruction in all basic areas for that course or specific learning experience. Clinical preceptors should be licensed at or above the level for which the student is preparing.

7. Students

a. Students shall be provided the opportunity to acquire and demonstrate the knowledge, skills and abilities for safe and effective nursing practice.
b. All policies relevant to applicants and students shall be available in writing.
c. Students shall be required to meet the health standards and criminal background checks as required in the state.

8. Curriculum

a. The curriculum of the nursing education program shall enable the student to develop the nursing knowledge, skills and competencies necessary for the level and scope of nursing practice.
b. The curriculum shall include:
   (1) Content regarding legal and ethical issues, history and trends in nursing, and professional responsibilities;
   (2) Experiences which promote the development of leadership and management skills and professional socialization consistent with the level of licensure;
   (3) Learning experiences and methods of instruction consistent with the written curriculum plan; and
   (4) Courses including, but not limited to:
      (a) Content in the biological, physical, social and behavioral sciences to provide a foundation for safe and effective nursing practice;
      (b) The nursing process; and
      (c) Didactic content and clinical experience in the promotion, prevention, restoration, and maintenance of health in clients across the life span and in a variety of clinical settings.
c. Delivery of instruction by distance education methods must be congruent with the program curriculum plan and enable students to meet the goals, competencies and objectives of the educational program and standards of the board.

E. Initial Approval of Nursing Education Programs.

1. Before a nursing education program is permitted to admit students, the program shall submit evidence of the ability to meet the Standards for Nursing Education (Section B, above).

F. Provisional Approval of New Nursing Education Programs.

1. The Board may grant provisional approval when it determines that a program is not fully meeting approval standards.

G. Ongoing Approval of Nursing Education Programs.

1. All nursing education programs shall be reevaluated every () years, upon request of the nursing education program, or at the discretion of the Board, to ensure continuing compliance with the Standards for Nursing Education (Section B, above).

H. Conditional Approval of Nursing Education Programs.

1. If the Board determines that an approved nursing education program is not meeting the criteria set forth in these regulations, the governing institution shall be given a reasonable period of time to submit an action plan and to correct the identified program deficiencies.
2. The Board may grant conditional approval when it determines that a program is not fully meeting approval standards.

I. Denial or Withdrawal of Approval.

1. The Board may deny Provisional (initial) Approval when it determines that a new nursing education program will be unable to meet the Standards for Nursing Education.
2. The Board may withdraw approval if:
   a. It determines that a nursing education program fails substantially to meet the Standards for Nursing Education.
   b. The nursing education program fails to correct the identified deficiencies within the time specified, the Board may withdraw approval.

J. Appeal.

A program denied approval or given less than full approval may appeal that decision within a () month period.

All such actions shall be effected in accordance with due process rights and this state's Administrative Procedures Act and/or Administrative Rules of the Board.

K. Reinstatement of Approval.

1. The Board may reinstate approval if the program submits evidence of compliance with plan within the specified time frame.

L. Closure of Nursing Education Program and Storage of Records.

1. A nursing education program may close voluntarily or may be closed due to withdrawal of Board approval. Provision must be made for maintenance of the Standards for Nursing Education during the transition to closure; placement for students who have not completed the nursing program; and for the storage of academic records and transcripts.

PR&E: Attachment E

NCSBN 2002 Proposed Revisions to the Model Nursing Administrative Rules Chapter 5 – Nursing Education

Coding Key:
New Language

Current Model Nursing Administrative Rules	Proposed Model Nursing Administrative Rules	Rationale/Comments
Chapter 5 - Nursing Education	Chapter 5 - Nursing Education	
A. Purpose of Standards. 1. To ensure that graduates of nursing education programs are prepared for safe and effective nursing practice. 2. To serve as a guide for the development of new nursing education programs. 3. To foster the continued improvement of established nursing education programs. 4. To provide criteria for the evaluation of new and established nursing education programs. 5. To assure eligibility for admission to the licensure examination for nurses, and to facilitate interstate endorsement of graduates of Board-approved nursing education programs.	**A. Purpose of Standards.** 1. To ensure that graduates of nursing education programs are prepared for safe and effective nursing practice. 2. To provide criteria for the development, evaluation, and improvement of new and established nursing education programs. 3. To assure **candidates are educationally prepared for licensure and recognition at the appropriate level.** **B. Standards of Nursing Education.** **1. The purpose and outcomes of the nursing program shall be consistent with the Nursing Practice Act and board-promulgated administrative rules, regulations, and other relevant state statutes.** **2. The purpose and outcomes of the nursing program shall be consistent with generally accepted standards of nursing practice appropriate for graduates of the type of nursing program offered.** **3. The input of consumers shall be considered in developing and evaluating the purpose and outcomes of the program.** **4. The nursing program shall implement a comprehensive, systematic plan for ongoing evaluation that is based on program outcomes and incorporates continuous improvement.** **5. Faculty and students shall participate in program planning, implementation, evaluation, and continuous improvement.** **6. The curriculum shall provide diverse learning experiences consistent with program outcomes.** **7. The fiscal, human, physical and learning resources**	Consolidated purpose statements 2, 3, and 4 into a single statement number 2. Allows the Board discretion in defining how approval may be granted if the Board does not conduct surveys. Clarifies that standards are set for the educational program rather than the institution in which they occur. Builds upon the standards framework established previously by Committee.

	are adequate to support program processes and outcomes. **8. The nursing program administrator shall be a professionally and academically qualified registered nurse with institutional authority and administrative responsibility for the program.** **9. Professionally and academically qualified nurse faculty is sufficient in number and expertise to accomplish program outcomes and quality improvement.10. Program information communicated by the nursing program shall be fair, accurate, inclusive, consistent, and readily available to the public.** **C. Models for Implementing Standards.** **The evaluation model for achievement of these standards is determined by each individual jurisdiction, and may be met by state approval and/or through accreditation by a recognized national, regional, or state accreditation body.**	Interpretive Guidelines will be developed to illustrate various regulatory strategies and models for implementing the standards.
B. Standards of Nursing Education.	**D. Required Components for Nursing Education Programs.**	
1. The organization and administration of the nursing education program shall be consistent with the law governing the practice of nursing.	1. The organization and administration of the nursing education program shall be consistent with the law governing the practice of nursing.	References *Standard One*.
2. Administer Qualifications. The administrator of the nursing education program shall be a Registered Nurse, licensed in this state, with the additional education and experience necessary to direct the program preparing graduates for the safe and effective practice of nursing. The administrator is accountable for the administration, planning, implementation and evaluation of the nursing education program. a. In a program preparing for practical/vocational nurse licensure: (1) Minimum of a master's with a major in nursing; (2) Preparation in education and administration; (3) () years of clinical experience; and (4) () years of education experience	2. Administrator Qualifications a. The administrator of the nursing education program shall be a Registered Nurse, licensed **or privileged to practice** in this state, with the additional education and experience necessary to direct the program preparing graduates for the safe and effective practice of nursing. The administrator is accountable for the administration, planning, implementation and evaluation of the nursing education program. b. In a program preparing for Practical/Vocational Nurse licensure: (1) minimum of a **baccalaureate** degree with a major in nursing; (2) **educational** preparation **or experience in** teaching, curriculum development and admin-	Provides for practicing on a privilege under the Nurse Licensure Compact. References *Standard Eight*. Establishes educational qualifications consistent with the requirements of the majority of Boards of Nursing; however, a Master's Degree is desirable. Enables qualification by experience or educational preparation, adds curriculum development as an essen-

	istration, **including at least two** years of clinical experience; **and** **(3) a current knowledge of nursing practice at the practical/vocational level.**	tial aspect. Assures administrative knowledge of the practice setting for which students are prepared.
b. In a program preparing for registered nurse licensure: (1) A doctoral degree in nursing or related field; (2) Preparation in education and administration; (3) () years of clinical experience; and (4) () years of education experience.	c. In a program preparing for Registered Nurse licensure: (1) **minimum of a master's degree with a major in nursing;** (2) **educational** preparation **or experience in** teaching**, curriculum development and** administration, **including at least two y**ears of clinical experience; and (3) **a current knowledge of professional nursing practice.**	Establishes qualifications consistent with the requirements of the majority of Boards of Nursing. For accreditation purposes a doctoral degree is generally required for administrative positions in baccalaureate and higher programs. In some states a doctoral degree is "preferred" or required for associate degree or diploma programs.
3. Faculty There shall be sufficient faculty with graduate preparation and nursing expertise to meet the objectives and purposes of the nursing education program. a. Qualifications: (1) Nursing faculty who teach in a program leading to licensure as a Practical/Vocational Nurse shall: (a) Be currently licensed as a Registered Nurse in this state; (b) Have a minimum of a baccalaureate degree in nursing; and (c) Have () years of clinical experience relevant to areas of responsibility and () years in nursing education. (2) Nursing faculty who teach in programs leading to licensure as a Registered Nurse shall: (a) Be currently licensed as a Registered Nurse in this state; (b) Have a minimum of a master's degree in nursing; and (c) Have () years of clinical experience relevant to areas of responsibility and () years in nursing education.	**3. Faculty** a. There shall be sufficient **a number of qualified faculty** to meet the objectives and purposes of the nursing education program. b. Qualifications: (1) nursing faculty who teach in a program leading to licensure as a Practical/Vocational Nurse shall: (a) be currently **licensed or privileged to practice** as a Registered Nurse in this state; (b) have a minimum of a baccalaureate degree **with a major in nursing**; and (c) have () years of clinical experience (2) Nursing faculty who teach in programs leading to licensure as a Registered Nurse shall: (a) be currently licensed **or privileged to practice** as a Registered Nurse in this state; (b) have a minimum of a master's degree in nursing **with a major in nursing;** and (c) have () years of clinical experience **4. Adjunct Clinical Faculty** **a. Faculty employed solely to supervise clinical nursing experiences of students shall meet all the qualifications above with the exception of education level.**	Stresses the importance of qualified numbers of faculty. Provides for practicing on a privilege under the Nurse Licensure Compact. In the absence of clinical experience in area of teaching, other faculty or clinical mentors may be utilized to supplement educational experiences for students. Provides for practicing on a privilege under the Nurse Licensure Compact. References *Standard Nine*. Clinical faculty teaching BSN students should have a minimum of a Bachelors degree. Schools are expected to provide for effective communication between adjunct clinical faculty and faculty members to achieve course objectives and program outcomes. References *Standards Seven, Nine*.

b. Faculty who teach non-clinical nursing courses, e.g., issues and trends, pharmacology, nutrition, research, management, and statistics, shall have advanced preparation appropriate to these areas of content.	**5. Interdisciplinary Faculty** a. Faculty who teach non-clinical nursing courses, e.g., issues and trends, **nursing law and ethics,** pharmacology, nutrition, research, management and statistics, shall have advanced preparation appropriate to these areas of content.	Exception clause for individuals to teach in relevant non-clinical nursing courses and in other areas.
c. Preceptors. Clinical preceptors may be used to enhance clinical learning experiences, after a student has received clinical and didactic instruction in all basic areas of nursing, or within a course after students have received clinical and didactic instruction in all basic areas for that course or specific learning experience. Clinical preceptors should be licensed at or above the level for which the student is preparing.	**6. Preceptors** a. Clinical preceptors may be used to enhance clinical learning experiences, after a student has received clinical and didactic instruction in all basic areas for that course or specific learning experience. Clinical preceptors should be licensed at or above the level for which the student is preparing.	**Schools are responsible for using preceptors who are experienced in the assigned clinical area, familiar with the facility and able to facilitate student learning.**
4. Students a. Students shall be provided the opportunity to acquire and demonstrate the knowledge, skills and abilities for safe and effective nursing practice. b. All policies relevant to applicants and students shall be available in writing. c. Students shall be required to meet the health standards required by the clinical agencies, in the interest of client welfare.	**7. Students** a. Students shall be provided the opportunity to acquire and demonstrate the knowledge, skills and abilities for safe and effective nursing practice. b. All policies relevant to applicants and students shall be available in writing. c. Students shall be required to meet the health standards and **criminal background checks as required in the state.**	References *Standard One*. **May include requirements of nursing programs and/or clinical facilities.**
5. Curriculum The curriculum of the nursing education program shall enable the student to develop the nursing knowledge, skills and competencies necessary for the level of nursing practice. The curriculum shall include: a. Content regarding legal and ethical issues, history and trends in nursing, and professional responsibilities; b. Experiences which promote the development of leadership and management skills and professional socialization consistent with the level of licensure; c. Learning experiences and methods of instruction consistent with the written curriculum plan	**8. Curriculum** a. The curriculum of the nursing education program shall enable the student to develop the nursing knowledge, skills and competencies necessary for the level **and scope of nursing practice.** b. The curriculum shall include: (1)Content regarding legal and ethical issues, history and trends in nursing, and professional responsibilities; (2)Experiences which promote the development of leadership and management skills and professional socialization consistent with the level of licensure; (3)Learning experiences and methods of instruction consistent with the written curriculum	References *Standards Two, Four - Six*. References *Standards One, Two, Six* .

and d. Courses including, but not limited to: (1) Courses in the biological, physical, social and behavioral sciences to provide a foundation for safe and effective nursing practice; (2)The nursing process; and (3)Didactic content and clinical experience in the promotion, prevention, restoration, and maintenance of health in clients across the life span and in a variety of clinical settings.	plan; and (4)Courses including, but not limited to: a. **Content** in the biological, physical, social and behavioral sciences to provide a foundation for safe and effective nursing practice; b. The nursing process; and c.Didactic content and clinical experience in the promotion, prevention, restoration, and maintenance of health in clients across the life span and in a variety of clinical settings. **c. Delivery of instruction by distance education methods must be congruent with the program curriculum plan and enable students to meet the goals, competencies and objectives of the educational program and standards of the board.**	
C. Approval of Nursing Education Programs. 1. Before a nursing education program is permitted to admit students, the program shall submit evidence of the ability to meet the Standards for Nursing Education (Part B. above.)	**E. Initial Approval of Nursing Education Programs.** 1. Before a nursing education program is permitted to admit students, the program shall submit evidence of the ability to meet the Standards for Nursing Education (Section B. above). **F. Provisional Approval of New Nursing Education Programs** **The Board may grant provisional approval when it determines that a program is not fully meeting approval standards.**	Distinguishes initial approval from ongoing/continuing approval; Provides for public protection (students and patients) for out-of-state/country distance learning programs offering learning experiences in the jurisdiction. Provides for current regulatory practices of Boards.References All Standards
2. All nursing education programs shall be reevaluated every () years, upon request of the nursing education program, or at the discretion of the Board, to ensure continuing compliance with the Standards for Nursing Education in Section B above.	**G. Ongoing Approval of Nursing Education Programs.** 1. All nursing education programs shall be reevaluated every () years, upon request of the nursing education program, or at the discretion of the Board, to ensure continuing compliance with the Standards for Nursing Education (Section B. above). **H. Conditional Approval of Nursing Education Programs.** **1. If the Board determines that an approved nursing**	Allows for state differences regarding the process for reevaluation and determining ongoing approval. Examples of criteria for reevaluation and/or survey visits include: complaints, major changes in the program/curriculum, trends of lower licensure examination pass rates, changes in numbers/types of faculty, less than full accreditation, or other reasons at the discretion of the board. References *all Standards*. Provides for current regulatory practices of Boards.

	education program is not meeting the criteria set forth in these regulations, the governing institution shall be given a reasonable period of time to submit an action plan and to correct the identified program deficiencies. **2. The Board may grant conditional approval when it determines that a program is not fully meeting approval standards.**	
D. Denial or Withdrawal of Approval. 1. The Board may deny Provisional Approval when it determines that a nursing education program will be unable to meet the Standards for Nursing Education. 2. The Board may deny approval when it determines that a nursing education program fails substantially to meet the Standards of Nursing Education. 3. The Board may withdrawal approval when it determines that a nursing education program had not provided sufficient evidence that the Standards for Nursing Education are being met. 4. All such actions shall be effected in accordance with due process rights and this state's Administrative Procedures Act and/or Administrative Rules of the Board.	**I. Denial or Withdrawal of Approval.** 1. The Board may deny Provisional **(initial)** Approval when it determines that a **new** nursing education program will be unable to meet the Standards for Nursing Education. 2. The Board may **withdraw approval if:** **a. it determines that a nursing education program fails substantially to meet the Standards for Nursing Education.** **b. The nursing education program fails to correct the identified deficiencies within the time specified, the Board may withdraw approval.**	Specifies relationship to new programs seeking initial approval. References *all Standards*. Specific to currently approved programs. Provides for plans of correction and Board action if deficiencies are not corrected.
E. Appeal and Reinstatement. If the Board determines that an approved nursing education program is not meeting the criteria set forth in these regulations, the governing institution shall be given a reasonable period of time to correct the identified program deficiencies. If the nursing education program fails to correct the identified deficiencies within the time specified, the Board may withdraw the approval following a hearing held pursuant to the provisions of the Administrative Procedure Act.	**J. Appeal.** **A program denied approval or given less than full approval may appeal that decision within a () month period. All such actions shall be effected in accordance with due process rights and this state's Administrative Procedures Act and/or Administrative Rules of the Board.** **K. Reinstatement of Approval.** **1. The board may reinstate approval if the program submits evidence of compliance with plan within the specified time frame.**	Assures Due Process. Provides for current practices of Boards. References *all Standards*.
F. Closure of Nursing Education Program and Storage of Records. A nursing education program may close voluntarily or may be closed due to withdrawal of Board approval. Provision must be made for maintenance of the Standards for Nursing Education during the transition to	**L. Closure of Nursing Education Program and Storage of Records.** 1. A nursing education program may close voluntarily or may be closed due to withdrawal of Board approval. Provision must be made for maintenance of the Standards for Nursing Education during the	References *Standard Ten*.

	transition to closure; placement for students who have not completed the nursing program; and for the storage of academic records and transcripts.	
closure; placement for students who have not completed the nursing program; and for the storage of academic records and transcripts.		

PR&E Committee – Attachment F

Standards for Nursing Education Programs

Standard 1 – The purpose and outcomes of the nursing program shall be consistent with the Nursing Practice Act, board-promulgated administrative rules/regulations, and other relevant state statutes.

Standard 2 – The purpose and outcomes of the nursing program shall be consistent with generally accepted standards of nursing practice appropriate for graduates of the type of nursing program offered.

Standard 3 – The input of consumers shall be considered in developing and evaluating the purpose and outcomes of the program.

**Standard 4 – The nursing program shall implement a comprehensive, systematic plan for ongoing evaluation that is based on program outcomes and
incorporates continuous improvement.**

Standard 5 – Faculty and students shall participate in program planning, implementation, evaluation and continuous improvement.

Standard 6 – The curriculum shall provide diverse learning experiences consistent with program outcomes.

Standard 7 – The fiscal, human, physical and learning resources are adequate to support program processes and outcomes.

Standard 8 – The nursing program administrator shall be a professionally and academically qualified registered nurse with institutional authority and administrative responsibility for the program.

Standard 9 – Professionally and academically qualified nurse faculty are sufficient in number and expertise to accomplish program outcomes and quality improvement.

Standard 10 – Program information communicated by the nursing program shall be fair, accurate, inclusive, consistent and readily available to the public.

The evaluation model for achievement of these standards is determined by each individual jurisdiction, and may be met by state approval and/or through accreditation by a recognized national/regional/state accreditation body.

PR&E Committee – Attachment G

Alliance for Nursing Accreditation
Statement on Distance Education Policies
March 2002 (revised)

The growth of distance education courses and programs for the delivery of nursing education has increased and is expected to continue to increase. Recognizing this growth and the need to ensure the public that nursing education programs maintain a high standard of quality, the Alliance for Nursing Accreditation endorses the following standard:

All nursing education programs delivered solely or in part through distance learning technologies must meet the same academic program and learning support standards and accreditation criteria as programs provided in face-to-face formats, including the following:

- *Student outcomes are consistent with the stated mission, goals, and objectives of the program; and*
- *The institution assumes the responsibility for establishing a means to assess student outcomes. This assessment includes overall program outcomes, in addition to specific course outcomes, and a process for using the results for continuous program improvement.*

Mechanisms for ongoing faculty development and involvement in the area of distance education and the use of technology in teaching-learning processes are established. Appropriate technical support for faculty and students is provided.

When utilizing distance learning methods, a program provides learning opportunities that facilitate development of students' clinical competence and professional role socialization and establishes mechanisms to measure these student outcomes.

When utilizing distance learning methods, a program provides or makes available resources for the students' successful attainment of all program objectives.

Each accreditation and program review entity incorporates the review of distance education programs as a component of site visitor/evaluator training.

PR&E Committee – Attachment H

Regulatory Priorities Ranking by Averages

1 Year	2-5 Years	Year 2010
1. Nursing Shortage (3.55)	1. Nursing Shortage (3.70)	1. Nursing Shortage (3.57)
2. Ensuring Quality Nursing Education (3.32)	2. Ensuring Quality Nursing Education (3.45)	2. Ensuring Quality Nursing Education (3.40)
3. Discipline (3.18)	3. Discipline (3.24)	3. Discipline (3.29)
4. UAP and Delegation (3.00)	4. UAP and Delegation (3.16)	4. Continued Competence (3.17)
5. Foreign-Educated Nurses (3.00)	5. Continued Competence (3.15)	5. Regulatory Excellence (3.08)
6. Continued Competence (2.98)	6. Foreign-Educated Nurses (3.00)	6. UAP and Delegation (2.94)
7. Regulatory Excellence (2.93)	7. Regulatory Excellence (3.00)	7. Foreign-Educated Nurses (2.88)
8. Nurse Licensure Compact (2.80)	8. LPN/VN roles and scope of practice (2.88)	8. Practice Breakdown (2.81)
9. LPN/VN Roles and Scope of Practice (2.79)	9. Practice Breakdown (2.88)	9. LPN/VN Roles and Scope of Practice (2.72)
10. Practice Breakdown (2.74)	10. Nurse Licensure Compact (2.78)	10. Nurse Licensure Compact (2.67)
11. Role of Accreditors (2.56)	11. Role of Accreditors (2.61)	11. Role of Accreditors (2.49)

Ranking Scale

1 = Not at all a priority
2 = Somewhat a priority
3 = A high priority
4 = A critical priority

Task Force Members

Katherine Thomas, Executive Officer, TX-RN, Area III, Chair

Shannon Fitzgerald, Board Member, WA, Area I

Margaret Franckhauser, Board Member, NH, Area IV

Jane Garvin, Board President, MD, Area IV

Tracy Klein, Board Staff, OR, Area I

Deborah Maichle, Board President, DE, Area IV

Georgia Manning, Board Staff, AR, Area III

Janet Younger, Board President, VA, Area III

Charlene Hanson, Member-at-Large, GA, Area III

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Deborah Bohannon-Johnson, Board President, ND, Area II Director

Staff

Nancy Chornick, Director of Credentialing and Professional Development

Carin L. Zuger, Administrative Assistant

Report of APRN Task Force

Recommendations to the Delegate Assembly

Approve Revision of the Alternative Mechanism Element of the Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements.

Rationale

A broad preparation for APRNs should be considered the minimum preparation for entry into advanced practice nursing for legal recognition.

Background

The Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements were approved by the Delegate Assembly in 2000. At that time, an alternative mechanism element was included in the requirements to enable advanced practice nurses who did not have a certification examination for their specialty to be licensed. The rationale for including the alternative mechanism was to ensure that a growing portion of the nursing profession was not restricted prematurely. Specifically, the alternative mechanism stated**:**

> *For applicants for whom there is no appropriate certifying exam available, states may develop alternate mechanisms to assure initial competence.*

Since the APRN uniform requirements were approved, there have been rapid changes in the field of advanced practice nursing. Most valid specialty areas now have a certification program through examination. However, educational programs are now developing new subspecialty programs, such as 'pain management' and 'palliative care.' The proliferation of these subspecialties has lead to great concern among nurse regulators. These concerns have been expressed during NCSBN policy calls and directly to the APRN Task Force. Member Board concerns are based on issues of how to regulate subspecialty advanced practice nurses within their scope of practice. The APRN Task Force also has concerns regarding the low numbers of candidates taking the examinations. Due to the low number of candidates, the validity and reliability of these examinations are difficult to substantiate and, therefore, they may not be psychometrically sound.

The task force recommends that broad preparation for APRNs should be considered the minimum preparation for entry into advanced practice nursing for legal recognition. A broad, generalist preparation will give the advanced practice nurse a basis on which to practice safely. The intent is to move toward a broad generalist preparation as opposed to a narrow subspecialty preparation. APRN certification in a subspecialty can be obtained after credentialing in a generalist category has been completed.

To support these recommendations, the task force believes that the alternative mechanism provision in the APRN uniform requirements should be revised to read:

> **Proposed Requirement**: *For applicants for whom there is no appropriate certifying exam available, states may develop alternative mechanisms to assure initial competence until January 1, 2005. Evidence of an equivalent mechanism to certification examinations will not be accepted after January 1, 2005, and individuals will no longer be licensed without an approved APRN examination.*

Rationale: *A broad preparation for APRNs should be considered the minimum preparation for entry into advanced practice nursing for legal recognition.*

Comments/Remarks: *The APRN Task Force does not support recognition without examination. Further, there are concerns regarding the proliferation of examinations that may not be psychometrically sound. The intent is to move toward a broad generalist preparation as opposed to a subspecialty preparation. Certification in a subspecialty can be obtained after credentialing in a generalist category has been completed.*

Highlights of FY02 Activities

- Developed preparatory materials for the APRN Compact.
- Finalized the selection of ABNS as a second accrediting agency.
- Finalized the Criteria for Certification Programs and Requirements for Accrediting Agencies.
- Developed a position paper on the Regulation of Advanced Practice Nursing.
- Held the 2002 APRN Roundtable on April 25, 2002.
- Recommended a revision for the uniform requirements.
- Met with accrediting agencies and certification organizations to discuss the regulatory perspectives on certification.

Future Activities

- Develop application materials for APRN certification programs.
- Provide resource materials for Member Boards.
- Evaluate certification programs with approved criteria.
- Continue to monitor APRN regulatory issues.

Definitions

Accrediting Agency – An organization which establishes and maintains standards for professional nursing programs and recognizes those programs that meet these standards.

APRNs – Advanced practice registered nurses, including certified nurse midwives (CNMs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and nurse practitioners (NPs).

Certifying Body – A non-governmental 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.

Certification Program – An examination designed by a certifying body to evaluate candidates for advanced practice nursing.

Relationship to Strategic Plan

Strategic Initiative 2 – Regulatory Effectiveness: The National Council will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome 4: Approaches and resources assist Member Boards in the regulation of advanced practice registered nurses.

Meeting Dates

- October 25-26, 2001
- January 31 & February 1, 2002
- April 24 - 26, 2002

Attachments

A. Proposed revision to the Uniform APRN Requirements
B. Requirements for Accrediting Agencies and Criteria for Certification Programs
C. Implementation of NCSBN's APRN Certification Examination Review Program
D. Position paper on the Regulation of Advanced Practice Nursing

APRN Task Force – Attachment A

Proposed Revision to the Uniform Advanced Practice Registered Nurse Licensure/ Authority to Practice Requirements

Background

The Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements were approved by the Delegate Assembly in 2000. At that time, an alternative mechanism element was included in the requirements to enable advanced practice nurses who did not have a certification examination for their specialty to be licensed. The rationale for including the alternative mechanism was to ensure that a growing portion of the nursing profession was not restricted prematurely. Specifically, the alternative mechanism stated**:**

> *For applicants for whom there is no appropriate certifying exam available, states may develop alternate mechanisms to assure initial competence.*

Since the APRN uniform requirements were approved, there have been rapid changes in the field of advanced practice nursing. Most valid specialty areas now have a certification program through examination. In addition, certifying bodies are now developing new subspecialty programs. The proliferation of these subspecialties has lead to great concern among nurse regulators. These concerns have been expressed during NCSBN policy calls and directly to the APRN Task Force. Member Board concerns are based on issues of how to regulate subspecialty advanced practice nurses within their scope of practice. The APRN Task Force also has concerns regarding the low numbers of candidates taking the examinations. Due to the low number of candidates, the validity and reliability of these examinations are difficult to substantiate and, therefore, they may not be psychometrically sound.

The task force recommends that broad preparation for APRNs should be considered the minimum preparation for entry into advanced practice nursing for legal recognition. A broad, generalist preparation will give the advanced practice nurse a basis on which to practice safely. The intent is to move toward a broad, generalist preparation as opposed to a narrow, subspecialty preparation. APRN certification in a subspecialty can be obtained after credentialing in a generalist category has been completed.

To support these recommendations, the task force believes that the alternative mechanism provision in the APRN Uniform Requirements should be revised to read:

> **Proposed Requirement:** *For applicants for whom there is no appropriate certifying exam available, states may develop alternative mechanisms to assure initial competence until January 1, 2005. Evidence of an equivalent mechanism to certification examinations will not be accepted after January 1, 2005, and individuals will no longer be licensed without an approved APRN examination.*
>
> **Rationale:** *A broad preparation for APRNs should be considered the minimum preparation for entry into advanced practice nursing for legal recognition.*
>
> **Comments/Remarks:** *The APRN Task Force does not support recognition without examination. Further, there are concerns regarding the proliferation of*

examinations that may not be psychometrically sound. The intent is to move toward a broad, generalist preparation as opposed to a subspecialty preparation. Certification in a subspecialty can be obtained after credentialing in a generalist category has been completed.

The above changes are shown in the following graph.

Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements[1]

Adopted August 12, 2000

Proposed Uniform Requirements	Rationale	Comments/Remarks
APRN Uniform Requirements – U.S.-Educated, Initial		
1. Licensed RN (unencumbered)	*APRN practice is built upon the foundation of RN education and experience.* *Encumbered RN licenses should be evaluated individually by the Board for potential applicability to the APRN practice category. It is recommended that practice be limited to the jurisdiction of action until the basis for disciplinary action is resolved.*	1. APRN Liaison Organizations-Consensus[2] 2. The intent is that this does not apply to provisional authority for new graduates pending examination. The APRN Task Force determined that an untested new graduate should not have interstate practice privilege. States may grant authority to practice within the state, but the interstate privileges would not apply.
2. Graduated from or completed a graduate level APRN program accredited by a national accrediting body by 2003.	*The knowledge skills and abilities essential for safe and competent advanced nursing practice are beyond those attained by an individual prepared in a basic nursing education program. Through graduate level education, a nurse can further develop abstract and critical thinking, the ability to assess at an advanced level, as well as advanced nursing and other essential therapeutic skills. Educational preparation should encompass both knowledge and the clinical component unique to the specific advanced practice nursing role.*	1. APRN Liaison Organizations-Sense of group[2] – all but CNMs support this requirement. 2. Compact rules, when developed, can address the criteria for recognition of accrediting bodies. The intent of the wording "or completed a graduate level APRN program" is to recognize post-graduate programs at the masters or higher level designed to prepare APRNs in the advanced nursing role and specialty. 3. The APRN Task Force chose 2003 as the implementation date because: students enrolled in an educational program need time to complete the program; programs need time to move from certificate to graduate level; and the time should be sufficient for individuals to be given notification. This requirement will have an implementation date of 2003. 4. Masters programs may not be offered through a school of nursing; e.g., a master's degree in nurse anesthesia offered by a College of Allied Health. The intent of the requirement is to allow these programs to be recognized if they are accredited. Accreditation validates that programs meet acceptable standards. Criteria for recognition of accrediting bodies may be established by states.

Proposed Requirements	Rationale	Comments/Remarks
3. Currently certified by national certifying body in the APRN specialty appropriate to educational preparation.	*A Board using professional certification as a qualification for licensure/authority to practice should establish criteria for accepting the certification and retains control of the licensure/authority to practice.* *Untested new APRN graduates should not have interstate practice privilege during any period of provisional authority pending examination.* The National Council APRN Task Force has worked closely with the certifying organizations to develop standards and a process for external review of certification programs.	1. APRN Liaison Organizations-Consensus. 2 Compact rules, when developed, can address recognition of certifying bodies through an external review process. Examples of external review accreditation programs for certification include NCCA and ABNS. 3. Historically, the lack of accreditation for NP and CNS programs has been a concern for Member Boards. We anticipate CCNE and NLNAC will address these matters in the near future. Both organizations are considering including NONPF National Task Force Criteria and AACN Essentials of Master's Education, which address the inclusion of pharmaco-therapeutics in the curriculum. 4. NCSBN will continue to monitor the compliance of certifying bodies with established accreditation criteria.
4. For applicants for whom there is no appropriate certifying exam available, states may develop alternate mechanisms to assure initial competence until January 1, 2005. Evidence of an equivalent mechanism to certification examinations will not be accepted after January 1, 2005, and individuals will no longer be licensed without an approved APRN examination.	*A broad preparation for APRNs should be considered the minimum preparation for entry into advanced practice nursing for legal recognition.*	*The APRN Task Force does not support recognition without examination. Further there are concerns regarding the proliferation of examinations that may not be psychometrically sound. The intent is to move towards a broad generalist preparation as opposed to a subspecialty preparation. Certification in a subspecialty can be obtained after credentialing in a generalist category has been completed.*
APRN Uniform Requirements-Renewal		
1a. Maintain national certification in the appropriate APRN specialty through an ongoing certification maintenance program of a nationally recognized certifying body, OR	*This requirement recognizes the responsibility of the APRN to maintain competence in the APRN category. Certification maintenance may include education, practice and/or examination components.*	1. APRN Liaison Organizations-Consensus. 2. Even if certifying body does not require participation in a competence maintenance program, participation will be required.
1b. Applicants for whom no recognized certification is available must participate in a competence maintenance program.	*Continued competence activities include needs assessment, planning to identify learning objectives, implementation of learning strategies to meet those needs and evaluation of the effectiveness of continued competence activities. For license/authority to practice renewal, Boards may direct APRNs to maintain documentation of continued competence activities and keep them on file.*	1. APRN Liaison Organizations-Consensus. 2. For APRNs who did not have a specific, recognized APRN Certification examination available (prior to January1, 2005), the requirements to assure continued competence can be left to the states. Criteria for competence maintenance would be developed in compact rules (see initial/U.S. -educated, #4 above).

Proposed Requirements	Rationale	Comments/Remarks
APRN Uniform Requirements – Foreign Educated		
1. Same as U.S.-educated/initial criteria, except the APRN educational program must meet criteria for accreditation equivalent to that of a national accrediting body.	*These requirements provide a mechanism for qualified APRNs educated in foreign jurisdictions to obtain licensure/ authority to practice in the U.S.*	1. APRN Liaison Organizations-Consensus. 2. Foreign-educated nurses can be recognized if they meet the following criteria: (a) Licensed RN (unencumbered). (b) Graduated from or completed a graduate level APRN program accredited by a national accrediting body. In lieu of a U.S. national accrediting body approval, states could determine equivalency of the foreign program to U.S.-accredited programs based on criteria established in the compact rules. It is anticipated that the compact rules will address specific criteria to be used by the states in determining equivalency of foreign programs with CCNE and NLNAC accreditation. (c) Currently certified by a national certifying body in the APRN specialty appropriate to educational preparation. (d) For applicants for whom there is no appropriate certifying examination available, states will have a mechanism to assure initial competence. (See initial/U.S.-educated, #4). NCSBN will continue to monitor international collaboration.
APRN Uniform Requirements – Endorsement		
1. Licensed as RN (unencumbered), AND 2. APRN licensure/authority to practice unencumbered in another jurisdiction, AND 3. Currently certified by a national certifying body in the APRN specialty appropriate to the educational preparation or authorized to practice as an APRN in another jurisdiction through a mechanism to ensure initial competence when no appropriate certification exam is available, AND		
4a. Meets educational requirements for initial licensure/authorization to practice OR 4b. Demonstrates successful completion	*Endorsement allows the mobility of APRNs between states currently, and would also be needed under an APRN compact to allow change of resident state. This provision*	1. APRN Liaison Organizations-Consensus on 1-4a. No agreement on 4b; dates suggested ranged from 2000-2007. 2. The intent is to permit grandparent-

Proposed Requirements	Rationale	Comments/Remarks
of approved APRN certificate program prior to 2003.	*provides grandparenting provisions for currently recognized APRNs. The APRN Task Force selected the year 2003 to allow students enrolled before the uniform requirements to be grandparented.It is anticipated that compact states will be able to grandparent APRNs endorsing from another state even if not meeting the 2003 criteria as long as the endorsee met another jurisdiction's requirements prior to 2003.*	ing of currently recognized APRNs. The APRN Task Force chose the date 2003 when consensus could not be reached among the APRN organizations. The APRN Task Force chose 2003 because: students enrolled in an educational program need time to complete the program; programs need time to move from certificate to graduate level; and the time should be sufficient for individuals to be given notification of grandparenting. 3. Compact states can grandparent APRNs endorsing from another state even though the endorsee does not meet the 2003 criteria as long as the endorsee met another jurisdiction's requirements prior to 2003. Requirements 4a and 4b provide grandparenting for APRNs who have been legally recognized and are practicing safely in a jurisdiction prior to 2003.
APRN Uniform Requirements – Re-Entry into Practice		
None.	*Extensive discussion with the APRN Liaison Organizations about re-entry requirements led to the conclusion that relatively few individuals might wish to re-enter advanced practice. A specific process may be identified in the future from the mechanisms used by the states.*	Extensive discussion took place with the APRN Liaison Organizations about re-entry requirements. The conclusion was that few individuals might wish to re-enter advanced practice and the variety of mechanisms used by the states might identify an effective re-entry process for the future.

[1]The **mechanism of legal recognition** can be any of the various ones used by states to authorize advanced practice, e.g., certificate of authority, licensure, or recognition.
[2]**Consensus and Sense of Group** – Consensus means that all participating APRN liaison organizations agreed. Sense of the Group means a majority of the participating APRN liaison organizations agreed.

Several meetings took place from December 1997 to December 1998 with the APRN professional and certifying organizations to develop the draft Uniform Licensure/Authority to Practice Requirements. The term "consensus" and "sense of the group" relate specifically to the outcomes of those discussion.

APRN Task Force – Attachment B

Requirements for Accrediting Agencies and Criteria for APRN Certification Programs

APRN Certification Examination Review Program
National Council of State Boards of Nursing
January 2002

Preface

Purpose

The purpose of the *Requirements for Accrediting Agencies and the Criteria for Certification Programs* is to provide criteria for an external review process that would ensure boards of nursing of the suitability of advanced practice certification examinations for regulatory purposes.

Requirements For Accrediting Agencies

1. **Accrediting agency must have standards for accreditation that are sufficiently rigorous to ensure that the agency is a reliable authority regarding quality of the program it accredits.**
   A. Accreditation standards effectively address the quality of the program.
   B. Standards development and revision process includes input from the field and reflects current practice.
   C. Standards regarding national application are realistic.

2. **Accrediting agency must have effective mechanisms for evaluating a program's compliance with the agency's standards in order to reach a decision to accredit the program.**
   A. Accrediting agency evaluates whether a program is successful in achieving its objectives.
   B. Accrediting agency consistently applies and enforces its standards.
      1. Has effective controls against inconsistent application of agency's standards.
      2. Bases decisions on published standards.
      3. Has reasonable basis for determining that the information the agency relies on for making accrediting decisions is accurate.
   C. Accrediting agency evaluates the accredited program every five years, and monitors throughout the accreditation period to ensure that the credentialing program remains in compliance with the agency's standards.
   D. Accrediting agency has documentation that is evidenced-based.

3. **Accrediting agency must provide a detailed description of the agency's survey process.**
   A. Frequency of review is a minimum of five years.
   B. Copies of agency's survey forms, guidelines are available.
   C. Procedures used to notify accredited agencies' deficiencies and procedures used to monitor the correction of the deficiencies are in place.
   D. Accreditation decision categories (e.g., full, provisional, partial, etc.) are available.

Definitions

Accrediting Agency – an organization which establishes and maintains standards for professional nursing programs and recognizes those programs that meet these standards.

APRNs – Advanced practice registered nurses, including certified nurse midwives (CNMs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and nurse practitioners (NPs).

Certifying Body – a non-governmental agency that validates by examination, based on pre-determined standards, an individual nurse's qualifications and knowledge for practice in a defined functional or clinical area of nursing.

Certification Program – an examination designed by a certifying body to evaluate candidates for advanced practice nursing.

External Review Process – a review process by an accrediting body to assure appropriate standards are met.

E. Information about the individuals who perform surveys for the accrediting agency is available.
1. Education experience requirements that individuals must meet are established.
2. Inservice training is provided.
3. Policies and procedures with respect to an individual's participation in the survey or accreditation decision process of any program with which the individual is professionally or financially affiliated.

4. Accrediting agency must have a data management and analysis system with respect to its accreditation decisions including the kinds of reports, tables, etc.

5. Accrediting agency must have procedures for responding to and for the investigation of complaints against certifying bodies.

6. Accrediting agency must have policies and procedures with respect to the withholding or removal of accreditation status for certifying bodies that fail to meet standards or requirements including:
A. Notification to NCSBN in writing of any program that has had its accreditation removed, withdrawn or revised or has had any other remedial or adverse action taken against it by the accrediting agency within 30 days of any such action taken.
B. Notification within 10 days of a deficiency identified in any accrediting entity when the deficiency poses an immediate jeopardy to public safety.

7. Accrediting agency must submit to the National Council:
A. A copy of any annual report prepared by the agency.
B. Notice of final accrediting findings and actions taken by the agency with respect to the program it accredits.
C. Any proposed change in the program's policy, procedures or accreditation standards that might alter the program's scope of recognition.

Revised 11-15-01

Criteria For Evaluating Certification Programs

Criteria	Elaboration
I. The program is national in the scope of its credentialing.	A. The advanced nursing practice category and standards of practice have been identified by national organizations. B. Credentialing services are available to nurses throughout the United States and its territories. C. There is a provision for public representation on the certification board. D. A nursing specialty organization that establishes standards for the nursing specialty exists. E. A tested body of knowledge related to the advanced practice nursing specialty exists. F. The certification board is an entity with organizational autonomy.
II. Conditions for taking the examination are consistent with acceptable standards of the testing community.	A. Applicants do not have to belong to an affiliated professional organization in order to apply for certification offered by the certification program. B. Eligibility criteria rationally related to competence to practice safely. C. Published criteria are enforced. D. In compliance with the American Disabilities Act. E. Sample application(s) are available. 1. Certification requirements included. 2. Application procedures include: • Procedures for assuring match between education and clinical experience, and APRN specialty being certified. • Procedures for validating information provided by candidate. • Procedures for handling omissions and discrepancies. 3. Professional staff responsible for credential review and admission decisions. 4. Examination should be administered frequently enough to be accessible but not so frequently as to over-expose items. F. Periodic review of eligibility criteria and application procedures to ensure that they are fair and equitable.
III. Educational requirements are consistent with the requirements of the advanced practice specialty.	A. Current U.S. registered nurse licensure is required. B. Graduation from a graduate advanced practice education program meets the following requirements: 1. Education program offered by an accredited college or university offers a graduate degree with a concentration in the advanced nursing practice specialty the individual is seeking. 2. If post-masters certificate programs are offered, they must be offered through institutions meeting criteria B.1. 3. Both direct and indirect clinical supervision must be congruent with current national specialty organizations and nursing accreditation guidelines. 4. The curriculum includes, but is not limited to: • Biological, behavioral, medical and nursing sciences relevant to practice as an APRN in the specified category; • Legal, ethical and professional responsibilities of the APRN; and • Supervised clinical practice relevant to the specialty of APRN. 5. The curriculum meets the following criteria: • Curriculum is consistent with competencies of the specific areas of practice. • Instructional track/major has a minimum of 500 supervised clinical hours overall. • The supervised clinical experience is directly related to the knowledge and role of the specialty and category. C. All individuals, without exception, seeking a national certification must complete a formal didactic and clinical advanced practice program meeting the above criteria.

Criteria	Elaboration
IV. The standard methodologies used are acceptable to the testing community such as incumbent job analysis study, logical job analysis studies.	A. Exam content based on a job/task analysis. B. Job analysis studies are conducted at least every five years. C. The results of the job analysis study are published and available to the public. D. There is evidence of the content validity of the job analysis study.
V. The examination represents entry-level practice in the advanced nursing practice category.	A. Entry-level practice in the advanced practice specialty is described including the following: • Process. • Frequency. • Qualifications of the group making the determination . • Geographic representation. • Professional or regulatory organizations involved in the reviews.
VI. The examination represents the knowledge, skills and abilities essential for the delivery of safe and effective advanced nursing care to the clients.	A. The job analysis includes activities representing knowledge, skills and abilities necessary for competent performance. B. The examination reflects the results of the job analysis study. C. Knowledge, skills and abilities, which are critical to public safety, are identified. D. The examination content is oriented to educational curriculum practice requirements and accepted standards of care.
VII. Examination items are reviewed for content validity, cultural bias and correct scoring using an established mechanism, both before use and periodically.	A. Each item is associated with a single cell of the test plan. B. Items are reviewed for currency before each use at least every three years. C. Items are reviewed by members of under-represented gender and ethnicities who are active in the field being certified. Reviewers have been trained to distinguish irrelevant cultural dependencies from knowledge necessary to safe and effective practice. Process for identifying and processing flagged items is identified. D. A statistical bias analysis is performed on all items. E. All items are subjected to an "unscored" use for data collection purposes before their first use as a "scored" item. F. A process to detect and eliminate bias from the test is in place. G. Reuse guidelines for items on an exam form are identified. H. Item writing and review is done by qualified individuals who represent specialties, population subgroups, etc.
VIII. Examinations are evaluated for psychometric performance.	A. Reference groups used for comparative analysis are defined.
IX. The passing standard is established using acceptable psychometric methods, and is re-evaluated periodically.	A. Passing standard is criterion-referenced.
X. Examination security is maintained through established procedures.	A. Protocols are established to maintain security related to: 1. Item development (e.g., item writers and confidentiality, how often items are re-used). 2. Maintenance of question pool. 3. Printing and production process. 4. Storage and transportation of examination is secure. 5. Administration of examination (e.g., who administers, who checks administrators). 6. Ancillary materials (e.g., test keys, scrap materials). 7. Scoring of examination. 8. Occurrence of a crisis (e.g., exam is compromised, etc).
XI. Certification is issued based upon passing the examination and meeting all other certification requirements.	A. Certification process is described, including the following: 1. Criteria for certification decisions are identified. 2. The verification that passing exam results and all other requirements are met.

Criteria	
	3. Procedures are in place for appealing decisions. B. There is due process for situations such as nurses denied access to the examination or nurses who have had their certification revoked. C. A mechanism is in place for communicating with candidate. D. Confidentiality of nonpublic candidate data is maintained.
XII. A retake policy is in place.	A. Failing candidates permitted to be reexamined at a future date. B. Failing candidates informed of procedures for retakes. C. Test for repeating examinees should be equivalent to the test for first time candidate. D. Repeating examinees should be expected to meet the same test performance standards as first time examinees. E. Failing candidates are given information on content areas of deficiency. F. Repeating examinees are not exposed to the same items when taking the exam previously.
XIII. Certification maintenance program, which includes review of qualifications and continued competence, is in place.	A. Certification maintenance requirements are specified (e.g., continuing education, practice, examination, etc.). B. Certification maintenance procedures include: 1. Procedures for assuring match between continued competency measures and APRN specialty. 2. Procedures for validating information provided by candidates. 3. Procedures for issuing re-certification. C. Professional staff oversee credential review. D. Certification maintenance is required a minimum of every five years.
XIV. Mechanisms are in place for communication to boards of nursing for timely verification of an individual's certification status, changes in certification status, and changes in the certification program, including qualifications, test plan and scope of practice.	A. Communication mechanisms address: 1. Permission obtained from candidates to share information regarding the certification process 2. Procedures to provide verification of certification to Boards of Nursing 3. Procedures for notifying Boards of Nursing regarding changes of certification status 4. Procedures for notification of changes in certification programs (qualifications, test plan or scope of practice) to Boards of Nursing
XV. An evaluation process is in place to provide quality assurance in its certification program.	A. Internal review panels are used to establish quality assurance procedures. 1. Composition of these groups (by title or area of expertise) is described 2. Procedures are reviewed 3. Frequency of review B. Procedures are in place to insure adherence to established QA policy and procedures.

Revised 11-6-01

Implementation Time Line

1. Implementation process
   - Implementation of the program will begin with the approval by the Board of Directors.
   - Development of application materials will be completed during summer, 2002
   - Certifying bodies participating in NCSBN's previous review program will be invited to participate in NCSBN's APRN Certification Examination Review Program in fall 2002. These programs will be informed of the requirements for participation and the additional information identified as needed to meet the *Criteria* will be requested.
2. APRN certification programs of other certifying bodies will be reviewed at the certifying body's request.
3. New APRN certification programs of participating APRN certifying bodies will be reviewed by NCSBN.
4. Annual reports provided by certifying bodies will provide data on each approved APRN certification program regarding any changes in the programs and information regarding exceptions, pass rates, etc.

APRN Task Force – Attachment C

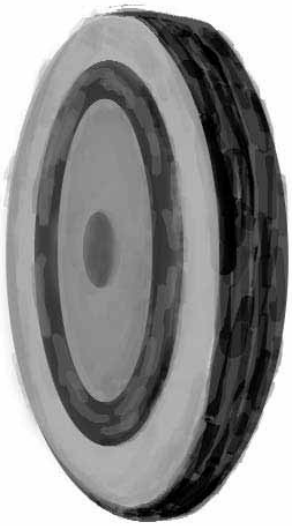
Implementation of NCSBN's APRN Certification Examination Review Program

Process

1. Accrediting Agencies. Accrediting agencies will be selected based on NCSBN's *Requirements for Accrediting Agencies*.
   - Accreditation by one of the accrediting agencies that have met NCSBN's *Requirements for Accrediting Agencies* will be required of APRN certifying bodies participating in NCSBN's APRN Certification Examination Review Program.
   - Information required by the *Criteria for Certification Programs* but not usually requested by the accrediting agencies will be compiled and this information will be requested from participating APRN certifying bodies.
2. APRN Certifying Bodies
   - APRN certifying bodies already in the previous NCSBN APRN review program will be invited to participate in the program. Each APRN certification program will be reviewed by NCSBN's APRN Task Force using the Criteria for Certification Program. Certifying bodies will be notified of the results.
   - APRN certifying bodies not already participating in the previous NCSBN APRN review program will also be invited to participate. Certifying bodies requesting to participate in the program will be reviewed by the APRN Task Force and notified of the results.
   - If an APRN certification program is accepted, notification will be provided to the certifying body and Member Boards will be notified.
   - If an APRN certification program is rejected, notification along with rationale for rejection of the certification program will be provided to the certifying body. The justification for not accepting the certification program will be released to Member Boards.
   - New APRN certification programs of participating APRN certifying bodies are not reviewed by the accrediting agencies until the certification body's next accreditation cycle. These new programs will be reviewed by the APRN Task Force using the *Criteria for Certification Programs*. The certifying body and Member Boards will be notified of the findings.
3. Participation in NCSBN's APRN Certification Examination Review Program will require the APRN certifying bodies to:
   - Meet the approved NCSBN *Criteria for APRN Certification programs*.
   - Be accredited by one of NCSBN's two approved accrediting agencies (American Boards of Nursing Specialties or National Commission for Certifying Agencies).
   - Provide additional information to NCSBN as requested regarding new examinations, annual accreditor's reports, etc.
4. NCSBN will disseminate information to Member Boards regarding the recommended APRN certification programs.

Communication

1. To Member Boards
   - APRN regulatory perspectives and updates on APRN regulatory issues will be provided through development of a position paper, newsletter articles, and other NCSBN communication vehicles.
   - The *Criteria for Certification Programs* and *Requirements for Accrediting Agencies* document will be distributed to Member Boards and will be available for downloading from NCSBN's Web site.
   - The process with timeline for NCSBN's APRN Certification Examination Review Program will be released to Member Boards. Included will be the implementation and maintenance of the program.
   - Reports on each APRN certification program of a certifying body will be distributed annually.
   - Updates on new APRN certification programs including NCSBN reviews of the examinations.
2. To Certifying Bodies
   - Expectations of participants in NCSBN's APRN Certification Examination Review Program will be conveyed to certifying bodies. Expectations will be based on the *Criteria for Certification Programs*.
   - Information about NCSBN's APRN Certification Examination Review Program process including implementation, timeline, and maintenance will be conveyed to APRN certification programs.
   - Information regarding the regulatory perspective and supporting rationale will be communicated to certifying bodies via the APRN Roundtable, position papers, etc.
   - Meetings with individual certifying bodies will take place as needed.
3. To Accreditors
   - Expectations of approved accreditors based on the *Requirements for Accreditation Agencies* will be provided to accrediting agencies.
   - Information regarding NCSBN's APRN Certification Examination Review Program and how the accrediting agencies articulate with the process will be provided.
4. To Public
   - Position paper on the regulatory perspective regarding advanced practice nursing will be available on NCSBN's Web site.



Executive Summary

The National Council of State Boards of Nursing (NCSBN) proposes this position paper to provide guidance to boards of nursing in the regulation of advanced practice nursing and to provide information to interested parties on the regulation of advanced nursing practice. A review of the background of the regulation of advanced practice nursing and an examination of education, certification and accreditation as a basis for regulation provides the rationale for the position paper. Advanced practice nurses include nurse practitioners, nurse anesthetists, nurse-midwives and clinical nurse specialists.

Review of previous statements of NCSBN and a review of current education, certification, accreditation and practice standards leads to the following recommendations:

- Advanced practice registered nurse (APRN) should be used as an umbrella term to include nurse anesthetists, nurse midwives, nurse practitioners and clinical nurse specialists to designate appropriately credentialed nurses who assume primary responsibility for the direct care of clients
- APRN licensure is the preferred method of regulation for advanced nursing practice because of the nature of the practice that requires advanced knowledge, clinical proficiency, independent decision-making and autonomy. The risk of harm from unsafe and incompetent providers at this level of complex care is high.
- Boards of nursing should adopt the *Uniform Advanced Practice Registered Nurse Licensure/ Authority to Practice Requirements (2000).*

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APRN Task Force – Attachment D

Regulation of Advanced Practice Nursing 2002 National Council of State Boards of Nursing Position Paper

Premises

1. The purpose for regulation of APRN practice is the protection of public health, safety and welfare.
2. Regulation criteria for APRN practice should reflect minimum requirements and be the least burdensome criteria consistent with public protection.
3. The public has a right to the access of health care, and to make informed choices regarding selection of health care options through knowledge of the area of expertise, qualifications and credentials of individuals who provide health care.
4. The public has a right to rely on the credentials of health care providers in making choices and decisions regarding health care.
5. Boards of nursing should regulate APRN practice by licensure due to the nature of the practice, which requires advanced knowledge, clinical proficiency, independent decision-making and autonomy. The risk of harm from unsafe and incompetent providers at this level of complex care is high.

Background

NCSBN's strategic initiatives have focused on APRN regulatory issues for the past two decades. In 1986, the NCSBN adopted a position paper on Advanced Clinical Nursing Practice. The paper addressed APRN practice as a concept varying in interpretation and regulation, defined the educational preparation to be at least a master's degree in nursing and concluded that the preferable method of regulating APRNs was designation/recognition.

A revised Position Paper on APRNs was adopted in 1993. Although many premises of the 1986 position paper were still valid, the 1993 position paper recognized that rapid changes in health care based on economics, legislation and policy within the health care arena had influenced advanced practice nursing and that these changes had implications for nursing regulation. The paper defined the various levels of regulation and the factors to consider when selecting the method of regulation for advanced practice nursing. It recommended that licensure, the most stringent level, was the preferred type of regulation for APRNs.

Four levels of regulation for APRNs were described in NCSBN's 1993 Advanced Practice Nursing position paper. Levels of regulation range from the first level of regulation, and least restrictive approach, designation/recognition, to the fourth level of regulation and the most restrictive approach, licensure. Licensure is used when regulated activities are complex and requires specialized knowledge, skills, and independent decision-making. The licensure process includes the predetermination of qualifications necessary to perform a unique scope of practice safety and an evaluation of licensure applications to determine that the qualifications are met. Licensure provides a specified scope of practice that may only be performed legally by licensed individuals. It also provides authority to take disciplinary action should the licensee violate provisions of the law or rules. Licensure is applied to a profession when the practice of that profession could cause greater risk of harm to the public without a high level of accountability.

When legislatures select a level of regulation for professional practice, elements to consider include the potential for risk of harm to the consumer; the specialized education, skills and abilities required for the professional practice; the level of autonomy; the scope of practice; economic impact; alternatives to regulation; and a determination of the least restrictive regulation consistent with the public safety.

Licensing requirements define what is necessary for the majority of individuals to be able to practice the profession safely and validate that the applicant has met those requirements. Setting minimal educational requirements for any type of professional licensure creates the possibility that some capable individuals, who have learned through non-traditional means and experience, would be excluded from practice. It is important that a sufficient time frame or a "phasing in" for meeting the requirements be provided to allow such individuals to continue in practice if they choose. There are also situations when someone who has met the set requirements proves to be unsafe or fails to maintain competence. Licensing boards have the authority to initiate appropriate disciplinary action against the licenses of unsafe individuals. Education, practice and other ongoing requirements are set by many boards to assist in maintenance of competency.

In 1995, to assist boards of nursing in deciding whether to use certification as one of the requirements for licensure, the Delegate Assembly directed NCSBN to collaborate with nurse practitioner certification organizations to determine if certification examinations were psychometrically sound and legally defensible for regulatory purposes. NCSBN met with these organizations to develop a mutually acceptable process that would assure boards of nursing of the regulatory sufficiency of private APRN certification programs. Extensive negotiations with certification programs led to a process using the National Commission for Certifying Agencies (NCCA) accreditation supplemented with a review of additional criteria established by NCSBN. The purpose of this process was to assure boards of nursing that it was appropriate to use professional certification examinations in partial fulfillment of regulatory requirements for APRNs.

NCSBN continues to be actively involved in APRN regulatory issues. At the 2000 Delegate Assembly, *the Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements* were passed. These requirements included: (1) Unencumbered RN license; (2) Graduation from a graduate level advanced practice program accredited by a national accrediting body; (3) Currently certified by a national certifying body in the advanced practice specialty appropriate to educational preparation; and (4) Maintenance of certification or evidence of maintenance of competence. The purpose of developing uniform core licensure requirements was to promote mobility of APRNs while maintaining licensure standards critical to protecting the public health, safety and welfare. Facilitating nurse mobility assures that health care consumers have access to nursing services and that these providers are qualified according to consistent standards across the country.

In 2002, NCSBN's Advanced Practice Task Force developed updated criteria for evaluating APRN certification programs (*Requirements for Accrediting Agencies and Criteria for APRN Certification Programs, 2002)*. In brief, these criteria include the following:

1. The scope of credentialing is national;
2. Conditions for taking the examination are consistent the acceptable standards for testing;
3. Educational requirements are consistent with the requirements of the advanced practice specialty;
4. A logical job analysis exists;

- Combined with advanced practice graduate nursing education, professional certification examinations should be used as one qualification for licensure when the board of nursing has established criteria for accepting the certification and maintains regulatory authority for the licensure process.
- Licensure should be granted only if the concentration in the APRN education program and the area of the certification exam are congruent.
- Movement should be toward consistent educational requirements, titling and uniform use of terminology to improve public protection, promote informed consumer health care decisions and result in a more effective utilization of services provided by APRNs.
- APRN licensure should be in relatively broad categories of practice, such as Adult Nurse Practitioner, and not subspecialty areas, such as Diabetes Nurse Practitioner, that may lack the essential experience with commonly occurring health problems.
- Additional specialized certifications may be used to expand the APRN's scope of practice within the limits of the category of practice in which the license is granted.
- Prescriptive authority should be within the scope of the license to practice and only granted upon completion of substantial pharmacotherapeutic course work and clinical supervision of prescribing in the master's program. If prescriptive authority requirements are met after program completion, a preceptorship/specific clinical hours, continuing education or clinical supervision component should be added.

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- APRNs are responsible for practice that reflects the state of the science and the evidence-based guidelines that form the standard of care.
- Nurses licensed or otherwise authorized to practice at an advanced level when new regulations are proposed should be permitted to continue practicing in the APRN category through "grandparenting" provisions recognized in all states.

5. The examination represents entry-level practice;
6. The examination represents the knowledge, skills and abilities essential for the delivery of safe and effective advanced nursing care to clients;
7. Examination items are reviewed for content validity, cultural bias and correct scoring using an established mechanism;
8. Examinations are evaluated for psychometric performance;
9. The passing standard is established using acceptable psychometric methods;
10. Examination security is maintained through established procedures;
11. Certification is issued based upon passing the examination and meeting all other certification requirements;
12. A retake policy exists;
13. Certification maintenance, which includes review of qualifications and continued competence, is in place;
14. Mechanisms are in place for communication to boards of nursing for timely verification of an individual's certification status and changes in the certification program; and
15. An evaluation process is in place to provide quality assurance.

Among the most significant changes in the updated January 2002 version is the specification of educational requirements in number three above. Among other specifications, they include provision that both direct and indirect clinical supervision be consistent with current national specialty organizational and nursing accreditation guidelines, include a minimum of 500 supervised clinical hours and that the supervised clinical experience is directly related to the knowledge and role of the specialty and category (*Requirements for Accrediting Agencies and Criteria for APRN Certification Programs, 2002)*.

Current State of Advanced Practice Nursing

Changes in the United States health care system, such as increasing costs and dramatic advances in scientific knowledge, have caused nursing to evolve into multiple levels of practice with an increasingly differentiated body of knowledge. In many jurisdictions, APRNs are practicing independently and performing procedures previously reserved for physician practice.

Nurses with advanced skills are seeking professional and economic recognition through certification and the authority to practice through nursing regulation. Unfortunately, a lack of consistency in education, titling, credentialing, program accreditation, scope of practice and reimbursement have confused the public, legislators, regulators and nurses themselves, and have hindered efforts to make full use of contributions of APRNs to health care.

Advanced Practice Education Programs

Additional professional education is necessary for an APRN to perform within a scope of practice beyond traditional registered nursing practice. Through graduate level education, a nurse further develops abstract and critical thinking, the ability to assess at an advanced level, knowledge of research and its interpretation for practice, and other essential therapeutic skills. Graduate education is generally required to produce competent, independent professionals. Further, legislators, third party payers and the public have typically not accepted those who lack this formal education as appropriate to provide the levels of complex and independent practice typical of APRNs.

NCSBN's *Criteria for APRN Certification Programs* (2002) identifies critical elements of advanced practitioner education. According to the criteria, APRNs

should graduate from a formal graduate advanced practice program with a concentration in the advanced nursing practice specialty consistent with the certification that the individual is seeking and in accordance with the National Task Force *Criteria for Evaluation of Nurse Practitioner Programs* (1997, 2002). The program should consist of both formal didactic and clinical components. Both direct and indirect clinical supervision should be congruent with current certification and nursing program accreditation guidelines. The curriculum should include biological, behavioral, medical and nursing sciences relevant to the practice as an APRN in the specified category and a minimum of 500 supervised clinical hours. The supervised clinical experience should be directly related to the knowledge and role of the specialty and category and should be provided by a person licensed appropriately for that health care role.

It is the position of NCSBN that broad preparation for APRNs should be considered the minimum preparation for entry into advanced practice nursing for legal recognition. Examples of broad preparation include areas such as adult health, pediatrics, psychiatric mental health, etc. Broad preparation will give the APRN a basis on which to recognize a range of commonly occurring health problems and to practice safely. Regulators must recognize, in their public protection efforts, that APRNs who are certified in a subspecialty, such as a specific disease entity, have a narrow scope of practice. This becomes problematic when the advanced practitioner is faced with a wide variety of health disorders in practice and regulators must restrain that APRN to practice within a narrow, specified scope of practice. It is also very difficult to evaluate the validity and reliability of certification examinations administered to only a small number of candidates, which is typical of subspecialty categories, making these examinations unsuitable for regulatory purposes. Therefore, it is unwise to continue to proliferate subspecialty programs because graduates of these programs expect to be licensed as APRNs and legal recognition of narrow scope is inappropriate. Some educational programs may wish to provide special emphasis areas that are subspecialty focused as an appropriate educational direction. However, from the viewpoint of licensure, it is important to continue to meet the criteria for certification and subsequent licensure in the boarder category.

Accreditation of educational programs by nationally recognized accrediting bodies should be one of the requirements for licensure. Accrediting bodies examine the quality of the faculty, curriculum, resources, evaluation and integrity of programs. A significant factor in the determination of quality of programs is that the program meets established standards, such as those in the *Essentials of Master's Education for Advanced Practice Nursing* (1996) and the *National Task Force Criteria for Evaluation of Nurse Practitioner Programs* (1997, 2002), and *Standards for Accreditation of Nurse Anesthesia Educational Programs* (1999).

Integrity, on the part of the APRN educational program, requires that students are given accurate information about their eligibility for certification and subsequent licensure, and that certifying bodies are given accurate information about the program. For regulatory purposes, it is important that accreditation processes provide for conclusive verification of these elements.

APRN Certification

Professional nursing organizations have supported the recognition of advanced nursing practice through the mechanism of voluntary certification. In response to the growing presence of APRN, certification bodies have dramatically increased APRN certification examinations. The use of these certification examinations as a basis for licensure has implications for public safety. If those examinations are to

be used as a qualification for licensure, the development and administration of the examinations must be above reproach to ensure that the standards needed to protect the public are met. NCSBN's *Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements* includes the use of certification by national certifying bodies.

A guiding principle of NCSBN's *Criteria for Certification Programs* is that the sufficiency of an examination must be evaluated in light of its intended purposes. Criteria used to evaluate an examination's sufficiency will differ depending on its intended use. For instance, criteria used to measure excellence through experience are different from the criteria used by state government to grant legal authority to practice a defined scope of professional practice. To be used for regulatory purposes, examinations must be legally defensible and psychometrically sound. The foundational basis for regulatory sufficiency of a certification examination is the examination's ability to measure entry-level competence in the essential functions of the professional position. If any other attribute were measured, the entire process of granting/denying legal authorization would be subject to charges of indefensible decision-making by the regulatory board. Certification examinations, on the other hand, may be calibrated to a higher or lower level of difficulty. In addition, they may cover a too broad or too narrow scope of practice than would otherwise be appropriate for regulation. For example, a certification program covering a very narrow scope, such as a specific disease entity, would not necessarily validate that the APRN is capable of practice consistent with the authority granted by the license. In other words, the APRN may not be a safe practitioner for clients' with a broad spectrum of health concerns.

NCSBN's criteria address essential aspects of certification programs used for regulatory purposes. If a certifying body intends its examination for regulatory use, it is necessary for these examinations: to measure only job-related knowledge, skills, and abilities; to be at entry-level; require minimal level competence; and be psychometrically sound. Additionally, criteria to determine that the candidate meets conditions for taking the exam include a requirement that the education of the candidate is consistent with the APRN certification examination taken. NCSBN's criteria also considered whether examinations met accepted testing standards such as non-discriminatory practices, security of examination content and appropriate accommodation for disabilities.

Certifying bodies also provide examinations in areas other than those intended for licensure. These "value-added" certifications offer a means of documenting special competencies within a practice area of an existing license. This use of certification is separate from purposes of licensure.

Responsibilities of Regulation

The foremost responsibility of nursing regulation is protection of the public health, safety and welfare. This goal is promoted through the identification of essential qualifications for advanced practice licensure, evaluation of whether an individual meets those qualifications and assurance to the public that licensees meet the qualifications. When boards of nursing accept results of certification examinations as one of the qualifications for licensure, they must not surrender regulatory authority by passive acceptance without evaluation of the examination content, procedures and scoring process. Boards of nursing cannot cede this authority to private entities. Boards of nursing must assure that the certification examination is psychometrically sound and legally defensible for use in regulation. Once assured, recognizing established certification programs as a basis for regulation avoids duplication of effort and is less expensive for states and

licensees. It is essential that boards of nursing establish and apply criteria for recognition of certification examinations and maintain responsibility for the licensing process.

A board of nursing that designates a single private certification as the only acceptable credential could be challenged for excluding professional certifications granted by other certifying bodies. A process of establishing criteria and specifications for acceptable credentials, including the opportunity for interested private agencies to demonstrate that they can meet the established criteria, avoids the automatic exclusion of other organizations, either current or future, which may comply with the board's requirements.

Since regulation may limit entry into advanced nursing practice, consideration must be given to possible legal challenges. Two possible areas of challenge would be infringement of constitutional rights and constitutional delegation. Individuals have the right to pursue employment of their choosing. However, this individual right to seek employment must be balanced with the state responsibility to protect the health, safety and welfare of the public. Boards of nursing are advised to justify the relationship between the restrictions imposed by regulations and the health, safety and welfare of the public and to give attention to assuring guarantees of procedural due process, such as notice and an opportunity to be heard, to protect against charges of proceeding with arbitrary, discriminatory or unreasonable regulations.

Regulations must continue to minimize barriers to health care imposed by unnecessarily restrictive regulation. NCSBN has assisted boards of nursing to implement mutual recognition of the RN license, the process whereby states agree to accept the license granted by another state as the basis for practice. NCSBN is now in the process of developing an Advanced Practice Nursing Compact. At the Annual Meeting of 2000, the Delegate Assembly adopted the *Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements* to guide boards of nursing toward advanced practice regulation that is sufficiently similar to permit mutual recognition to occur. This step is necessary to keep pace with the technology of telehealth and the mobility of citizens. The ability to cross state lines and practice without barriers or delays will increase access to qualified practitioners.

Responsibilities of APRNs

APRNs, with additional education and experience, function with substantial autonomy and independence. Nurse practitioners, nurse anesthetists, nurse midwives and clinical nurse specialists each have a distinguishable scope of practice with some overlapping functions. The legal scope of practice reflects the uniqueness of each role. APRNs are responsible for knowing the regulatory requirements in the jurisdiction in which they intend to practice and complying with these requirements.

Nurse practice acts identify boundaries of practice. For instance, the granting of prescriptive authority should be specific to the practice area, e.g., a pediatric nurse practitioner should not prescribe medications for geriatric clients. Licensed APRNs are also accountable for practice that reflects the state of the science and the evidence-based guidelines that form the standard of care. This standard requires continuing competency and quality improvement.

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Conclusion

Failure to regulate advanced nursing practice creates potential risks for the public. Without licensure, complex activities requiring a high level of specialized knowledge, and independent decision-making may be performed by individuals without sufficient preparation and skill. Without licensure, professionals are not held legally accountable for their practice. Without licensure, the public does not have the benefit of an unbiased forum to resolve complaints regarding issues of safety and competence.

For most boards of nursing, the current approach to licensure involves reliance on educational credentials, certification examinations and the information provided by the applicant. Thus, cooperation of educational institutions, accrediting bodies, credentialing organizations, regulators and licensees is essential to produce the best result for the health care of the public. Support for communication among these organizations for the sake of public protection is an ongoing goal of NCSBN.

Report of the APRN Compact Development Subcommittee

Recommendations to the Delegate Assembly

Adopt the Advanced Practice Registered Nurse Compact.

Rationale
The basis of the development of the Advanced Practice Registered Nurse (APRN) Compact was the approval in December 1997 by the Delegate Assembly "to approve the proposed language for an interstate compact in support of a standard approach to a mutual recognition model of nursing regulation." This motion was passed during a special session of the delegates at which time the Strategies for Implementation of the Mutual Recognition Model of Nursing Regulation were also approved. The decision to accept the mutual recognition model of nursing regulation was made with the understanding that development of an APRN Compact would proceed at a later date and as a separate compact than that for Registered Nurses and Licensed Practical Nurses/Vocational Nurses.

Prior to the special session and after a great deal of thought and deliberation, the Board of Directors endorsed a mutual recognition model of regulation for all levels of nursing to be implemented with appropriate time lines. However, the Board of Directors recognized that the issues surrounding the regulation of advanced nursing practice had not been adequately studied to bring forth a proposal at the 1997 Delegate Assembly.

Members of the Board of Directors supported the inclusion of APRNs into a mutual recognition model of regulation. However, some states indicated an inability to sign an interstate compact that includes APRNs because of the current non-standard manner in which APRNs are regulated and defined. Therefore, the decision to accept the mutual recognition model of nursing regulation was made with the understanding that APRN regulation would proceed, but according to a different time line and separate compact language than that for Registered Nurses and Licensed Practical Nurses/Vocational Nurses.

Following that decision, an Advanced Practice Task Force was formed in 1999 to develop uniform licensure requirements for advanced practice regulation. These requirements were developed with input from NCSBN membership and APRN certifying bodies and other APRN nursing organizations. The *Uniform APRN Licensure/Authority to Practice Requirements (Attachment A)* complemented the Uniform Core Licensure Requirements for RNs and LPNs developed by the 1999 Nursing Practice and Education Committee and adopted by the 1999 Delegate Assembly. The unprecedented process of negotiation of the *Uniform APRN Licensure/Authority to Practice Requirements* with the certifying bodies and other nursing organizations was completed more than two years ago after careful study and with significant input from NCSBN members. The *Uniform APRN Licensure/Authority to Practice Requirements* were subsequently adopted by the 2000 Delegate Assembly to establish the foundation for an APRN interstate compact and to promote quality, consistency and accessibility of advanced practice nursing care within the state and across state lines.

The *Uniform APRN Licensure/Authority to Practice Requirements* approved by the 2000 Delegate Assembly establish the foundation for the APRN Compact in order to promote quality, consistency and accessibility of advanced practice nursing care within states and across state lines.

Subcommittee Members

Laura Poe, Executive Director, UT, Area I, Chairperson

Kimberly Boothby-Ballantyne, Board Member, ME, Area IV

James Johnston, Board General Counsel, TX-RN, Area III

Fred Knight, Board General Counsel, AR, Area III

Katherine Thomas, Executive Director, TX-RN, Area III

Board Liaison
Deborah Bohannon-Johnson, Board President, ND, Area II Director

Staff
Donna Nowakowski, Associate Executive Director for Nursing Regulation

Relationship to Strategic Plan

Strategic Initiative 2 – Regulatory Effectiveness:: The National Council will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome 4: Approaches and resources assist Member Boards in the regulation of advanced practice registered nurses.

Outcome 7: National Council supports, monitors and evaluates the implementation of the mutual recognition model.

Meeting Dates

- October 17, 2001 (teleconference call)
- November 26-27, 2001
- January 14-15, 2002
- February 25, 2002 (teleconference call)
- April 26-27, 2002

Attachments

A. *Uniform APRN Licensure/ Authority to Practice Requirements*
B. Proposed Final Draft APRN Compact
C. Call for comments letters regarding the APRN Compact
D. Proposed Uniform APRN Licensure/Authority to Practice Requirements (Supporting Paper)
E. Strategic Outline for Implementation Plan
F. Summary of Benefits, Limitations and Barriers to the APRN Compact
G. Common Questions about the APRN Compact

The subcommittee concluded the most significant differences among states and across the four categories of APRNs centered around two scope of practice issues: prescriptive authority and collaborative agreements with physicians. Therefore, the proposed APRN Compact does not address scope of practice issues in light of these differences.

Background of the APRN Compact Development Subcommittee

The APRN Compact Development Subcommittee was charged by the Board of Directors to develop the APRN compact model for consideration by the 2002 Delegate Assembly. The Board of Directors further instructed the subcommittee to include the recommendations of the APRN Task Force member feedback and the opinions of external stakeholders in its deliberations.

The APRN Compact Development Subcommittee approached its charge by reviewing existing regulatory practices regarding APRNs and conducting a member survey November 2001. This information was necessary to understand the extent of and specific state differences in the regulation of advance practice nurses. The subcommittee concluded the most significant differences among states centered around two scope of practice issues: prescriptive authority and collaborative agreements with physicians.

The subcommittee prepared several drafts of the APRN Compact. During its deliberations, the subcommittee established the following premises regarding the proposed APRN Compact *(Attachment B)*:

1. The APRN compact model will be based on the Nurse Licensure Compact to the extent feasible, but will be a separate compact.
2. The *APRN Uniform Licensure/Authority to Practice Requirements* forms the basis of the APRN Compact.
3. Boards of nursing seeking to implement the APRN Compact must also implement the Nurse Licensure Compact.
4. The APRN Compact would apply to the broadest definition of APRN and include the four APRN categories. States would need to determine the categories included in the Compact based on the state definition of APRN and their state authority.
5. Scope of practice issues would not be addressed in the APRN Compact in light of the differences in requirements existing in some states.

The APRN Compact was presented to the Nurse Licensure Compact Administrators (NLCA) at the March 2002 meeting. Although the NLCA concurred with the subcommittee assessment of the differences in the regulation of APRN across states, the group agreed with the importance of the APRN Compact as a means to promote uniformity in essential requirements. NLCA members indicated that the adoption of the APRN Compact was the necessary step to states' adoption of the *APRN Uniform Licensure/Authority to Practice Requirements*.

On April 9, 2002, a call for comments regarding the APRN Compact was distributed to NCSBN members and external nursing organization colleagues *(Attachments C & D)*. The purpose of this request was to elicit review and comment on the APRN Compact and to seek opinions regarding outstanding issues.

On April 25, 2002, the APRN Roundtable provided for a discussion of the APRN Compact with members of the APRN Task Force, APRN Compact Development Subcommittee and external organizations. Following a comprehensive overview by the subcommittee chair, Laura Poe, the discussion centered upon questions for clarification with several sections of the draft. There were a

few substantive changes suggested and several participants requested additional time to review and seek endorsement of their organizations. However, the response was overwhelmingly positive in favor of the APRN Compact.

The subcommittee completed the final draft of the APRN Compact in April 2002 by making minor edits to address the comments and questions voiced at the APRN Roundtable. As drafted, an estimated 10 to 12 states are currently eligible to enact the compact based upon the foundational premises of having enacted the Nurse Licensure Compact and having adopted the *APRN Uniform Licensure/ Authority to Practice Requirements*.

In approaching the remainder of its charge, the subcommittee developed an outline for the implementation plan and two additional resource documents. This was accomplished by considering the language in the draft APRN Compact, assessing the state of regulation of the APRN, and review of input received from members, the NLCA and APRN groups.

Highlights of FY02 Activities

- Conducted and analyzed findings of two membership surveys regarding APRN regulation.
- Drafted an APRN Compact to implement the mutual recognition model for APRNs.
- Developed the Strategic Outline for its Implementation Plan *(Attachment E)*.
- Drafted the Summary of Benefits, Limitations and Barriers to the APRN Compact document *(Attachment F)*.
- Compiled Common Questions regarding the APRN Compact document for member and stakeholder use *(Attachment G)*.
- Developed an initial version of a PowerPoint presentation regarding the APRN Compact that can be used as a member resource.

Future Activities

- Complete recommendations for an implementation plan to the Board of Directors.
- Develop necessary resources to support Member Boards.
- Develop information for stakeholder education.
- Prepare a detailed document comparing any variations in regulatory requirements for APRNs across states.

APRN Compact Development – Attachment A

Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements[1]

Adopted August 12, 2000

APRN Uniform Requirements – U.S.-Educated, Initial

1. Licensed RN (unencumbered).
2. Graduated from or completed a graduate level APRN program accredited by a national accrediting body by 2003.
3. Currently certified by national certifying body in the APRN specialty appropriate to educational preparation.
4. For applicants for whom there is no appropriate certifying exam available, states may develop alternate mechanisms to assure initial competence. (This clause is being considered for amendment by the 2002 Delegate Assembly).

APRN Uniform Requirements – Renewal

1a. Maintain national certification in the appropriate APRN specialty through an ongoing certification maintenance program of a nationally recognized certifying body, **OR**

1b. Applicants for whom no recognized certification is available must participate in a competence maintenance program.

APRN Uniform Requirements – Foreign-Educated

1. Same as U.S.-educated/initial criteria, except the APRN educational program must meet criteria for accreditation equivalent to that of a national accrediting body.

APRN Uniform Requirements – Endorsement

1. Licensed as RN (unencumbered), **AND**
2. APRN licensure/authority to practice unencumbered in another jurisdiction, **AND**
3. Currently certified by a national certifying body in the APRN specialty appropriate to the educational preparation or authorized to practice as an APRN in another jurisdiction through a mechanism to ensure initial competence when no appropriate certification exam is available, **AND**

4a. Meets educational requirements for initial licensure/authorization to practice **OR**

4b. Demonstrates successful completion of approved APRN certificate program prior to 2003.

APRN Uniform Requirements–Re-Entry into Practice

None.

[1]*The **mechanism of legal recognition** can be any of the various ones used by states to authorize advanced practice, e.g., certificate of authority, licensure, or recognition.*

APRN Compact Development – Attachment B

Proposed Final Draft: Advanced Practice Registered Nurse Compact

ARTICLE I
Findings and Declaration of Purpose

a. The party states find that:
   1. The health and safety of the public are affected by the degree of compliance with APRN licensure/authority to practice requirements and the effectiveness of enforcement activities related to state APRN licensure/authority to practice laws;
   2. Violations of APRN licensure/authority to practice and other laws regulating the practice of nursing may result in injury or harm to the public;
   3. The expanded mobility of APRNs and the use of advanced communication technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of APRN licensure/authority to practice and regulation;
   4. New practice modalities and technology make compliance with individual state APRN licensure/authority to practice laws difficult and complex;
   5. The current system of duplicative APRN licensure/authority to practice for APRNs practicing in multiple states is cumbersome and redundant to both APRNs and states;
   6. Uniformity of APRN requirements throughout the states promotes public safety and public health benefits; and
   7. Access to APRN services increases the public's access to health care, particularly in rural and underserved areas.

b. The general purposes of this Compact are to:
   1. Facilitate the states' responsibilities to protect the public's health and safety;
   2. Ensure and encourage the cooperation of party states in the areas of APRN licensure/authority to practice and regulation including promotion of uniform licensure requirements;
   3. Facilitate the exchange of information between party states in the areas of APRN regulation, investigation and adverse actions;
   4. Promote compliance with the laws governing APRN practice in each jurisdiction; and
   5. Invest all party states with the authority to hold an APRN accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses.

ARTICLE II
Definitions

As used in this Compact:
a. "Advanced Practice Registered Nurse" or "APRN" means a Nurse Anesthetist; Nurse Practitioner; Nurse Midwife; or Clinical Nurse Specialist to the extent a party state licenses or grants authority to practice in that APRN role and title.
b. "Adverse Action" means a home or remote state disciplinary action.
c. "Alternative program" means a voluntary, non-disciplinary monitoring program approved by a licensing board.

d. "APRN Licensure/Authority to Practice" means the regulatory mechanism used by a party state to grant legal authority to practice as an APRN.
e. "APRN Uniform Licensure/Authority to Practice Requirements" means those agreed upon minimum uniform licensure, education and examination requirements adopted by licensing boards for the recognized APRN role and title.
f. "Coordinated licensure information system" means an integrated process for collecting, storing and sharing information on APRN licensure/authority to practice and enforcement activities related to APRN licensure/authority to practice laws, which is administered by a non-profit organization composed of and controlled by state licensing boards.
g. "Current significant investigative information" means:
    1. Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the APRN to respond if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or
    2. Investigative information that indicates that the APRN represents an immediate threat to public health and safety regardless of whether the APRN has been notified and had an opportunity to respond.
h. "Home state" means the party state that is the APRN's primary state of residence.
i. "Home state action" means any administrative, civil, equitable or criminal action permitted by the home state's laws which are imposed on an APRN by the home state's licensing board or other authority including actions against an individual's license/authority to practice such as: revocation, suspension, probation or any other action which affects an APRN's authorization to practice.
j. "Licensing board" means a party state's regulatory body responsible for issuing APRN licensure/authority to practice.
k. "Multistate advanced practice privilege" means current, authority from a remote state permitting an APRN to practice in that state in the same role and title as the APRN is licensed/authorized to practice in the home state to the extent that the remote state laws recognize such APRN role and title. A remote state has the authority, in accordance with existing state due process laws, to take actions against the APRN's privilege, including revocation, suspension, probation, or any other action that affects an APRN's multistate privilege to practice.
l. "Party state" means any state that has adopted this Compact.
m. "Prescriptive authority" means the legal authority to prescribe medications and devices as defined by party state laws.
n. "Remote state" means a party state, other than the home state:
    1. Where the patient is located at the time APRN care is provided, or,
    2. In the case of APRN practice not involving a patient, in such party state where the recipient of APRN practice is located.
o. "Remote state action" means:
    1. Any administrative, civil, equitable or criminal action permitted by a remote state's laws which are imposed on an APRN by the remote state's licensing board or other authority including actions against an individual's multistate advanced practice privilege in the remote state, and
    2. Cease and desist and other injunctive or equitable orders issued by remote states or the licensing boards thereof.
p. "State" means a state, territory, or possession of the United States.
q. "State practice laws" means a party state's laws and regulations that govern APRN practice, define the scope of advanced nursing practice including prescriptive authority, and create the methods and grounds for imposing discipline. State practice laws do not include the requirements necessary to obtain

and retain APRN licensure/authority to practice as an APRN, except for qualifications or requirements of the home state.

r. "Unencumbered" means that a state has no current disciplinary action against an APRN's license/authority to practice.

ARTICLE III
General Provisions and Jurisdiction

a. All party states shall participate in the Nurse Licensure Compact for registered nurses and licensed practical/vocational nurses in order to enter into the APRN Compact.

b. No state shall enter the APRN Compact until the state adopts, at a minimum, the APRN Uniform Licensure/Authority to Practice Requirements for each APRN role and title recognized by the state seeking to enter the APRN Compact.

c. APRN Licensure/Authority to practice issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate advanced practice privilege to the extent that the role and title are recognized by each party state. To obtain or retain APRN licensure/authority to practice as an APRN, an applicant must meet the home state's qualifications for authority or renewal of authority as well as all other applicable state laws.

d. The APRN multistate advanced practice privilege does not include prescriptive authority, and does not affect any requirements imposed by states to grant to an APRN initial and continuing prescriptive authority according to state practice laws. However, a party state may grant prescriptive authority to an individual on the basis of a multistate advanced practice privilege to the extent permitted by state practice laws.

e. A party state may, in accordance with state due process laws, limit or revoke the multistate advanced practice privilege in the party state and may take any other necessary actions under the party state's applicable laws to protect the health and safety of the party state's citizens. If a party state takes action, the party state shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

f. An APRN practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time care is provided. The APRN practice includes patient care and all advanced nursing practice defined by the party state's practice laws. The APRN practice will subject an APRN to the jurisdiction of the licensing board, the courts, and the laws of the party state.

g. Individuals not residing in a party state may apply for APRN licensure/authority to practice as an APRN under the laws of a party state. However, the authority to practice granted to these individuals will not be recognized as granting the privilege to practice as an APRN in any other party state unless explicitly agreed to by that party state.

ARTICLE IV
Applications for APRN Licensure/Authority to Practice in a Party State

a. Once an application for APRN licensure/authority to practice is submitted, a party state shall ascertain, through the Coordinated Licensure Information System, whether:
   - The applicant has held or is the holder of a nursing license/authority to practice issued by another state;

- The applicant has had a history of previous disciplinary action by any state;
- An encumbrance exists on any license/authority to practice; and
- Any other adverse action by any other state has been taken against a license/authority to practice.

This information may be used in approving or denying an application for APRN licensure/authority to practice.

b. An APRN in a party state shall hold APRN licensure/authority to practice in only one party state at a time, issued by the home state.
c. An APRN who intends to change primary state of residence may apply for APRN licensure/authority to practice in the new home state in advance of such change. However, new licensure/authority to practice will not be issued by a party state until after an APRN provides evidence of change in primary state of residence satisfactory to the new home state's licensing board.
d. When an APRN changes primary state of residence by:
   1. Moving between two party states, and obtains APRN licensure/authority to practice from the new home state, the APRN licensure/authority to practice from the former home state is no longer valid.
   2. Moving from a non-party state to a party state, and obtains APRN licensure/authority to practice from the new home state, the individual state license issued by the non-party state is not affected and will remain in full force if so provided by the laws of the non-party state.
   3. Moving from a party state to a non-party state, the APRN licensure/authority to practice issued by the prior home state converts to an individual state license, valid only in the former home state, without the multistate licensure privilege to practice in other party states.

ARTICLE V
Adverse Actions

In addition to the General Provisions described in Article III, the following provisions apply:

a. The licensing board of a remote state shall promptly report to the administrator of the coordinated licensure information system any remote state actions including the factual and legal basis for such action, if known. The licensing board of a remote state shall also promptly report any significant current investigative information yet to result in a remote state action. The administrator of the coordinated licensure information system shall promptly notify the home state of any such reports.
b. The licensing board of a party state shall have the authority to complete any pending investigations for an APRN who changes primary state of residence during the course of such investigations. It shall also have the authority to take appropriate action(s), and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.
c. A remote state may take adverse action affecting the multistate advanced practice privilege to practice within that party state. However, only the home state shall have the power to impose adverse action against the APRN licensure/authority to practice issued by the home state.
d. For purposes of imposing adverse action, the licensing board of the home state shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, it shall apply its own state laws to determine appropriate action.

e. The home state may take adverse action based on the factual findings of the remote state, so long as each state follows its own procedures for imposing such adverse action.
f. Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the party state's laws. Party states must require APRNs who enter any alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from such other party state.
g. All home state licensing board disciplinary orders, agreed or otherwise, which limit the scope of the APRN's practice or require monitoring of the APRN as a condition of the order shall include the requirements that the APRN will limit her or his practice to the home state during the pendency of the order. This requirement may allow the APRN to practice in other party states with prior written authorization from both the home state and party state licensing boards.

ARTICLE VI
Additional Authorities Invested in Party State Licensing Boards

Notwithstanding any other powers, party state licensing boards shall have the authority to:

a. If otherwise permitted by state law, recover from the affected APRN the costs of investigations and disposition of cases resulting from any adverse action taken against that APRN;
b. Issue subpoenas for both hearings and investigations, which require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located;
c. Issue cease and desist orders to limit or revoke an APRN's privilege or licensure/authority to practice in their state; and
d. Promulgate uniform rules and regulations as provided for in Article VIII(c).

ARTICLE VII
Coordinated Licensure Information System

a. All party states shall participate in a cooperative effort to create a coordinated database of all APRNs. This system will include information on the APRN licensure/authority to practice and disciplinary history of each APRN, as contributed by party states, to assist in the coordination of APRN licensure/authority to practice and enforcement efforts.
b. Notwithstanding any other provision of law, all party states' licensing boards shall promptly report adverse actions, actions against multistate advanced practice privileges, any current significant investigative information yet to result in adverse action, denials of applications, and the reasons for such denials, to the coordinated licensure information system.
c. Current significant investigative information shall be transmitted through the coordinated licensure information system only to party state licensing boards.
d. Notwithstanding any other provision of law, all party states' licensing boards contributing information to the coordinated licensure information system may

designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.

e. Any personally identifiable information obtained by a party states' licensing board from the coordinated licensure information system may not be shared with non-party states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.
f. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information, shall also be expunged from the coordinated licensure information system.
g. The Compact administrators, acting jointly with each other and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this Compact.

ARTICLE VIII
Compact Administration and Interchange of Information

a. The head of the licensing board, or his/her designee, of each party state shall be the administrator of this Compact for his/her state.
b. The Compact administrator of each party state shall furnish to the Compact administrator of each other party state any information and documents including, but not limited to, a uniform data set of investigations, identifying information, licensure data, and disclosable alternative program participation information to facilitate the administration of this Compact.
c. Compact administrators shall have the authority to develop uniform rules to facilitate and coordinate implementation of this Compact. These uniform rules shall be adopted by party states, under the authority invested under Article VI (d).

ARTICLE IX
Immunity

No party state or the officers or employees or agents of a party state's licensing board who acts in accordance with the provisions of this Compact shall be liable on account of any act or omission in good faith while engaged in the performance of their duties under this Compact. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness.

ARTICLE X
Entry into Force, Withdrawal and Amendment

a. This Compact shall enter into force and become effective as to any state when it has been enacted into the laws of that state. Any party state may withdraw from this Compact by enacting a statute repealing the same, but no such withdrawal shall take effect until six months after the withdrawing state has given notice of the withdrawal to the executive heads of all other party states.
b. No withdrawal shall affect the validity or applicability by the licensing boards of states remaining party to the Compact of any report of adverse action occurring prior to the withdrawal.
c. Nothing contained in this Compact shall be construed to invalidate or prevent any APRN licensure/authority to practice agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.

d. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

ARTICLE XI
Construction and Severability

a. This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any state party thereto, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.
b. In the event party states find a need for settling disputes arising under this Compact:
   1. The party states may submit the issues in dispute to an arbitration panel which will be comprised of an individual appointed by the Compact administrator in the home state; an individual appointed by the Compact administrator in the remote state(s) involved; and an individual mutually agreed upon by the Compact administrators of all the party states involved in the dispute.
   2. The decision of a majority of the arbitrators shall be final and binding.

Approved by the NCSBN Board of Directors, May 3, 2002
To be considered by the NCSBN Delegate Assembly August 2002

The following two letters were printed on NCSBN letterhead.

APRN Compact Development – Attachment C

Call for Comments – Letters Regarding the APRN Compact

April 9, 2002
Dear Executive Officer:

The purpose of this letter is to request your review and comment regarding a draft APRN Compact developed in accordance with the intent of work begun in 1997 to develop uniform requirements that would be compatible with an APRN mutual recognition model.

In September 2001, the National Council of State Boards of Nursing Board of Directors appointed a committee to develop an Advanced Practice Registered Nurse (APRN) Compact and an action plan for its' implementation. NCSBN members and many important stakeholders from national advanced practice organizations identified the need for an APRN Compact. Previous work of the NCSBN in collaboration with these stakeholders resulted in the development of the *Uniform APRN Licensure/Authority to Practice Requirements*, subsequently adopted by the NCSBN Board of Directors and Delegate Assembly August 2000.

It is important to present to you information regarding the foundational premises reflected in the draft compact and articulation of the outstanding and challenging issues that remain. The subsequent paragraphs will provide that for you. A supporting paper developed for the *Uniform APRN Licensure/Authority to Practice Requirements* is also attached and provides pertinent historical background.

Premises:

1. **Any state that enacts the APRN Compact must have adopted the *APRN Licensure/Authority to Practice Requirements*.**

   Rationale: In order for the mutual recognition model to be implemented, there must be agreed upon core, uniform requirements to reduce variability in regulation of APRNs across states. New practice modalities and technology make compliance with individual state APRN licensure/authority to practice laws difficult and complex. Uniformity of APRN requirements throughout the states promotes public safety and public health benefits. These requirements provide the most rational approach for assuring public safety as well as APRN mobility. Further, these requirements have been developed collaboratively with APRNs, APRN certifying bodies and APRN professional organizations and adopted by the NCSBN.

2. **The APRN Compact is based upon and has language similar to that of the Nurse Licensure Compact (NLC) to the extent appropriate.**

   Rationale: Consistency of both compacts will promote understanding and the APRN Compact benefits from the wisdom of developers of the NLC.

3. **Any state that enacts the APRN Compact must have also adopted the Nurse Licensure Compact.**

   Rationale: Enactment of the APRN Compact following of the implementation NLC will significantly assist in transitional and implementation issues of the APRN Compact and will promote consistency in regulation and grant the same privileges to all nurses within a given state.

4. Due to significant variation in state requirements for APRN licensing, those elements posing the greatest differences and compromise the uniformity of requirements are excluded from the compact.

Rationale: The political landscape of each state, differences among states, and varying cycles of enactment and implementation of many provisions in act and rule necessitate excluding certain elements. The most notable are prescriptive authority (requirements for initial/continued recognition, level of authority, controlled substances) and physician involvement/non-involvement for advanced practice (prescriptive authority, practice protocols, supervision, consultation, guidelines). Additionally, states differ widely in requirements for regulation of the four categories of APRNs regarding these critical elements.

The original plan contemplated a recommendation to the NCSBN Board of Directors and Delegate Assembly in 2002. However, a decision regarding this has not yet been made. It is essential to provide sufficient opportunity and time for feedback from members and stakeholders and to address several critical, outstanding issues. These outstanding issues include:

1. Those referenced in premise number four above pertaining to variations in prescriptive authority requirements and physician involvement. Will exclusion of these elements provide a compact of sufficient value and one that will achieve the benefits intended?
2. The limited number of states eligible to enter into the APRN Compact as currently drafted (those that have enacted the NLC and have adopted the *Uniform APRN Licensure/Authority to Practice Requirements*.
3. Issues and concerns about fairness and equivalency as they pertain to different implementation years of the *Uniform APRN Licensure/Authority to Practice Requirements*. For example, if a state begins requiring the graduate degree after January 1, 2003, how does that impact and potentially advantage advanced practice nurses eligible to be "grand fathered" in those states? What are the legal implications of granting the privilege to some nurses who do not meet the uniform requirements?

Attached is the draft of the APRN Compact for public comment. I ask for your thorough review of the document, consideration of its implementation implications, and your general opinion regarding whether your organization and/or board can support this model for regulation of advance practice nurses. Additionally, feedback regarding the outstanding issues and the means to address them will be appreciated.

On behalf of NCSBN, its Board of Directors, and APRN Compact Development Subcommittee, I thank you in advance for your consideration and candid input.

Sincerely,
Donna Nowakowski, MS, RN, CAE
Associate Executive Director for Nursing Regulation

cc: Board of Directors

Attachments to this letter included:

Final Draft APRN Compact
Summary of Benefits, Limitations and Barriers to the APRN Compact

May 17, 2002

Dear Executive Officers:

The purpose of this letter is to request your review and organization endorsement of the final draft of the Advanced Practice Registered Nurse (APRN) Compact developed by the National Council of State Boards of Nursing (NCSBN) APRN Compact Development Subcommittee. Previously, you were sent a letter dated April 9, 2002, requesting your review and comment on an initial comment draft.

The attached final draft has been slightly modified as a result of the comments received from the NCSBN membership and those voiced at the APRN roundtable held April 25, 2002. The changes were made to elucidate language that was unclear and to assure technical accuracy.

On May 3, 2002, the NCSBN Board of Directors approved the recommendation of the APRN Compact for consideration by the 2002 Delegate Assembly. In light of the abbreviated comment period provided previously and changes made since your last review, NCSBN now provides a second opportunity for comment. The Subcommittee will contemplate any additional comments received and if changes are made, present an amended version to the NCSBN Board of Directors and Delegate Assembly.

The foundational premises reflected in the initial draft compact remain in this final draft version. To reiterate the important decisions regarding the drafting of the APRN Compact, the premises are summarized as follows:

1. Any state that enacts the APRN Compact must have adopted the *APRN Licensure/ Authority to Practice Requirements*.
2. The APRN Compact is based upon and has language similar to that of the Nurse Licensure Compact (NLC) to the extent appropriate.
3. Any state that enacts the APRN Compact must have also adopted the Nurse Licensure Compact.
4. Due to significant variation in state requirements for APRN licensing, those elements posing the greatest differences are excluded from the compact, those being scope of practice (prescriptive authority) and collaborative practice agreements.

Attached is the final draft of the APRN Compact for public comment. The deadline for public comment is **July 12, 2002**. All feedback received will be seriously considered. We also would encourage and appreciate you sharing and discussing the APRN Compact draft with your Board, staff, and constituents. Of course, delegates will be provided additional and ample opportunity for comment continuing through the annual meeting of the Delegate Assembly.

The original draft and attachments previously sent to you are not included here, but are available upon request. The final version and all attachments will be included in the NCSBN 2002 Annual Meeting Business Book and posted to the NCSBN web site in the near future. The APRN Compact presentation will be held at the 2002 Annual Meeting on Thursday morning, August 15, 2002.

On behalf of NCSBN, its Board of Directors, and the APRN Compact Development Subcommittee, I thank you for your support, consideration and input in the development of the APRN Compact. You may contact me directly at (312) 787-6555, ext. 141 or e-mail dnowakowski@ncsbn.org.

Sincerely,
Donna Nowakowski, MS, RN, CAE
Associate Executive Director for Nursing Regulation

cc: Board of Directors

APRN Compact Development – Attachment D

Proposed Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements

A Supporting Paper

Background

Professional licensure requirements assure that the individuals who are granted the authority to practice nursing have demonstrated specified educational, examination and behavioral requirements. The purpose of developing uniform core licensure requirements is to assure mobility of licensed nurses while maintaining licensure standards critical to protect the public health, safety and welfare. In light of concerns that licensure sometimes erects unnecessary barriers, public protection should be viewed to include adequate access to nursing services. Facilitating nurse mobility assures that health care consumers have access to nursing services and that these providers are qualified according to consistent standards regardless of where in the country the consumer lives.

Increased consistency in licensure requirements is an appropriate direction for regulation in a rapidly shrinking world. The opportunities for sharing of information and resources via communication and travel have produced an evolution of nursing practice standards from local practices that varied greatly to standards that are much more alike than different in all the regions of the nation. Uniform requirements would be less confusing for patients, nurses, other health team members and third party payors as well as legislators and policy makers.

The 1999 National Council of State Boards of Nursing (NCSBN) adopted Uniform Core Licensure Requirements for RNs and LPN/VNs developed by the Nursing Practice and Education Committee (NP&E) Committee. However, unlike the licensure requirements for RNs and LPN/VNs that were found to be similar with a few outlier elements, both APRN requirements and approaches to APRN regulation vary widely from state-to-state and even among APRN categories within a state. More work was needed to both identify appropriate requirements and build consensus toward the acceptance of these standards. For these reasons, Advanced Practice Registered Nurses (APRN) were not included in this first phase development of uniform licensure requirements and were not included in the Nurse Licensure Compact.

NCSBN has recognized the need to include Advanced Practice Registered Nurses (APRNs) in multistate regulation because of the importance of the APRN role in the continuum of nursing practice and the public's need for access to this critical nursing resource. APRNs are increasingly engaged in multistate practice. Like other nurses, APRNs are employees of staffing agencies, managed care organizations and integrated delivery systems that require physical travel across state lines or practice by telecommunications technology. However, to the consternation of many who saw the potential benefits of mutual recognition for APRNs, NCSBN moved forward with a compact for RN/LPN practice, with the intention of developing a separate mechanism for APRN practice as soon as possible.

Indeed, work was already under way in 1997 as the APRN Task Force began to develop uniform requirements that would be compatible with an APRN mutual recognition model. The APRN Task Force believed that, in the face of the

impact of significant regulatory change, inclusion of APRN professional organizations in the development of these requirements was essential. Five meetings were held between December 1997 and December 1998, in Chicago, San Diego and Washington, DC. Representatives from APRN professional groups including accrediting and certifying bodies, specialty organizations and general nursing organizations were invited to participate in these meetings for the purpose of developing uniform requirements. Draft requirements were also shared with Boards of Nursing and presented for the first time at a 1998 Delegate Assembly Forum.

The APRN Task Force continued their work and again brought the APRN Licensure/Authority to Practice Requirements documents to the 1999 Annual Meeting for discussion. Since then, the proposed requirements were addressed at the 2000 Advanced Practice Roundtable sponsored by NCSBN. The 2000 APRN Task Force and the 2000 NP&E Committee considered the comments and feedback received from these sources. Both groups recommended to the Board of Directors that the Proposed Requirements be presented to the 2000 Delegate Assembly for adoption.

Premises

The premises developed by the 1999 NP&E Committee for the Uniform Core Requirements for RNs and LPN/VNs also provide a foundation for consideration of the proposed APRN requirements.

1. It is critical to focus on what the public needs.
2. It is desirable to divide the huge challenge of uniform licensure requirements into manageable portions.
3. It is crucial to avoid simply choosing the least common denominator. The elements selected for inclusion in the uniform requirements must provide the most rational approach for assuring public safety as well as APRN mobility.
4. It is essential that Member Boards continue to be responsible for verification that individual licensure applicants meet these uniform requirements.
5. It is assumed that boards that approve the proposed requirements will accept any reasonable approach selected by a board of nursing for conducting verification of these requirements. The mechanism of legal recognition can be any of the various ones used by states to authorize advanced practice, e.g., certificate of authority, licensure, or recognition.
6. The underlying goal is to promote public safety in the least restrictive manner.
7. Participation of APRNs, APRN certifying bodies and APRN professional organizations in the development of these requirements is essential.

Summary of Uniform APRN Licensure/Authority to Practice Requirements

A summary of requirements with rationale and comments is attached to this paper.

Discussion

A strength of the proposed requirements is the collaborative process that was used to develop them, which included APRNs, APRN certifying bodies and APRN professional organizations. The input of APRN groups was invaluable and helped move the requirements forward. While complete consensus was not achieved (in particular, the certified nurse midwife groups had reservations regarding the graduate education requirements) there was a positive "sense of the group" in that a majority of the participating APRN liaison organizations agreed. In supporting

the Uniform Licensure/Authority to Practice Requirements, the participating organizations did not necessarily support the concept of an interstate compact.

It was discovered during analysis of 1999 NP&E Committee survey responses (regarding RN and LPN/RN licensure requirements) a board might have one or two elements that were outliers of the majority of boards. But no board had *only* the most restrictive or *only* the least restrictive licensing requirements. The NP&E Committee believed that this reflected the impact of board experience on regulatory activities. Certain elements become a focus, an issue, or a cause because of a difficult case, a particular interested legislator, or a specific board member's agenda. In other words, outliers are more likely to reflect that board's history and tradition than rational inquiry and decision-making. And if history and tradition played a role in RN and LPN/VN licensure, the story of advanced nursing practice in this country has been one of looking for opportunities to demonstrate the competency and effectiveness of advanced practice. This history largely accounts for the variation in requirements and regulatory approaches.

Consistency and uniformity in standards and licensing requirements make sense. The practice arena is very different than at the time when administrative agencies and professional licensing were created. Nurses and patients are more mobile, and communication and travel that used to require days and weeks now takes seconds, minutes and hours. While there is still variation in how advanced practice is regulated, one has only to look at how advanced practice and advanced practice regulation have evolved in the last ten years to recognize that there is less regional variation than a decade ago.

It is true that the proposed uniform APRN licensure/authority to practice requirements may require legislation in some states. In fact, moving toward uniform requirements will cause some discomfort. However, the focus should be on what is best for the public good. The 1999 NP&E Committee posed a pivotal question to the delegates who adopted the RN and LPN/VN uniform licensure requirements. This question is again timely for individuals cautious about giving up time-honored APRN traditions: *Do you really think that advanced practice nursing is really that much different, that much safer on your side of the state boundary line?*

Conclusion

In 1999, the NCSBN Delegate Assembly made history when it adopted uniform licensure requirements for RNs and LPN/VNs. There continue to be three things needed to achieve uniform licensure/authority to practice requirements in the United States:

- Willingness to place emphasis on the public good.
- Willingness to compromise.
- Willingness to trust other boards.

Boards of nursing take their responsibility very seriously. For a board with a more restrictive element, it is difficult to give up some aspect of control, to trust another board's experience and judgment. But it is critical to focus on what are the minimal, essential requirements for licensure and authority to practice, and achieve public protection through the least restrictive means. The NP&E Committee and the APRN Task Force respectfully recommend that the Delegate Assembly complete the work started last year: that the Delegate Assembly adopts the proposed *Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements*.

**This paper was prepared in August 2000 to support the consideration of the Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements.*

APRN Compact Development – Attachment E

Strategic Outline for Implementation Plan

1. Conduct Phase 2 of the call for comments pending the Board of Directors approval of the current compact draft and a decision about consideration by the 2002 Delegate Assembly.
2. Seek endorsements once the APRN Compact is approved.
3. Work though and provide possible implementation scenarios based on individual state variations in regulations and processes.
4. Continue to monitor state issues, comments, and work through implementation challenges.
5. Resolve any identified outstanding issues.
6. Develop a comprehensive implementation guideline and resource for states' use.
7. Begin preliminary work on the rules.
8. Conform the *APRN Uniform Licensure/Authority to Practice Requirements* to the compact rules (i.e. clarify states can adopt requirements regardless of the date certain to require the graduate degree).
9. Prepare education plan regarding how states define APRN in accordance with the boards' regulatory authority.
10. Compare state requirements regarding collaborative practice agreements and prescriptive practice, and assist NLCA to identify state differences and commonalities (APRN will follow state law where they are practicing unless states have entered into an agreement regarding equivalency in the rule; clarify that collaborative agreements are obtained in the *remote state* where practice occurs).
11. Consider the implications of a response from the Drug Enforcement Agency pending request for clarification regarding whether there is a need for more than one DEA number under an APRN Compact.
12. Develop recommendations for a communications and outreach strategy (build upon current resources for the Nurse Licensure Compact.

APRN Compact Development – Attachment F

A Summary of Benefits, Limitations and Barriers to the APRN Compact

Benefits

1. Promotes access to care for citizens, particularly those in rural and underserved areas.
2. Facilitates states' responsibility to protect the public's health and safety through the least restrictive means.
3. Promotes adoption of uniform APRN Licensure/Authority to Practice Requirements.
4. Promotes standardization of scope of practice including prescriptive authority.
5. Facilitates exchange of information between party states.
6. Promotes mobility of APRNs.
7. Facilitates access to APRNs to practice in states during times of disaster or other emergent situations.
8. Addresses the current APRN practice environment including telenursing.
9. Decreases redundant paperwork for APRNs and Licensing Authorities.
10. Decreases regulatory costs to APRNs.
11. The mutual recognition model decreases administrative costs by reducing duplicative application reviews, investigations and disciplinary actions.
12. Creates an unduplicated database of APRN information.

Limitations of the APRN compact

1. Results in a limited number of states eligible to participate secondary to the requirement to have passed the Nurse Licensure Compact and adopt the Uniform Requirements.
2. May result in loss of revenue from fees for Licensing Authorities.

Barriers to APRN Practice

1. APRNs will continue to receive prescriptive authority from each state in which they practice.
2. Variability across states still exists in laws and regulations.
3. Lack of uniform recognition of some categories of APRNs.
4. Federal requirements to procure separate DEA numbers for each state of practice.

APRN Compact Development – Attachment G

Common Questions about the Advanced Practice Registered Nurse (APRN) Compact

1. **What is the mutual recognition model?**
   The mutual recognition model of nurse licensure/authority to practice, would allow an APRN to have only one license/authority to practice in the home state (his or her state of residency) and practice in other party states (remote state) under a multistate privilege. The APRN is subject to each state's practice laws and discipline. In order to achieve mutual recognition, each state would have to enter into an interstate compact that allows APRNs to practice in more than one state.

2. **What is an interstate compact?**
   "An interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of multistate concern." (*Black's Law Dictionary*)
   An interstate compact:
   - supersedes state laws.
   - may be amended by all party states agreeing and then changing individual state laws.
   - is the mechanism to implement the APRN Compact.

3. **How many jurisdictions must enact a compact before it becomes effective?**
   A compact could be effective after only two jurisdictions enact it into law.

4. **Where does an APRN need to be licensed/authorized to practice?**
   The APRN must be licensed/authorized to practice in his or her primary state of residence. The primary state of residence is referred to as the home state. Any other party state in which the APRN practices is called a remote state. All APRN Compact states are "party states."

5. **How would primary residency for licensure/authority to practice purposes be determined?**
   The APRN Compact administrators would define primary residence in the compact rules and regulations. The sources used to verify primary residence may include, but are not limited to, driver's license, federal income tax return or voter registration.

6. **Why was residency, not practice location, used for determining jurisdiction?**
   The APRN Compact is similar to many other familiar activities based on state or place of residence, including obtaining a driver's license, paying taxes and voting. Given the many employment configurations in which APRNs work, there is likely to be less confusion about where an APRN resides than about the location of his or her primary state of practice. Tracking down an APRN in the event of a complaint/investigation would be more readily accomplished with a residence link, or address, than a practice, or employment, link.

7. **Why is an APRN limited to one license/authority to practice at a time?**
   The one license/authority to practice concept has a number of advantages including:
   - Reduces the barriers to interstate practice.
   - Improves tracking for disciplinary purposes.

- Promotes cost effectiveness and simplicity for the APRN.
- Creates an unduplicated listing of regulated APRNs.
- Facilitates interstate commerce.

An APRN practicing in a non-party state must be licensed/authorized to practice in that state.

8. **What is meant by APRN multistate licensure privilege?**
   APRN multistate licensure privilege means the authority to practice as an APRN in a remote state under the APRN compact. It is not an additional license/authority to practice.

9. **Will the APRN Compact model reduce the level of a state's licensure/authority to practice requirements?**
   No. Under the APRN Compact, a state that enacts the APRN Compact must have adopted, as a minimum, the Uniform APRN Licensure/Authority to Practice Requirements. This will create a minimum standard for licensure/authority to practice requirements, which reflect those requirements that have been recognized by the NCSBN Delegate Assembly and major APRN stakeholder groups. Also, states will continue to have authority in determining disciplinary actions on an APRN's license/authority to practice, per the state's laws and regulations.

10. **How does the APRN Compact address the varying scopes of APRN practice as authorized by each party state?**
    The APRN Compact provides that the APRN is held accountable for the APRN practice laws and other regulations in the state where the patient is located at the time care is rendered. This accountability is similar to the motor vehicle driver who must obey the driving laws in the state where he or she is driving. The accountability is no different from what is expected today.

11. **Does the APRN Compact affect the authority of the home state to discipline?**
    No. As provided in the APRN Compact, both the state of licensure ("home state") and state where the patient is located at the time the incident occurred ("remote state") may take disciplinary action and thus directly address the practice of the out-of-state APRN. The compact will not diminish current authority of the home state to discipline, but will actually enhance the home state's ability to discipline. The APRN Compact will enable exchange of investigatory information, allowing the home state to have the most current and accurate information to better determine the appropriate course of action.

12. **How would violations be reported and/or be processed under the APRN Compact?**
    Complaints would be addressed by the home state (place of residence) and the remote (practice) state. Complaints to the home state concerning a violation in the home state would be processed as is currently being done. A complaint to the home state concerning a violation in a remote state would be processed cooperatively. For example, the remote state may issue a cease and desist order to the APRN, and the home state may take disciplinary action against the license/authority to practice of that APRN. A complaint to the remote state concerning a violation in the remote state would be processed by the remote state and also reported to the home state.

13. **What is meant by home state action?**
    Home state action means any administrative, civil, or criminal action imposed against an APRN's license/authority to practice. Only the home state can take action against the license/authority to practice.

14. **What is meant by remote state action?**
Remote state action is a new authority provided by the APRN Compact. Remote state action is any administrative, civil, or criminal action imposed on an APRN by a remote state's licensure board or other authority, including actions against an APRN's multistate privilege to practice in the remote state.

15. **What disciplinary actions must a home state take based on a remote state action?**
The home state will evaluate the APRN's practice, which led to the remote action and will respond based on the laws of the home state. The home state is required by the APRN Compact to evaluate the APRN's practice in the same manner (i.e., "with the same priority and effect") as it would had the incident occurred in the home state, but the home state is not required to take any particular actions nor to enforce the remote state's laws.

16. **Concerning complaints, what information would be reasonably necessary to share with a party state?**
Each party state shares information or documents relevant to a current, significant investigation.

17. **Are there any situations in which an APRN is not allowed to practice in other party states?**
Under the APRN Compact, practice in other party states would be allowed unless:
    - The APRN is under board discipline or other agreement that restricts practice.
    - The APRN is participating in an alternative program for substance abuse or mental illness.
    - The party state does not recognize the role and title of that APRN.

18. **Will a state board have the authority to deny licensure/authority to practice by endorsement to an applicant who has had discipline action in another state?**
Yes. The licensing authority in the state where an application is made may choose not to license or authorize practice if the applicant does not meet the qualifications or standards for granting a license/authority to practice.

19. **Does the APRN Compact differ from the Nurse Licensure Compact (RN/LPN/VN) and does it include scope of practice issues?**
The proposed APRN Compact is based upon and has similar language to the Nurse Licensure Compact. The APRN Compact addresses licensure/authority to practice issues and does not affect scope of practice issues such as prescriptive authority.

20. **When will the APRN Compact be implemented?**
A general provision of the APRN Compact requires State legislatures to enact the Nurse Licensure Compact in order to enact the APRN Compact.

21. **How does enactment of the APRN Compact affect a state's current practice laws?**
The compact gives states additional authority in such areas as granting practice privileges, taking actions and sharing information with other party states.

22. **How does enactment of the APRN Compact affect the APRN?**
The APRN residing in a party state will be able to practice in all party states, unless there is a restriction placed on the APRN multistate privilege or the party state does not recognize the APRN role and title. The APRN residing

in a non-party state will continue to be licensed/authorized to practice in that state, just as at present.

23. **If an APRN lives in a party state and obtains a license/authority to practice in a non-party state, must she or he give up the license/authority to practice from the party state?**
No.The license/authority to practice from the home state allows the APRN to practice in all the party states. The license/authority to practice obtained from the non-party state would allow practice in just that state.

24. **The APRN Compact enables the APRN Compact administrators to develop rules and regulations to administer the compact. How do these rules and regulations provide authority in the individual party states?**
The APRN Compact is a legal contract between states that enables advanced nursing practice across state lines. In each state that adopts the APRN Compact, the APRN Compact is an additional statutory layer above the individual state's law, which remains in place. The APRN Compact administrators develop the rules and regulations to administer the APRN Compact, and then individual state licensing boards adopt the rules. If an individual state refuses to adopt the rules the APRN Compact administrators develop, that state would be in violation of the contract established by the APRN Compact and thus could lose the status of party state to the APRN Compact.

25. **How will an employer verify an APRN's license/authority to practice?**
The responsibility to verify licensure is the same as it is now. Employers may contact the licensing authority to obtain current information.

Task Force Members

Constance Kalanek, Executive Officer, ND, Area II, Co-Chair

Margaret Kotek, Board President, MN, Area II, Co-Chair

Mary Blubaugh, Executive Officer, KS, Area II

Kathleen Breguet, Board Member, RI, Area IV

Roberta Connelley, Board Member, LA, Area III

Maura Egan, Board Staff, WA, Area I

Mattie Marshall, Board Member, AL, Area III

Gayle McNish, Board Staff, OK, Area III

Barbara Swehla, Executive Officer, MT, Area I

Rachel Tierney, Board President, MA, Area IV

Janette Wackerly, Board Staff, CA, Area I

Board Liaison

Mark Majek, Director of Operations, TX, Area III (Board Liaison Phase II)

Staff

Lynda Crawford, Director of Research Services

Donna Nowakowski, Associate Executive Director for Nursing Regulation

Lamika Obichere, Services Program Administrative Assistant

Meeting Dates

- October 22 & 23, 2001
- February 1-4, 2002
- April 11 & 12, 2002
- June 17, 2002

Attachments

Action plan follows.
A. PERC Action Plan
B. Pathway to Congruence of Practice, Education & Regulation

Report and Recommendations of the Practice, Regulation and Education Congruence (PERC) Task Force

Executive Summary

The Practice, Education, and Regulation Congruence (PERC) Task Force was established by the NCSBN Board of Directors as a result of discussion regarding current and future challenges facing the nursing profession. This task force was charged with exploring the ways regulators, educators, nurses, and nurse executives involved in current practice, education, or regulation interface to assure a nursing workforce able to provide safe and effective care.

The members of the task force represent staff or board members of state boards of nursing experienced in practice, education or regulation of nurses. The task force is composed of members who make board site visits to nursing programs, experts in policy and regulation, faculty from all types of nursing programs, experienced clinicians, and members involved in similar projects at their state levels.

Through the process of scenario planning, the following recommendations were developed:

Recommendation 1
Commit to an organizational environment supportive of change and innovation in Practice, Education, and Regulation.

Recommendation 2:
Promote regulatory excellence based on ongoing data collection and best practices.

Recommendation 3:
Ensure that US and foreign educated graduates and new nurses are prepared for safe practice.

Recommendation 4:
Establish scopes of practice for the roles of all nurses, measures of continued competence of all nurses, and parameters of practice for nursing assistive personnel.

These four recommendations address the most critical incongruencies and form the basis of the action plan and potential tactics. Recommendations follow as a separate report.

Highlights of FY02 Activities and Future Activities

Included in following action plan.

Action Plan to Establish Congruence Among Practice, Education, and Regulation

The Practice, Education, and Regulation Congruence (PERC) Task Force was established by the NCSBN Board of Directors as a result of discussion regarding current and future challenges facing the nursing profession. The following resolution had been passed by the 2000 Delegate Assembly:

> *Resolved, that the National Council assume the leadership role and develop an action plan to clearly delineate and establish congruence among education, practice, and regulation for the roles of all nurses. The plan shall be developed in collaboration with a broad base of health care stakeholders for presentation no later than the 2002 Delegate Assembly for a decision regarding implementation of the plan.*

This task force was charged with exploring the ways regulators, educators, nurses, and nurse executives involved in current practice, education, or regulation interface to assure a nursing workforce able to provide safe and effective care.

The Task Force was co-chaired by Constance Kalanek, Executive Director of the North Dakota Board of Nursing, and Margaret Kotek, President of the Minnesota Board of Nursing. The 11 members are listed in the left column on page 196, along with others who also supported the work.

These members represent staff or board members of state boards of nursing experienced in practice, education, or regulation of nurses. The task force is composed of members who make board site visits to nursing programs, experts in policy and regulation, faculty from all types of nursing programs, experienced clinicians, and members involved in similar projects at their state levels.

This final report describes the process used to develop the action plan, provides a detailed explanation of each of the recommendations, recognizes related work currently underway at NCSBN, and explores the impact of each recommendation into the future. All incongruencies among practice, education, and regulation identified during Phase I of the project are addressed in the action plan.

The Process Toward Developing the Action Plan

For purposes of the work of the PERC Task Force, congruence is defined as a state of concordant agreement, connection, and response among nursing practice, education, and regulation for the purpose of public protection and safety.

A conceptual framework guiding the work of the task force was developed. Initially, the framework was depicted as a series of concentric circles.

Strategic Recommendations

Recommendation 1
Commit to an organizational environment supportive of change and innovation in Practice, Education, and Regulation.

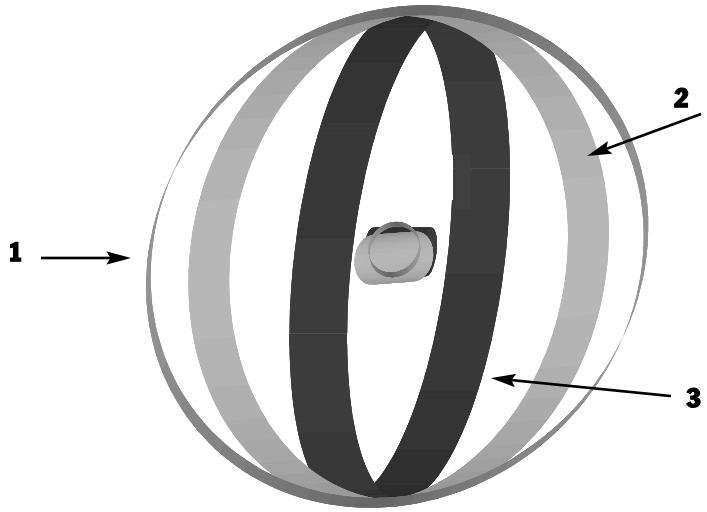
Recommendation 2
Promote regulatory excellence based on ongoing data collection and best practices.

Recommendation 3
Ensure that US and foreign educated graduates and new nurses are prepared for safe practice.

Recommendation 4
Establish scopes of practice for the roles of all nurses, measures of continued competence of all nurses, and parameters of practice for nursing assistive personnel.

The larger, encompassing circle is the "wallpaper" of the project: the larger, changing health care environment. At the center of the model, and the outcome of concern to nursing, is the public good (for regulation, the public good is public protection and safety). Nursing is positioned within the health care environment for the benefit of the public. The "infrastructure" of the nursing profession consists of practice, education, and regulation. Practice leaders must respond to the nursing needs of the public, patients, and clients and the community as a whole and evaluate the competence of nurse employees in meeting those needs. Education leaders prepare the student nurse for entry-level practice and may contribute to ongoing competency in practice through continuing or advanced education of more experienced nurses. Regulation leaders develop and enforce legislative and regulatory measures to assess and promote the competence of each nurse licensee from entry into practice and throughout the professional continuum. The relationships among these three leadership groups are symbiotic and integral. The complexity of the changing health care environment impacts on all three. Therefore, communication and collaboration, trust, and the ability to respond to changes quickly and appropriately are essential for a congruent relationship.

As the work of the task force evolved, the conceptual framework became more complex. The task force created a more useful, three-dimensional model to describe the potential impact of incongruence on the nursing profession.



Key
1. Practice
2. Education
3. Regulation

The model demonstrates practice, education, and regulation as circular bands. The smaller circles in their centers represent public protection and safety, the ultimate goal of each. Pictured as a ball, the circles are close together and the centers aligned. With this level of congruence among practice, education, and regulation, they form an almost perfect ball. The essence of this metaphor is that the more perfectly round a ball is, the more functional (i.e., the ball can bounce).

With incongruence, one or more of the circles is misaligned, the centers are further apart, and the ball becomes asymmetrical representing a potential negative impact on the nurse and therefore the patient.

Involvement of Health Care Stakeholders

The task force prepared an initial set of congruencies and incongruencies using information gained from a review of the literature and a brainstorming technique.

The task force then invited comment from more than 200 nursing, government, and regulatory organizations. The purpose of eliciting written comment was to be informed about external stakeholder perceptions regarding congruencies and incongruencies from their unique perspectives, and adhere to the resolution requiring stakeholder involvement. The open invitation was distributed by mail and posted on the NCSBN Web site. Fourteen stakeholders were then selected to meet with the task force during its October meeting to enable members to hear these perspectives directly, clarify written information previously presented by stakeholders, and finalize the first phase of the work. A list of stakeholders who submitted written comment and those who presented oral remarks by attending the roundtable meeting are provided is provided in Appendix A.

Identification of Areas of Congruence and Incongruence

From the comments submitted by external groups and after an extensive review of the literature, the task force identified areas of congruence and incongruence among practice, education, and regulation. Four areas of interface were explored: interface between practice and regulation, education and regulation, education and practice, and the interface of all three.

The resulting descriptions of congruence and incongruence in each of the four areas were not meant to be comprehensive, but a cross section at one point in time. Each of the points supported a larger perspective. Because little data exist for many aspects of health care, qualitative analysis was used when data were not available. Contributions from the diverse backgrounds and experiences of the 11 task force members and stakeholders ensured an enriched collective experience.

One central theme that emerged during the process and stimulated debate and thoughtful discussion was the purpose of regulation (public protection) and the degree of congruence among regulation, practice, and education that would be desirable. In many ways, practice, education, and regulation now operate as micro-systems, as if each domain existed in mutually exclusive environments. The degree to which regulation is congruent with practice and education has long been a subject of much debate.

Key questions surfaced as we moved toward discussion of collaboration.

- Would total congruence (harmony, collaboration, or agreement among practice, education, and regulation) interfere with regulation's responsibility to protect the public?
- When does "congruence" blur the lines between the interests of education and regulation, or between the concerns of the cost-conscious health care delivery system and regulation?
- If some degree of separation is desirable, how separate is separate?

Although some argued that maintenance of isolated micro-systems has led to a fragmented approach to problem-solving (written comment, 2001), it became apparent that there are times when regulation should operate in isolation, and others when regulation should work closely with education and practice in integrated working relationships. The task is to decide when integration serves the public and when it does not. It was agreed that public safety must be the focus of any model developed, yet recognizing the contributions of other leaders toward the public safety goal.

It became evident to the task force that a greater degree of congruence will certainly be needed to create a preferred future for nursing in a complex and dynamic health care environment. Many organizations, responding to an invitation to provide written comment, expressed concern about the fragmentation of the

nursing profession and its uncertain future. The stakeholders identified a need for strong nursing leadership and commitment from practice, education, and regulation to work collaboratively to elucidate critical issues and find solutions to strengthen the profession.

If examined as three microsystems, practice, education and regulation are different both structurally (i.e., statutory authority, political relationships, and economics) and philosophically (i.e., values, mission, goals, relationships with other systems).

- Nursing practice values creativity in developing new practice models that are cost effective and promote quality care (Kjervik, written comment, 2001).
- Nursing education is premised upon academic freedom and protects faculty and student freedom to think creatively and choose areas of learning and research.
- Nursing regulation is oriented to finding and setting limits on practice considered dangerous to the public.

It is where each of these three systems overlap that congruencies and incongruencies were identified (see Appendix A).

Scenario Planning as a Means for Setting Priorities and Direction

The task force met in February 2002 to begin development of the action plan to address the incongruencies identified in Phase I. The committee utilized the scenario planning process to begin development of the action plan. During scenario planning, participants consider various plausible futures, bring them to life through group discussion and personal reflection, and then make strategic decisions that will be sound for all possible futures.

Decisions made from the perspective of a point in time are limited unless consideration is given to the larger, environmental factors that will impact on the life and work of the organization over time. Similar to a pebble in the middle of a swiftly moving stream that will be carried further downstream if something upstream increases the force of the current.

The task force began to explore the "upstream" factors that might impact on nursing's future, divided into two groups: factors that will most certainly occur (predetermined factors) and those that may or may not occur (uncertain elements). The group pulled information from its previous work and variables identified during discussions of the following areas: societal attitudes, public health, technology, regulation, cultural diversity, nursing competency (entry- and post-entry practice), and nursing roles.

From the discussion about what we knew to be true about the future and possible influences that could impact the nursing profession, a series of plausible futures was identified. It seemed that the four areas in which nursing future could be played out were education, practice, regulation, and financing health care. For each of these four areas, all possible futures were outlined. In all, 22 possible futures were identified.

From these collective possibilities, four distinctly different and plausible scenarios of the year 2010 emerged. Each was given a name that illustrated the future and each was developed in rich detail by a subgroup. Each subgroup "lived" in its respective future for an afternoon, exploring the current realities and the relationships of nursing education, practice, and regulation. Later, individuals spent reflective time alone writing a story in the first person about a fictitious person living in that future. The result was a rich and detailed description shared with each other.

The four 2010 scenarios developed by the task force included:

1. United We Stand

In the "United We Stand" scenario, the values of trust, openness and acceptance are evident in the collaborative relationships among all stakeholders (educators, health care providers, regulators, the public, and special interest groups). Most boards of nursing have agreed upon uniform regulation among jurisdictions. Multistate licensure was pivotal in bringing about congruency and practice across the different states; during this process, many of the special interest groups and the old habit of turf protection was eliminated, so people could work together and agree upon sets of standards. Government was impressed with these standards and the way all groups worked together and increasingly trusted that regulators and educators would work together for the future to do the right thing. In 2010 we now see the board of nursing in the role of being educational consultants to education and practice.

2. Lift Off

"Lift Off" is a world of accelerating innovation, especially within health care facilities. All countries are in communication with each other constantly, and all information is readily available around the world. Health care organizations have built capacities to allow change to take place. All work is done in real time, so there is no longer a waiting for lab results. Most licensed providers other than nursing no longer exist.

Nursing remains the leader of the health team, coordinating client care. Most innovation in health care takes place in practice. Nurses are diagnosing and treating every day. The scopes of practice for nursing personnel are at higher levels than they were in 2002, and technical skills required in 2002 are often no longer needed. All regulation (of professionals, facilities, etc.) has had to become broader and more flexible. Regulation no longer functions in a gatekeeper role but focuses on the business of health care and measuring competence.

3. Buyer Beware

The "buyer beware" scenario is a world in which regulatory boards have lost their authority over most people functioning as nurses. Because regulation has become a rich source of income in the private sector, associations and private companies have taken over the functions nursing boards had chosen not to do. New technical roles have been carved out within health care facilities, including new advanced practice roles. No one regulatory board, private company, or agency knows where nurses are practicing. "Nursing" practice has become high tech, low touch, and low care. It's hard to find nursing care as we knew it before 2002.

4. Comfort Measures Only

The "comfort measures only" scenario is a world with decreased regulation. Boards of nursing have less of a role in nursing regulation and a more narrow range of authority. Because NCSBN decided not to regulate UAPs in 2003, the acute nursing shortage, and other factors since 2002, there have been higher levels of skill and responsibility allowed for all levels of health care personnel from those unlicensed to advanced practice nurses. Boards of nursing have limited ability to control scopes of practice. The rate of medical and nursing errors has increased.

The four scenarios selected address the most critical incongruencies and form the basis of the action plan, resulting recommendations, and potential tactics. Each of these scenarios will be described in detail during the PERC Task Force Open Forum at the 2002 Delegate Assembly.

PERC Recommendation 1
Current related work at NCSBN

- New Executive Officer orientation programs are held annually and their reference materials are available to all NCSBN members on the Web site.
- Member Board Leadership Development Task Force (Regulatory Credentialing Development Task Force?) developing education programs for regulators about regulation.
- Current NCSBN bylaws permit open board and committee meetings for members (Article 8, Section 1C).
- A member satisfaction survey was conducted by an independent outside agency during spring 2002. This survey measured member satisfaction with NCSBN goods and services.
- A patient safety summit is planned for fall 2002.

Recommendation 1: Organizational Environment

Commit to an organizational environment supportive of change and innovation in Practice, Education, and Regulation.

This first recommendation addresses the organizational environment of NCSBN as related to its regulatory members and external stakeholders. Achieving this goal is considered by the task force as the fundamental priority to accomplish the action plan. An organizational environment supportive of change and innovation will be essential for successful completion of the remaining three recommendations. This recommendation focuses primarily on the role of the NCSBN in establishing the foundation for success of the plan and focuses on the need for congruence within the regulatory community. It is essential, a means toward the goal and not demonstrating an area of incongruence among practice, education, and regulation. There are no corresponding incongruencies identified in Phase One. The need for Recommendation 1 became evident during the scenario planning process when it was recognized that the future of nursing regulation would be first and foremost impacted by the strengths within NCSBN itself.

Recommended Action

Foster open, honest communication among member boards, Board of Directors, and NCSBN staff and enhance communication with nursing stakeholders and the public.

Stakeholders involved: NCSBN Members, Officers and Staff

Current strategic plan: SI 3, Outcomes A and B

Examples of potential future tactics:

- Develop a comprehensive communication/outreach plan for members, stakeholders and the public.
- Continue the policy of open board and committee meetings for members.
- Continue to post minutes on Web site.
- Offer Web-based media for purposes of listening to deliberations and decisions and/or by conference call.

Potential fiscal impact: Expenses will be related primarily to web enhancements to enhance communication capabilities.

Recommended Action

Strengthen communication among practice, education and regulation.

Stakeholders to be involved: Practice, Education and Regulation Leaders

Current strategic plan: SI 3, Outcome B

Examples of future tactics:

- Build coalitions of practice, education and regulatory leaders in states.
- Work on innovative projects that include education, practice, and regulation.

Potential fiscal impact: Expenses incurred through enhanced collaborative projects.

Recommended Action

Create a professional culture based on mutual respect and trust where opinions of practice, education, regulation representatives and members, and staff are valued.

Stakeholders to be involved: NCSBN and its members; Practice, Education, and Regulation leaders

Current strategic plan: SI 3, Outcome B

Examples of future tactics:

- Ensure involvement of a broad range of members and relevant stakeholders in committees and groups and provide ongoing opportunities for input.
- Offer open forums about contemporary nursing and health care issues involving internal and external stakeholders (i.e., patient safety and work environment issues).

Potential fiscal impact: Travel and meeting expenses incurred.

Recommended Action

Enhance educational and informational resources regarding the purpose of NCSBN and state boards of nursing.

Stakeholders to be involved: NCSBN, Regulation and Education, and the Public

Current strategic plan: SI 5, Outcomes A and B

Examples of future tactics:

- Continue to develop Web site presentations based on member needs. Create a member and staff directory.
- Expand regulatory and NCSBN orientation for newly appointed executive officers beyond current single day model.
- Develop and offer regulatory and NCSBN orientation for board presidents and members.
- Promote and provide resources for education of students and licensees.

Potential fiscal impact: Expenses will be incurred by Web site enhancements, orientation meetings for executive officers, and development of orientation materials for board presidents and members and resources for students and licensees.

Recommended Action

Commit to ongoing evaluation and improvement as an NCSBN core competency.

Stakeholders to be involved: NCSBN

Current strategic plan: SI 5, Outcome D

Examples of future tactics:

- Have an outside independent agency develop and implement evaluation tools for member boards to evaluate NCSBN.
- Implement an ongoing, systematic evaluation and performance improvement plan for member boards.

Potential fiscal impact: Costs will include payment to outside independent agency and those related to performance evaluation materials.

Recommended Action

Assess the health care and nursing environments and analyze the impact of change and innovation on regulation.

Stakeholders to be involved: NCSBN, Practice and Regulation

Current strategic plan: SI 3, Outcome C; SI 5, Outcome D

Examples of future tactics:

- Conduct a periodic environmental scan to assess the health care and nursing environments.
- Analyze practice changes and compare with state laws and regulations.
- Develop a model to assure consistency of nursing practice.

Potential fiscal impact: This action item will involve expenses for periodic surveys of the health care and nursing environments and model development.

Recommendation 2: Regulatory Excellence

Promote regulatory excellence based on ongoing data collection and best practices.

Nursing practice, education and regulation are microsystems that are closely linked by history and tradition, but divided by competing missions and values. Nursing regulation authority is derived from legislative action and based upon the police power of the state to enact reasonable laws necessary to protect the health, safety and welfare of its citizens. Legislation grants specific authority to boards of nursing to enforce nurse practice acts.

In 1998, the NCSBN Board of Directors decided to embark on a ground-breaking project: development of a system of performance measurement for state and territorial boards of nursing. The task force recommends building on this work, various projects such as Practice Breakdown and Continuing Education Effectiveness, and the work related to Nursys™ to (a) analyze relationships among data sets, (b) continue to collect sufficient data upon which to base policies and procedures at the state board level, (c) make this data readily available to member boards, (d) determine best practices, and (e) define excellence in nursing regulation.

Recommended Action

Develop and implement a performance measurement model and indicators of excellence in regulation.

Stakeholders to be involved: NCSBN and Regulation

Current strategic plan: SI 2, Outcome A

Examples of future tactics:

- Continue to collect data through the System of Performance Measurement project to identify best practices.
- Build an organizational communication model that strengthens networking among Member Boards.
- Evaluate the effectiveness of alternative discipline programs.
- Evaluate feasibility of improving uniformity and consistency in regulation.
- Increase participation in Nursys and HIPDB reporting.
- Examine the role of attorneys to assist in board functions.
- Collaborate with practice and education to work closely together, reduce duplication of efforts, and collectively collect data essential for excellent regulation.

Potential fiscal impact: Expenses will be incurred for implementation of the System of Performance Measurement (surveys, meetings of the Advisory Panel), Web enhancements to accommodate the intra-organizational communication system, data collection efforts (surveys) to measure the effectiveness of alternative discipline programs, increased participation in Nursys and HIPDB reporting, and collaborative projects with practice and education.

Recommended Action

Create a comprehensive, unduplicated database of nursing and regulatory information for member and public use.

Stakeholders to be involved: NCSBN and Regulation

Current strategic plan: SI 4, Outcome C

PERC Recommendation 2: Current related work at NCSBN

- Commitment to Excellence project is beginning to provide data and identify best practices.
- Nursys™ Advisory Committee and IT staff are working to enhance data collected through the Nursys project.
- Practice Breakdown Research project is providing information about risk factors related to error.
- Continuing Education Effectiveness study has measured the impact of continuing education and other variables on the evolution of nursing practice.
- Post-Entry Competence project will provide information on nursing practice over time.
- PR&E Committee continues to study the regulation of nursing programs.
- Disciplinary Curriculum Advisory Panel has planned and conducted education summit that addressed some of the key issues related to discipline and additional information and resources needed.
- NLCA has studied variations in rules and regulations among the participating boards.
- APRN Task Force.
- APRN Compact Development Subcommittee has developed model rules for the regulation of APRNs.

Incongruence addressed

An unhealthy separation exists when boundaries are in place that exclude nursing education and practice from providing input and do not take into account information from a variety of sources. This results in a belief on the part of

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stakeholders that they are not part of the process.

When practice, education, or regulation work to influence regulation from any agenda other than public protection, congruence is disrupted.

The variation and lack of standardization in regulations across jurisdictions are one cause of incongruence.

Examples of future tactics:

- Allow employer, other stakeholder and public access to defined data elements.
- Achieve 100% participation by members in Nursys.
- Create and maintain *Profiles* and System of Performance Measurement databases online.
- Identify and provide for members links to existing data sources (i.e., NCSBN, Colleagues in Caring, state Centers for Nursing, HRSA, Dept. of Labor).

Potential fiscal impact: Costs will be related to increased participation in Nursys and HIPDB reporting and creation of electronic *Profiles* and System of Performance Measurement databases.

Recommendation 3: Preparation of Nurses

Ensure that U.S.- and foreign-educated graduates and new nurses are prepared for safe practice.

Nursing regulation and education are linked by a history of regulatory oversight and standard setting. In fact, boards of nursing were originally established for the purpose of establishing standards of quality education. Today, most boards of nursing are responsible for approval/accreditation of educational programs. Many boards require a specific level of performance on NCLEX® examinations and monitor components of the programs, such as faculty qualifications and curricula.

Fifty-seven boards of nursing approve or accredit pre-licensure programs of nursing. Eighteen boards approve RN-baccalaureate completion programs, 15 certificate programs for advanced RN practice, 14 graduate programs in nursing, and 18 continuing education programs.

Thirty-seven boards include education committees as standing committees of the board. An additional 12 boards have ad hoc committees that focus on education. Board members of 27 boards conduct educational program visits. Many boards continue an active consultative role, visiting nursing programs on a routine basis.

Educators serve on boards of nursing. Most boards communicate with educators, and many collaborate with deans and directors on education-related issues within their respective states.

There are philosophical and operational differences between nursing program approval by boards of nursing and voluntary accreditation of programs by national accrediting bodies. While the mission of all boards of nursing is to protect the health, safety, and welfare of the public by establishing minimum standards for pre-licensure nursing programs, the mission of national accrediting bodies is "to ensure the quality and integrity" of nursing programs by "assessing and identifying programs that engage in effective educational practices" (CCNE, written comment, 2001). Boards of nursing are state government agencies; national accrediting bodies such as NLNAC and CCNE are not-for-profit organizations financially dependent on revenue earned from the voluntary accreditation of nursing programs.

Education must be responsive to changes in practice. Educational programs should adequately prepare students for practice roles. There is a philosophical tension that exists between education and practice: education for the future versus job training. Since both are needed (the new graduate must be prepared to enter the work force and yet must have the foundation necessary for life-long learning), this tension provides a system of "checks and balances."

Recommended Action

Develop and utilize evidence-based indicators of quality nursing education for the roles of all nurses and ensure quality nursing education programs.

Stakeholders to be involved: Regulation and Education

Current strategic plan: SI 2, Outcome C

Examples of future tactics:

- Promote information exchange among boards of nursing, educators, and accreditators.
- Develop plan for total nursing program evaluation based on evidenced-based indicators.

PERC Recommendation 3: Current related work at NCSBN

- PR&E committee continues to study the regulation of nursing programs.
- Subcommittee to Develop Model Rules is currently revising model rules related to the approval of nursing programs.
- Foreign Nurse Issues Subcommittee is exploring the issues related to regulation of nurses educated outside the U.S.
- Commitment to Excellence project conducted surveys of nursing programs to discover their interface and satisfaction with nursing regulation.
- NCSBN Education Consultants Network meets at NCSBN and conducts monthly conference calls to discuss current issues related to nursing education.

Incongruence addressed

- When students are not screened for criminal backgrounds early, they may graduate from a nursing program only to find that they are ineligible for licensure.
- Nursing graduates do not reflect the diversity of the larger U.S. population. The cultural diversity of patient populations is not reflected in nursing workforce. Research has shown that culturally diverse groups are discouraged from entering and/or completing nursing education.
- Although many in the nursing community perceive differentiated practice as essential for the establishment of effective relationships among practice, education, and regulation, there has been little attempt by employing facilities to differentiate within similar roles

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according to educational preparation. A national survey of entry-level nurses (NCSBN, 2001) demonstrated that ADN and BSN graduates are hired into the same types of positions and perform the same tasks within their first six months of practice.

- There is little evidence to indicate that differentiation should be driven by educational preparation. Rather, other factors, such as previous experience and personal competence may be more logical factors on which to base differentiation.
- When practice settings do not support the transition from student to practicing nurse through formal mentorship or preceptorship programs, newly licensed nurses do not feel prepared for practice. Newly licensed nurses report a disconnect between employer requirements and the nurses' expectations of the practice environment.
- Education programs are challenged to prepare students for increasingly complex practice. Newly licensed nurses do not feel adequately prepared for practice. Recent data collected by NCSBN (2001) demonstrated that graduates of all types of nursing education programs report similar levels of dissatisfaction with their preparation for essential entry-level nursing skills. Fewer than 60% of graduates of all programs perceived their preparation as adequate in most of these critical areas. Likewise, employers do not perceive new graduates as prepared for entry-level practice, regardless of educational preparation. In a study conducted by NCSBN (2001), employers rated fewer than 20% of new graduates as prepared to perform essential activities.
- Public health nursing and population-focused nursing concepts

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- Develop recommendations for ongoing dissemination of information related to nursing education programs, graduations, enrollments, and issues.

Potential fiscal impact: Expenses will be incurred by collection and dissemination of information related to nursing education programs, graduations, enrollments, and issues.

Recommended Action

Enhance model rules to reflect standards and indicators of quality nursing education.

Stakeholders to be involved: NCSBN and Regulation

Current strategic plan: SI 2, Outcome H

Example of future tactics:
- Identify evidence-based indicators of quality nursing education.
- Recommend changes of model rules to reflect quality nursing education indicators.

Potential fiscal impact: Studies will be conducted to measure the effectiveness of indicators/criteria for evaluating nursing programs and the degree of implementation of the 2002 NCSBN Model Rules for Nursing Program Approval (pending Delegate Assembly action).

Recommended Action

Collaborate with accrediting agencies and nursing education programs for an effective approval and accreditation process.

Stakeholders to be involved: Education, Regulation and NCSBN

Current strategic plan: SI 3, Outcome C

Examples of future tactics:
- Develop a position statement of the role of Boards of Nursing, accreditors and nursing education programs in ensuring quality nursing education that maintains board authority yet reduces duplication of effort.
- Develop criteria and a national model for the use of accreditation for regulatory purposes.

Potential fiscal impact: Costs will be incurred by task force meetings.

Recommended Action

Clarify current foreign nurse regulatory issues and identify potential solution.

Stakeholders to be involved: NCSBN, Regulation, Practice, CGFNS

Current strategic plan: SI 1, Outcome C; SI 3, Outcome C

Examples of future tactics:
- Evaluate the effectiveness of the eligibility criteria used by member boards to allow foreign-educated nurses to sit for NCLEX.
- Delineate basic competencies of foreign-educated nurses for safe, entry-level practice, language/communication skills, and nursing competencies.
- Evaluate implications of immigration/NAFTA for safe, entry-level practice.
- Anticipate and plan education of legislators regarding public safety implications of entry competence testing for foreign-educated nurses.

Potential fiscal impact: Studies will be conducted to measure the effectiveness of eligibility criteria used by member boards to allow foreign-educated nurses to sit for NCLEX®; to determine basic competencies of foreign-educated nurses for safe, entry-level practice, language and communication skills, and nursing competencies; and as educational materials for legislators.

Recommended Action

Develop model rules for licensing foreign-educated nurses.

Stakeholders to be involved: NCSBN and Regulation

Current strategic plan: SI 2, Outcome H

Example of future tactics:

- Based on empiric evidence, refine model rules for initial licensure and endorsement of foreign-educated nurses (English competency, nursing competence, evaluation of educational programs/curriculum).
- Disseminate refined model foreign-educated nurse rules to Member Boards.

Potential fiscal impact: Expenses will be incurred through dissemination of model rules.

Recommended Action

Identify and promote effective models to facilitate a successful transition by the foreign educated nurse into U.S. practice roles and environment.

Stakeholders to be involved: Regulation, Education and Practice

Current strategic plan: SI 2, Outcome A

Examples of future tactics:
Collect and disseminate information on the transition experiences of foreign-educated nurses and develop an effective model to address education and information gaps.

Potential fiscal impact: Studies will be conducted to collect information about the transitional experiences of foreign-educated nurses.

receive inadequate attention in the nursing curricula, in part because faculty at large do not understand these concepts and do not value their inclusion in the curricula (ASTDN, written comment, 2001). Few nursing programs provide sufficient content or experience in perioperative nursing (AORN, written comment, 2001).

- Education programs do not consistently provide theory content and clinical experience essential for practice. Curricula of today compares with that of 20 years ago, with additional content added. The acuity of patients and technology advancements are not consistently reflected in program curricula/syllabi.
- Among clinical specialties, there is sometimes not a match between educational preparation and the role of the specialist.
- Obtaining a more advanced degree does not necessarily result in an advanced knowledge of entry-level nursing or enhanced perceptions of adequacy. Nurses have few incentives, such as higher salaries, for getting a higher degree, and practice is not differentiated by educational preparation.
- Education is having a difficult time meeting the need for an adequate supply of qualified nurses. Nursing education programs have fewer applicants, graduates and faculty. The numbers of qualified applicants are not adequate to meet the current and future needs of the public for health care.
- Nursing graduates do not reflect the diversity of the larger U.S. population. The cultural diversity of patients is not reflected in nursing workforce. Research has shown that culturally diverse groups are discouraged from entering and/or completing nursing education.
- The variation and lack of standardization in regulations across jurisdictions are one cause of incongruence.

Recommendation 4: Regulation of All Nursing Personnel

Develop scopes of practice for the roles of all nurses, measures of continued competence of all nurses, and parameters of practice for nursing assistive personnel.

Nursing regulation and practice are linked by the mandate of public protection. First, boards of nursing develop, interpret and monitor Nurse Practice Acts. Fifty-seven boards of nursing establish practice standards and 48 make definitive practice decisions.

An effective interface between regulation and practice exists when boards provide a mechanism for discussion, decision-making and dissemination of practice issues; when nurse practice acts accommodate changes in nursing practice; and when practice decisions made by boards of nursing are communicated to practice facilities. In a recent survey of nurses, employers and associations in 12 states, respondents were asked for their views about existing statutes and administrative rules and regulations. They rated activities in the areas of practice standards (scope of practice) as 1 (too much regulation), 2 (adequate regulation), or 3 (too little regulation). The average rating among the three groups was 1.99, adequate regulation.

Some boards of nursing have authority over anyone practicing nursing without a license. Most practice settings verify licensure status upon employment and periodically thereafter.

Criteria required for RN licensure by examination include:
- Graduation from high school or its equivalence (36 boards);
- A state-approved or state-accredited nursing education program leading to an associate degree or diploma in nursing (54 boards);
- A state-approved or state-accredited nursing education program leading to a baccalaureate degree in nursing (55 boards);
- The New York Regent's external degree program (45 boards);
- Any other "distance learning" or virtual program (15 boards) or any other equivalency nursing education program (such as corpsman) (five boards).
- Five boards have age restrictions; 23 require good moral character; 22 require good physical and mental health; and 43 require proficiency in the English language.

Criteria required for LPN/VN licensure include:
- U.S. citizenship (one board);
- Graduation from high school or its equivalence (37 boards);
- Graduation from a state-approved or state-accredited nursing education program (55 boards);
- Graduation from an equivalency nursing education program such as corpsman (26 boards);
- Work experience in lieu of education (one board) or graduation from a "distance learning" program (eight boards).
- Eleven boards have an age restriction; 24 require good moral character; 23 require good physical and mental health; and 37 require proficiency in the English language.

Also, boards of nursing must ensure entry-level competency of new graduates and continuing competency of licensed nurses. Again, eligibility for initial licensure varies across jurisdictions.

The regulation of Advanced Practice varies widely across jurisdictions. Fifty-three boards of nursing regulate or recognize advanced practice nurses as a separate

PERC Recommendation 4:
Current related work at NCSBN

- Post-Entry Competence Study will provide information about the roles and competencies of RNs and LPN/VNs.
- APRN Task Force working to make scopes (of AP specialties) broad enough so that APRNs can practice safely; will be working on model rules FY2003. Currently, competencies are determined by AP specialty organizations.
- *Member Board Profiles* provides information about board structures and functions for all Member Boards.
- Practice Breakdown study providing information on variables that put nurses at risk for error.
- Continuing Education Effectiveness study has measured the impact of continuing education and other variables on the evolution of nursing practice.
- Post-Entry Competence study will help us understand continuing competence.

Incongruence addressed

- The variability in eligibility requirements for initial licensure creates disparity in qualifications of nurses across jurisdictions.
- Not all boards regulate all nursing caregivers which interferes with their ability to apply consistent regulatory standards to all nursing care providers.
- There is an assumption that nurse practice acts always lag behind changes in practice (written comment 2001). One regulator commented that statutes and regulations always lag behind developments in

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group. Some boards of nursing allow scopes of practice to be determined by certifying bodies, whose missions are primarily the advancement of the respective specialty area and who depend on revenue from certification exams.

Boards of nursing do not have jurisdiction over practice settings. Many practice errors are caused by a complex relationship of system and individual errors. Although some form of mandatory reporting of errors exists in 49 states, errors may or may not be reported to boards of nursing.

Recommended Action

Promote equivalency in essential elements of licensing and scope of practice for all nurses.

Stakeholders to be involved: NCSBN, Regulation, Education and Practice

Current strategic plan: SI 2, Outcome A

Examples of future tactics:

- Create an action plan to increase the uniformity of titles, scopes, and credentialing across all jurisdictions.
- Revise model nurse practice acts to reflect uniform titles, scopes of practice and credentialing of NAP across jurisdictions.
- Define roles/credentials/competencies of each level of licensure for LPNs, RNs, and APRNs (including parameters of delegation).
- Encourage adoption of the APRN Uniform Requirements.
- Adopt the Nurse Licensure Compact.

Potential fiscal impact: Costs could potentially include those related to committee/task force meetings, surveys, and practice analysis studies.

Recommended Action

Design ways to build flexible and consistent Nurse Practice Acts and regulations that allow for changes in practice across jurisdictions.

Stakeholders to be involved: NCSBN, Practice and Regulation

Current strategic plan: SI 2, Outcomes A and H

Examples of future tactics:

- Develop a mechanism for ongoing review and revision of the model act and its applicability to current practice.
- Create a plan for frequent evaluation of the use and effectiveness of the model act concepts and their outcomes.
- Educate Member Boards about model act revisions.
- Create uniform national guidelines and terminology for discipline.
- Evaluate and communicate success/challenges of nurse licensure compact model.
- Develop scopes of practice for APRN specialties that are broad enough so that APRNs can practice safely.

Potential fiscal impact: Costs could potentially include those related to committee/task force meetings, surveys, and educational materials.

practice because regulation is, by its very nature, political (FARB, written comments, 2001). There is little evidence, however, to support this assumption. Many believe that NPAs are written in broad enough language to allow practice to evolve. This assumption may stem from the way some boards interpret their statutes and rules; conservative and literal interpretations may not reflect current changes in practice.

- The lack of uniform requirements creates disparity in qualifications of nurses across jurisdictions. Research is needed to determine when this lack of uniformity is a barrier to congruence and when there should be standards in regulations.
- Although there is a potential conflict in mission, regulators currently rely on specialty certifying bodies to assure competency in advanced practice.
- Because of lack of uniformity of regulations across jurisdictions, educational programs must undertake multiple processes to ensure that students gain national certification and state recognition to practice (Consortium, 2000).
- Rules, policies and regulations sometimes conflict between boards of nursing and local, state, federal and facility regulation. There have been instances where the regulatory requirements, accreditation standards and internal policies/procedures of health care delivery conflict with respective nurse practice acts and rules.
- There is an overlap in the roles of two types of advanced practitioners (NP and CNS).
- Certification criteria for APRNs set by professional organizations are developed independent of regulation and

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education. Furthermore, there is confusion within the nursing community regarding the use of protected titles.
- Regulation, practice standards and nursing program curricula differ among jurisdictions.
- There are no clear definitions of nursing roles (at any level) agreed upon by practice, education and regulatory agencies. Inconsistencies also exist among APRN specialty program curricula, certification examinations and scope of practice.
- Other professional groups restrict the ability of boards of nursing to modify or update nurse practice acts because of conflict over scopes of practice. The result may be limited accessibility to nursing care by the public.
- Criteria for/measurement of continuing competence haven't been established, and license renewal processes are not contingent on validated continuing competency mechanisms.
- More evidence is needed to link nursing program graduation requirements and regulatory criteria with safe, entry-level practice.
- While an assumption is made that graduates of approved nursing programs who passed a licensing examination are able to practice safely at entry level, there is no agreement among practice, education and regulation on criteria to measure safe post-entry practice.
- Increasing numbers of reported negative outcomes for people who receive health care have been documented (IOM report), which is assumed to be the result of systems problems. Following this assumption, if all problems were fixed, all errors would go away.
- There is a lack of understanding

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Recommended Action

Develop tested measures and methods to ensure continued competence of all nurses and promote patient safety.

Stakeholders to be involved: NCSBN, Practice and Regulation

Current strategic plan: SI 1, Outcome F

Examples of future tactics:
- Utilizing data from the post-entry competence study, develop a technology-based tool to measure competency.
- Measure competencies needed for APRN practice.
- Organize a panel at NCSBN Midyear Meeting to update the models and outcomes of state "bridge" projects (transitioning students/new graduates from education to practice).
- NCSBN to serve as a clearinghouse of data and collaboration of all state "bridge" projects in measuring and evaluating outcomes.
- Modify employer survey tool to collect data for the various roles of nursing and several environmental variables that impact on practice.
- Develop post-licensure tools to measure continued competency and evaluate their effectiveness.
- Collaborate with certification, education and specialty organizations for determining effective regulation of APRNs.
- Apply the NCSBN 2002 Continuing Education study results.

Potential fiscal impact: Expenses will be related to tool development, job analysis studies, an educational program at Midyear meeting, enhancements to the Web site, conducting an employer survey, tool development, and travel to meetings.

Recommended Action

Assume a leadership role in designing processes to ensure patient safety in collaboration with health care system.

Stakeholders to be involved: NCSBN, Practice and Regulation

Current strategic plan: SI 2, Outcomes B and F

Examples of future tactics:
- Support innovative and collaborative national/state projects related to patient safety.
- Provide information to health care and public facilities regarding public protection processes and factors that put nurses at risk of making errors.
- Assist with legislative strategies to encourage implementation of model acts
- Develop model scopes for each type of licensure.

Potential fiscal impact: Costs will include development of educational materials and meetings of committees/task forces.

Recommended Action

Identify parameters of practice and competencies for nursing assistive personnel.

Stakeholders to be involved: Practice and Regulation

Current strategic plan: SI 2, Outcome E

Examples of future tactics:
- Review the NAPNES retention study (MISCO research).

- Clearly define roles of nursing assistive personnel.
- Describe essential competencies of nursing assistive personnel.
- Once core competencies are identified, determine minimum education requirements for credentialing nursing assistive personnel.
- Develop a white paper and a position statement that supports regulation of nursing assistive personnel by boards of nursing.

Potential fiscal impact: Most expenses will be related to committee/task force meetings.

Recommended Action

Identify and promote effective models to facilitate a successful transition be new nurses from education to practice.

Stakeholders to be involved: NCSBN, Practice, Education and Regulation

Current strategic plan: SI 2, Outcome C

Examples of future tactics:

- Collect information about demonstration projects for education to practice transition models.
- Conduct more frequent job-entry analysis surveys for all types of licensure and survey employers regarding their expectations.
- Collaborate with ANA/AONE to collect data regarding mentorship, preceptorship, and internship programs and their outcomes.
- Provide information regarding CIC state projects.
- Review NLNAC/CCNE standards regarding graduate and employer satisfaction surveys.
- Gather data from AHA and AHCA regarding retention.
- NCSBN to partner with AONE for a longitudinal study of the retention of nurses.

Potential fiscal impact: Expenses will be incurred by surveys, job analysis studies and a longitudinal study.

Recommended Action

Participate in strategies for retention of the new graduate.

Stakeholders to be involved: Practice and Regulation

Current strategic plan: SI 2, Outcome C

Examples of future tactics:

- Develop a mechanism to track retention outcomes for new graduates.
- Utilize evidence-based data regarding effectiveness of transition programs to create an education-practice transition model.
- Disseminate information on the education-practice transition model.

Potential fiscal impact: Costs will include the collection and dissemination of data.

among practice and education of the role of the licensure examination. Practice-focused nursing organizations have demonstrated a misconception of the role of the examination in driving curricula (ASTDN, written comments, 2001).

- Boards of nursing do not have authority to regulate the practice environment and, therefore, have limited ability to influence unsafe work environments or the incidence of system-related error.
- Language barriers and cultural diversity present challenges in all three domains. Creating reasonable accommodation for disabilities impacts regulation, education and practice; more solutions are needed to assure public safety and provide opportunities.
- A lack of reliable data regarding the nursing workforce, particularly those actively delivering patient care, impacts the ability to identify shortage areas, project future supply, or plan to resolve the shortage.
- Essential practice deficiencies are not reported by practice settings to boards of nursing in a timely and efficient manner.
- There are insufficient mechanisms, opportunities and funding to address the universe of system and individual practice errors consistently and effectively.
- Even in mandatory reporting states, not all categories of errors are reportable or reported. The process of determining when to report may not be an objective one. Legal liability and risk may influence an individual or organization to comply with reporting requirements.
- The variation and lack of standardization in regulations across jurisdictions are one cause of incongruence.

Conclusion

The Practice, Education, and Regulation Congruence (PERC) Task Force was established by the 2000 Board of Directors following the adoption by the 2000 Delegate Assembly of the following resolution:

> *Resolved, that the National Council assume the leadership role and develop an action plan to clearly delineate and establish congruence among education, practice, and regulation for the roles of all nurses. The plan shall be developed in collaboration with a broad base of health care stakeholders for presentation no later than the 2002 Delegate Assembly for a decision regarding implementation of the plan.*

This task force was charged with exploring the ways regulators, educators, nurses, and nurse executives involved in current practice, education, or regulation interface to assure a nursing workforce able to provide safe and effective care. Through the adoption of the action plan directed to achieving the priority recommendations, incongruence among practice, education, and regulation will be greatly reduced and the public will be served.

Recommendation 1: Organizational Environment of NCSBN
Commit to an organizational environment supportive of change and innovation in Practice, Education, and Regulation.

Recommendation 2: Regulatory Excellence
Promote regulatory excellence based on ongoing data collection and best practices.

Recommendation 3: Preparation of Nurses
Ensure that US and foreign educated graduates and new nurses are prepared for safe practice.

Recommendation 4: Regulation of All Nursing Personnel
Develop scopes of practice for the roles of all nurses, measures of continued competence of all nurses, and parameters of practice for nursing assistive personnel.

Appendix A: Congruence and Incongruence

This is a summary of the congruencies and incongruencies among practice, education, and regulation identified during phase one of the project. They are listed by areas.

Regulation and Education

Congruence: Regulation and education both value high quality nursing education.

Congruence: Educators serve on boards of nursing. Most boards communicate with educators, and many collaborate with deans and directors on education-related issues within their respective states.

Incongruence: Although the business of accreditation may pose a potential conflict of interest, ten (10) boards grant approval to nursing programs that meet national accreditation agency standards.

Incongruence: For those nursing programs that are reviewed by both their board of nursing and a national accrediting body, review processes are often not coordinated and review requirements duplicated. Also, documentation requirements sometimes differ. This duplication of resources and effort are a burden for nursing programs.

Incongruence: Although the mission of boards of nursing is to protect the public, they do not regulate all levels of nursing education. In those states where graduate programs are regulated by boards of nursing, there is **not** universal adoption of uniform core requirements for master's programs leading to advanced practice.

Congruence: The majority of nursing graduates pass NCLEX® and nursing programs teach content related to licensure requirements.

Congruence: Some boards of nursing are working with educators to conduct criminal background checks on those applying for admission to their respective programs. This prevents the situation of graduates being denied licensure because of criminal backgrounds.

Incongruence: When students are not screened for criminal backgrounds early, they may graduate from a nursing program only to find that they are ineligible for licensure.

Regulation and Practice

Congruence: An effective interface between regulation and practice exists when boards provide a mechanism for discussion, decision-making and dissemination of practice issues; when Nurse Practice Acts accommodate changes in nursing practice; and when practice decisions made by boards of nursing are communicated to practice facilities. In a recent survey of nurses, employers and associations in 12 states, respondents were asked for their views about existing statutes and administrative rules and regulations. They rated activities in the areas of practice standards (scope of practice) as 1 (too much regulation), 2 (adequate regulation), or 3 (too little regulation). The average rating among the three groups was 1.99, adequate regulation.

Congruence: Some boards of nursing have authority over anyone practicing nursing without a license. Most practice settings verify licensure status upon employment and periodically thereafter.

Incongruence: The variability in eligibility requirements for initial licensure creates disparity in the qualifications of nurses across jurisdictions.

Incongruence: Not all boards of nursing regulate all nursing caregivers, interfering with the ability of those boards to apply consistent regulatory standards to all nursing care providers.

Incongruence: There is an assumption that nurse practice acts always lag behind changes in practice (written comment 2001). One regulator commented that statutes and regulations always lag behind developments in practice because regulation is by its very nature political (FARB, written comments, 2001). There is little evidence, however, to support this assumption. Many believe that NPAs are written in broad enough language to allow nurse practice to evolve. This assumption may stem from the way some boards interpret their statutes and rules; conservative and literal interpretations may not reflect current changes in practice.

Incongruence: Other professional groups restrict the ability of boards of nursing to modify or update nurse practice acts because of conflict over scopes of practice. The result may be limited accessibility to nursing care by the public.

Congruence: All boards validate minimal competency for initial licensure through a testing mechanism, with the exception of some categories of advanced practice nurses.

Incongruence: Criteria for and measurement of continuing competence have not been established, and license renewal processes are not contingent on validated continuing competency mechanisms.

Incongruence: The lack of uniform requirements creates disparity in the qualifications of nurses across jurisdictions. Research is needed to determine when this lack of uniformity is a barrier to congruence and when there should be standards in regulations.

Incongruence: While foreign-educated nurses are a possible source of nurses able to provide care to the increasing numbers of non-English speaking patients, the licensing of foreign-educated nurses presents many challenges.

Congruence: All jurisdictions have some mechanism for discipline to protect the public. Some boards provide alternative programs for impaired nurses.

Incongruence: Although there is a potential conflict in mission, regulators currently rely on specialty certifying bodies to assure competency in advanced practice.

Incongruence: Because of the lack of uniformity of regulations across jurisdictions, educational programs must undertake multiple processes to ensure that students gain national certification and state recognition to practice (Consortium, 2000).

Incongruence: Essential practice deficiencies are not reported by practice settings to boards of nursing in a timely and efficient manner.

Incongruence: Rules, policies and regulations sometimes conflict between boards of nursing and local, state, federal and facility regulation. There have been instances where the regulatory requirements, accreditation standards, and internal policies and procedures of health care delivery facilities conflict with the respective Nurse Practice Acts and rules.

Incongruence: There are insufficient mechanisms, opportunities, and funding to address the universe of system and individual practice errors consistently and effectively.

Incongruence: Even in mandatory reporting states, not all categories of errors are reportable or reported. The process of determining when to report may not be an objective one. Legal liability and risk may influence an individual or organization to comply with reporting requirements.

Education and Practice

Congruence: Practice relies on education for clinicians. New and expanded roles are continuously being developed.

Incongruence: Education is having a difficult time meeting the need for an adequate supply of qualified nurses. Nursing education programs have fewer applicants, graduates and faculty. The numbers of qualified applicants are not adequate to meet the current and future needs of the public for health care.

Incongruence: Nursing graduates do not reflect the diversity of the larger U.S. population. Cultural diversity of patient populations is not reflected in the nursing workforce. Research has shown that culturally diverse groups are discouraged from entering and/or completing nursing education.

Incongruence: If the creation of different types of educational preparation was intended to create differences in scope of practice, this did not happen. Advanced educational preparation may more appropriately enhance career opportunities after the entry level period once a nurse has acquired the necessary clinical experience.

Incongruence: Although many in the nursing community perceive differentiated practice as essential for the establishment of effective relationships among practice, education, and regulation, there has been little attempt by employing facilities to differentiate within similar roles according to educational preparation. A national survey of entry-level nurses (NCSBN, 2001) demonstrated that ADN and BSN graduates are hired into the same types of positions and perform the same tasks within their first six months of practice.

Incongruence: There is little evidence to indicate that differentiation should be driven by educational preparation. Rather, other factors, such as previous experience and personal competence, may be more logical factors to base differentiation on.

Congruence: There are collaborative efforts by education and practice in some jurisdictions to provide extern, intern, mentor and preceptor programs.

Incongruence: When practice settings do not support the transition from student to practicing nurse through formal mentorship or preceptorship programs, newly licensed nurses do not feel prepared for practice. Newly licensed nurses report a disconnect between employer requirements and the nurses' expectations of the practice environment.

Congruence: There is a philosophical tension that exists between education and practice: education for the future versus job training. Since both are needed (the new graduate must be prepared to enter the work force and yet must have the foundation necessary for life-long learning), this tension provides a system of "checks and balances."

Incongruence: Education programs are challenged to prepare students for increasingly complex practice. Newly licensed nurses do not feel adequately prepared for practice. Recent data collected by NCSBN (2001) demonstrated that graduates of all types of nursing education programs report similar levels of dissatisfaction with their preparation for essential entry-level nursing skills. Fewer than 60% of graduates of all programs perceived their preparation as adequate in most of these critical areas. Likewise, employers do not perceive new graduates as

prepared for entry-level practice, regardless of educational preparation. In a study conducted by NCSBN (2001a), employers rated fewer than 20% of new graduates as prepared to perform essential activities.

Incongruence: Public health nursing and population-focused nursing concepts receive inadequate attention in the nursing curricula, in part because faculty at large do not understand these concepts and do not value their inclusion in the curricula (ASTDN, written comments, 2001). Few nursing programs provide sufficient content or experience in perioperative nursing (AORN, written comments, 2001).

Incongruence: Education programs do not consistently provide theory content and clinical experience essential for practice. Curricula of today compares with that of 20 years ago, with additional content added. The acuity of patients and technology advancements are not consistently reflected in program curricula or syllabi.

Incongruence: Among clinical specialties, there is sometimes not a match between educational preparation and the role of the specialist.

Congruence: Education programs are available to practicing nurses. Articulation models are available for licensed nurses to move into roles with broader scopes of practice.

Incongruence: Obtaining a more advanced degree does not necessarily result in an advanced knowledge of entry-level nursing or enhanced perceptions of adequacy. Nurses have few incentives, such as higher salaries, for getting a higher degree, and practice is not differentiated by educational preparation.

Incongruence: There is an overlap in the roles of two types of advanced practitioners (NP and CNS).

Regulation, Practice and Education

Congruence: Leaders within practice, education and regulation create opportunities for communication and collaboration to ensure patient safety.

Congruence: There are documented best practice outcomes for patients and clients who receive care from licensed nurses.

Incongruence: More evidence is needed to link nursing program graduation requirements and regulatory criteria with safe entry-level practice.

Incongruence: Certification criteria for APRNs set by professional organizations are developed independent of regulation and education. Furthermore, there is confusion within the nursing community regarding the use of protected titles.

Incongruence: Regulation, standards of practice, and nursing program curricula differ among jurisdictions.

Incongruence: While an assumption is made that graduates from an approved nursing program who passed a licensing examination are able to practice safely at an entry level, there is no agreement among practice, education and regulation on criteria to measure safe post-entry practice.

Incongruence: Increasing numbers of reported negative outcomes for people who receive health care have been documented (IOM report), which is assumed to be the result of systems problems. Following this assumption, if all problems were fixed, all errors would go away.

Incongruence: There are no clear definitions of nursing roles (at any level)

agreed upon by practice, education and regulatory agencies. Inconsistencies also exist among APRN specialty program curricula, certification examinations and scope of practice.

Incongruence: There is a lack of understanding among practice and education of the role of the licensure examination. Practice-focused nursing organizations have demonstrated a misconception of the role of the examination in driving curricula (ASTDN, written comments, 2001).

Congruence: All three agree on the need to collectively work to respond to and minimize the nursing shortage.

Incongruence: Boards of nursing do not have authority to regulate the practice environment and, therefore, have limited ability to influence unsafe work environments or the incidence of system-related error.

Incongruence: Language barriers and cultural diversity present challenges in all three domains. Creating reasonable accommodation for disabilities impacts regulation, education and practice; more solutions are needed to assure public safety and provide opportunities.

Incongruence: A lack of reliable data regarding the nursing workforce, particularly those actively delivering patient care, impacts the ability to identify shortage areas, project future supply, or plan to resolve the shortage.

Congruence: A healthy separation exists when regulation provides a process for input from all affected parties and considers the input received, but in the end focuses on what is in the best interest of the public. In some states, mechanisms are in place that allows input from stakeholders during the drafting phase of regulation. When the driving focus of such efforts is public protection, these mechanisms provide valuable information to regulators, decrease the perception that regulation is an excessive burden over which practice and education has no control, eliminate delay in promulgating rules, and educate stakeholders (ACNP, written comments, 2001).

Incongruence: An unhealthy separation exists when boundaries are in place that exclude nursing education and practice from providing input and do not take into account information from a variety of sources. This results in a belief on the part of stakeholders that they are not part of the process.

Incongruence: When practice, education or regulation work to influence regulation from any agenda other than public protection, congruence is disrupted.

Incongruence: The variation and lack of standardization in regulations across jurisdictions are one cause of incongruence.

PERC Task Force – Attachment A

PERC Action Plan (Work Plan Draft)

Action	Organizations/ Parties Involved	Examples of Possible Tactics
I. Commit to an organizational environment supportive of change and innovation in Practice, Education, and Regulation.		
1. Foster open, honest communication among member boards, Board of Directors, NCSBN staff and enhance communication with nursing stakeholders and the public.	• Members • NCSBN • Other Nursing and Public Stakeholders	• Develop a comprehensive communication/outreach plan for members, stakeholders and the public. • Continue policy of open board and committee meetings for members, minutes posted and available on Web site. Offer web-based media for purposes of listening to deliberations and decisions and/or by conference call.
2. Strengthen communication among practice, education and regulation.	• Practice, Education and Regulation	• Build coalitions of practice, education and regulatory leaders in states. • Work on innovative projects that include education, practice and regulation; report results to the 2004 Delegate Assembly.
3. Create a professional culture based on mutual respect and trust where opinions of practice, education, regulation representatives and members and staff are valued.	• NCSBN and its Members, • Practice, Education and Regulation	• Ensure involvement of a broad range of members and relevant stakeholders in committees and groups and provide ongoing opportunities for input. • Offer open forums about contemporary nursing and health care issues involving internal and external stakeholders (i.e. patient safety and work environment issues).
4. Enhance educational and informational resources regarding the purpose of NCSBN and State Boards of Nursing.	• NCSBN • Regulation and Education	• Web site presentations; member and staff contact directory based on member needs. • Expand regulatory and NCSBN orientation for newly appointed executive officers beyond current single day model. • Develop and offer regulatory and NCSBN orientation for board presidents and members. • Promote and provide resources for education of students and licensees.
5. Commit to ongoing evaluation and improvement as an NCSBN core competency.	• NCSBN	• Have an outside independent agency develop and implement evaluation tools for member boards to evaluate NCSBN. • Prepare and implement an ongoing, systematic evaluation and performance improvement plan.
6. Assess the health care and nursing environments and analyze the impact of change and innovation on regulation.	• NCSBN • Practice and Regulation	• Conduct a periodic environmental scan to assess the health care and nursing environments.

Action	Organizations/ Parties Involved	Examples of Possible Tactics
		• Analyze practice changes and compare with state laws and regulations. • Develop a model to assure consistency of nursing practice.
II. Promote regulatory excellence based on ongoing data collection and best practices.		
1. Develop and implement a performance measurement model and indicators of excellence in regulation.	• NCSBN • Regulation	• Commitment to Excellence project providing data and identifying best practices. • Board structure and function. • Communication model and networking amongst Member Boards. • Alternative discipline programs. • Uniform regulation. • Participation in Nursys, HIPDB. • Technology consistency. • Role of attorneys to assist in board functions. • Collaborate with practice and education.
2. Create a comprehensive, unduplicated database of nursing and regulatory information for member and public use.	• NCSBN • Regulation	• Allow employer, other stakeholder and public access to defined data elements. • Achieve 100% participation by members in Nursys. - Clarify benefits/costs for data sharing. - Effect value added through information. - Assist member boards to overcome legal and financial barriers. - Assist (fund) Member Boards with IT expertise. - Mechanism for Homeland Security – information. • Create and maintain *Profiles* databases online. • Utilize existing data sources (i.e., NCSBN, Colleagues in Caring, state Centers for Nursing, HRSA, Dept. of Labor).
III. Ensure that US and foreign educated graduates and new nurses are prepared for safe practice.		
1. Develop and utilize evidence-based indicators of quality nursing education for the roles of all nurses and ensure quality nursing education programs.	• Education and Regulation	• Promote information between BON, educators, accreditators. • Develop plan for total program (SON) evaluation based on evidenced-based indicators. • Develop recommendations for ongoing dissemination of nursing education program results.
2. Enhance model rules to reflect standards and indicators of quality nursing education.	• NCSBN • Regulation	• Evaluate model rules and make recommendations for change.

Action	Organizations/ Parties Involved	Examples of Possible Tactics
3. Collaborate with accrediting agencies and nursing education programs for an effective approval and accreditation process.	• Education and Regulation • NCSBN	• Develop a position statement of the role of boards of nursing, accreditors and nursing education programs in ensuring quality nursing education that maintains board authority yet reduces duplication of effort. • Develop criteria and a national model for the use of accreditation for regulatory purposes.
4. Clarify current foreign nurse regulatory issues and identify potential solutions.	• NCSBN • Regulation and Practice	• Analyze data and compare mechanisms regarding eligibility criteria of foreign-educated nurses to sit for NCLEX® among Member Boards. • Delineate basic competencies of foreign-educated nurses for safe entry-level practice language/communication skills; nursing competencies • Evaluate implications of immigration/NAFTA for safe entry-level practice. • Anticipate and plan education of legislators regarding public safety implications of entry competence testing for foreign educated nurses.
5. Develop model rules for licensing foreign-educated nurses.	• NCSBN • Regulation	• Refine model rules for initial licensure and endorsement of foreign educated nurses (English competency; nursing competence, evaluation of educational programs/curriculum). • Disseminate model foreign-educated nurse rules to Member Boards.
6. Identify and promote effective models to facilitate a successful transition by the foreign educated nurse into US practice roles and environment.	• Regulation, Education and Practice	• Collect and disseminate information on the transition experiences of foreign-educated nurses and develop an effective model to address education and information gaps.
IV. Develop scopes of practice for the roles of all nurses, measures of continued competence of all nurses, and parameters of practice for nursing assistive personnel (NAP).		
1. Promote equivalency in essential elements of licensing and scope of practice for all nurses.	• NCSBN • Regulation, Education and Practice	• Explore uniform titles, scopes, and credentialing across all jurisdictions. • Improve model nurse practice acts to reflect uniform titles, scopes of practice and credentialing of NAP across jurisdictions. • Define roles/credentials/competencies of each level of licensure for LPNs, RNs, and APRNs (including parameters of delegation). • Encourage adoption of the APRN Uniform Requirements.
2. Design ways to build flexible and consistent Nurse Practice Acts and regulations that allow for changes in practice across jurisdictions.	• NCSBN • Practice and Regulation	• Develop a mechanism for ongoing review and revision of the model act and its applicability to current practice. • Create a plan for frequent evaluation of the use and effectiveness of the model act concepts and their outcomes. • Develop a plan to educate Member Boards regarding model acts. • Create uniform national guidelines for discipline.

Action	Organizations/ Parties Involved	Examples of Possible Tactics
		• Evaluate and communicate success/challenges of nurse licensure compact model. • APRN Task Force to work on scopes of practice for APRN specialties (broad enough so that APRNs can practice safely). Work on model rules in FY2003.
3. Develop tested measures and methods to ensure continued competence of all nurses and promote patient safety.	• NCSBN • Practice and Regulation	• Provide a technology-based tool to measure competency. • Evaluate data from Job Analysis; evaluate data from CIC by education level; evaluate Member Board Profiles by education level and by jurisdiction. • Secure data for APRN practice (if available). • Organize a panel at Midyear Meeting re: models and outcomes of state demonstration projects. • NCSBN to serve as a clearinghouse of data and collaboration of all state projects in measuring and evaluating outcomes. • Modify employer survey tool to include data for all roles of nursing and several environmental variables. • Develop post-licensure tools to measure continued competency and evaluate their effectiveness. • Utilize post-entry competence study will give us information about the roles and competencies of RNs and PN/VNs. • Collaborate with certification, education and specialty organizations for determining APRN competencies. • Utilize CE study results.
4. Assume a leadership role in designing processes to ensure patient safety, collaborating with health care systems.	• NCSBN • Practice and Regulation	• Support innovative and collaborative national/state projects. • Collect and study trends in errors and practice breakdown. • Provide information to health care and public facilities regarding public protection processes. • Assist with legislative strategies to encourage implementation of model acts. • Develop model scopes for each level of licensure based on education by a task force of equal representation such as PERC. • Evaluate various BON, practice setting, and employer data.
5. Identify parameters of practice and competencies for nursing assistive personnel.	• Practice and Regulation	• Review NAPNES' retention study (MISCO research). • Clearly define roles of nursing assistive personnel. • Describe essential competencies of NAP. • Once core competencies are identified, determine minimum education requirements for credentialing Nursing Assistive Personnel. • NCSBN to develop a white paper and a position statement that

Action	Organizations/ Parties Involved	Examples of Possible Tactics
6. Identify and promote effective models to facilitate a successful transition by new nurses from education to practice.	• NCSBN • Practice, Education and Regulation	supports regulation of NAP by boards of nursing. • Collect information about demonstration projects for education to practice transition models. • Conduct more frequent job-entry analysis surveys and survey employers regarding their expectations). • Collaborate with ANA/AONE: data regarding mentorships, preceptorships, and internships. • Provide information regarding CIC: projects in states. • Review NLNAC/CCNE: standards regarding graduate and employer satisfaction surveys. • Gather data from AHA and AHCA about retention. • NCSBN to partner with AONE for longitudinal study.
7. Participate in strategies for retention of the new graduate.	• Practice and Education	• A mechanism to track retention outcomes for new graduates. • Utilize evidence-based data re: effectiveness of transition programs to create an education-practice transition model. • Disseminate information on the education-practice transition model.

PERC Flow Chart follows on next page...

Pathway to Congruence of Practice, Education and Regulation

THE PROBLEM: AREAS OF INCONGRUENCE AMONG PRACTICE, EDUCATION, REGULATION

- Differing requirements, standards, processes, expectations.
- Staff/faculty shortages and increased nursing complexity.
- Limited collaboration among nursing leadership groups.
- Blurring of nursing scopes of practice and roles of assistive personnel.
- Increased reports of negative outcomes for patients/clients.
- Duplication of efforts in spite of resource limitations.
- Insufficient evidenced based outcomes for practice, education, regulation and nurse competency.

NCSBN: PROMOTE EDUCATION, COLLABORATION, INFORMATION

- Foster open, honest communication among members, Board of Directors, NCSBN staff and enhance communication with nursing stakeholders and public (I).
- Create a professional culture based on mutual respect and trust where opinions of practice, education, regulation representatives and members and staff are valued (I).
- Enhance educational and informational resources regarding the purpose of NCSBN and State Boards of Nursing (I).
- Commit to ongoing evaluation and improvement as an NCSBN core competency (I).
- Assess the health care and nursing environments and analyze the impact of change and innovation on regulation (I).
- Create a comprehensive, unduplicated database of nursing and regulatory information for member and public use (II).
- Collaborate with accrediting agencies and nursing education programs for an effective approval and accreditation process (III).
- Enhance model rules to reflect standards and indicators of quality nursing education (III).
- Clarify current foreign nurse regulatory issues and identify potential solutions (III).
- Develop model rules for licensing foreign-educated nurses (III).
- Design ways to build flexible and consistent Nurse Practice Acts and regulations that allow for changes in practice across jurisdictions (IV).
- Promote equivalency in essential elements of licensing and scope of practice for all nurses (IV).
- Develop tested measures and methods to ensure continued competence of all nurses and promote patient safety (IV).
- Assume a leadership role in designing processes to ensure patient safety, collaborating with health care systems (IV).
- Identify and promote effective models to facilitate a successful transition by new nurses from education to practice (IV).

PRACTICE: ENSURE QUALITY OF PRACTICE BY NURSES AND ASSISTIVE PERSONNEL

- Assess the health care and nursing environments and analyze the impact of change and innovation on regulation (I).
- Develop and implement a performance measurement model and indicators of excellence in regulation (II).
- Create a comprehensive, unduplicated database of nursing and regulatory information for member and public use (II).
- Design ways to build flexible and consistent NPAs and regulations that allow for changes in practice across jurisdictions (IV).
- NCSBN and member boards take a leadership role in designing processes to ensure patient safety, collaborating with health care systems (IV).
- Identify parameters of practice and competencies for nursing assistive personnel (IV).
- Participate in strategies for retention of the new graduate (IV).

EDUCATION: ENSURE QUALITY NURSING EDUCATION & FACULTY

- Enhance educational and informational resources regarding the purpose of NCSBN and State Boards of Nursing (I).
- Develop and utilize evidence-based indicators of quality nursing education for the roles of all nurses and ensure quality nursing education programs (III).
- Collaborate with accrediting agencies and nursing education programs for an effective approval and accreditation process (III).
- Enhance model rules to reflect standards and indicators of quality nursing education (III).
- Participate in strategies for retention of the new graduate (IV).

PERC CHARGE

The committee will develop and recommend an action plan to the 2002 Delegate Assembly to clearly delineate and establish congruence among education, practice, and regulation for nursing. The committee will develop the plan in collaboration with members and a broad base of health care stakeholders for presentation no later than the 2002 Delegate Assembly for a decision regarding implementation of the plan.

PRACTICE, EDUCATION, REGULATION CONGRUENCE

- Strengthen communication among practice, education and regulation (I).
- Create a professional culture based on mutual respect and trust where opinions of practice, education, regulation representatives and members and staff are valued (I).
- Develop and implement a performance measurement model and indicators of excellence in regulation (II).
- Identify and promote effective models to facilitate a successful transition by the foreign educated nurse into US practice roles and environment (III).
- Identify and promote effective models to facilitate a successful transition by new nurses from education to practice (IV).
- Develop tested measures and methods to ensure continued competence of all nurses and promote patient safety (IV).
- Build collaboration to promote innovative strategies to address issues pertinent to education, practice and regulation.
- Ensure that US educated graduates are prepared for safe practice.
- Promote equivalency in essential elements of licensing and scope of practice for all nurses (IV).

REGULATION: ENSURE QUALITY REGULATORY PRACTICE & PUBLIC PROTECTION

- Foster open, honest communication among member boards, Board of Directors, NCSBN staff, and strengthen communication with nursing stakeholders and the public (I).
- Enhance educational and informational resources regarding the purpose of NCSBN and State Boards of Nursing (I).
- Assess the health care and nursing environments and analyze the impact of change and innovation on regulation (I).
- Develop and implement a performance measurement model and indicators of excellence in regulation (II).
- Create a comprehensive, unduplicated database of nursing and regulatory information for member and public use (II).
- Develop and utilize evidence-based indicators of quality nursing education for the roles of all nurses and ensure quality nursing education programs (III).
- Enhance model rules to reflect standards and indicators of quality nursing education (III).
- Collaborate with accrediting agencies and nursing education programs for an effective approval and accreditation process (III).
- Clarify current foreign nurse regulatory issues and identify potential solutions (III).
- Develop model rules for licensing foreign-educated nurses (III).
- Design ways to build flexible and consistent NPAs and regulations that allow for changes in practice across jurisdictions (IV).
- NCSBN and member boards take a leadership role in designing processes to ensure patient safety, collaborating with health care systems (IV).

Report of the Awards Recognition Panel

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of the Awards Recognition Panel

The Awards Recognition Panel was established by the Board of Directors to review the NCSBN awards program, to develop a new program to promote consistency and fairness, and to celebrate the accomplishments of the membership. The panel was given the charge to refine the nomination and selection process and establish clear, concise award objectives and criteria for eligibility. For FY02, the Awards Task Force was renamed the Awards Recognition Panel by the Board of Directors based on clarification of its purpose and an amendment to its charge.

Highlights of FY02 Activities

- Refined the 2001 NCSBN Awards program by implementing several revisions to:
  - Award names and award descriptions
  - Criteria for selection
  - Nomination process
  - Eligibility
- Promoted the 2002 Awards Program at the Midyear Meeting to encourage nominations from the membership.
- Collaborated with the managing editor to redesign the 2002 Awards Program brochure.
- Developed a process for the installation of new officers and for the recognition of outgoing officers at the Delegate Assembly closing ceremony.
- Established that all outgoing presidents of the Board of Directors receive a special resolution and crystal gavel at the end of their terms.
- Conducted an objective, blind review of all award nominations submitted for the 2002 Awards Program and recommended award recipients to the Board of Directors.
- Planned with the 25th Anniversary Planning Advisory Panel to host the NCSBN birthday party during the annual awards luncheon at 2003 Delegate Assembly.

Future Activities

- Evaluate the 2002 Awards Program and submit recommendations to the Board of Directors concerning the future of the Awards Recognition Panel.

Panel Members

Sharon Weisenbeck, Executive Director, KY, Area III, Chairperson

Donna Dorsey, Executive Director, MD, Area IV

Susan Wambach, Board Member, MI, Area II

Board Liaison
Barbara Morvant, Executive Director, LA-RN, Area III, Treasurer

Staff
Alicia Byrd, Member Relations Manager

Rosemary Gahl, Member Relations Assistant

Relationship to Strategic Plan

Strategic Initiative 5 – Governance & Leadership Development and Organizational Capacity:
The National Council will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome 2: Member Boards understand the services of National Council.

Meeting Dates

- November 12, 2001 (teleconference call)
- December 6, 2001
- January 9, 2002 (teleconference call)
- June 10, 2002

Attachments

None.

Committee Members

Laura Rhodes, Executive Officer, WV-RN, Area II, Chair

Theresa Bonanno, Executive Officer, MA, Area IV

Christine Glidden, Board President, NM, Area I (*resigned February 2002*)

Greg Harris, Board Member, AZ, Area I

Board Liaison
Myra Broadway, Executive Director, ME, Area IV, Director-at-Large

Staff
Kathy Apple, Executive Director

Relationship to Strategic Plan

Strategic Initiative 5 – Governance & Leadership Development and Organizational Capacity. The National Council will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome 3: A sound organizational governance and management infrastructure advances the National Council's mission and vision.

Meeting Dates

- October 30, 2001
- January 29, 2002
- February 26, 2002 (via conference call)
- March 26, 2002
- April 4, 2002

Attachments

None. See 2002 Standing Rules of the Delegate Assembly.

Report of the Bylaws Committee

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background

New Committee Charge
The Bylaws Committee became a standing committee based on revisions to the bylaws by the 2001 Delegate Assembly. The new charge to the committee is to review and make recommendations on proposed bylaws amendments as directed by the Board of Directors or the Delegate Assembly. No proposed bylaw amendments were directed to the committee from either the Delegate Assembly or the Board of Directors.

Review of the Standing Rules of the Delegate Assembly
The committee was directed this year to review and revise the Standing Rules of the Delegate Assembly. A thorough revision was conducted including input from the Resolutions Committee.

The Board of Directors approved the revised Standing Rules on May 2, 2002.

Highlights of FY02 Activities

- Revise the Standing Rules of the Delegate Assembly.

Future Activities

- Review and recommend bylaw amendments as directed by the Delegate Assembly or the Board of Directors.

Report of Commitment to Excellence Advisory Group and Pilot States

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of the Commitment to Excellence Project

In 1998, the NCSBN Board of Directors decided to embark on a ground-breaking project: the establishment of a performance measurement system that incorporates data collection from internal and external sources and the use of benchmarking strategies and identification of best practices. A Board-appointed project Advisory Group provided oversight and guided development of an innovative, sustainable system based on outcomes and focused on the identification of best practices. Twelve dedicated member boards (Kentucky, Louisiana RN, Maryland, Missouri, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Tennessee, Texas RN, and West Virginia PN) contributed time and resources to the development of 10 instruments used to gather data in five areas: discipline, licensure, practice, education, and governance.

Instruments have been developed to collect data on processes, outputs and outcomes boards of nursing, and a full data collection effort is currently under way. Deadlines for receipt of all 2000 data (including 5 templates) were March 1, 2002. An interim report of data analysis and "best practices" was presented at the 2002 Midyear meeting, and a final report of "best practices" will be presented at the education day prior to the 2002 Delegate Assembly.

Final tools developed for data collection included six board surveys tools (discipline, licensure, practice, education, and two governance tools) and six stakeholder tools (nurses who had been the subject of a complaint (NCA), persons who had made a complaint (PMC), a random selection of licensees (nurses), employers of nurses, associations, and nursing programs.

Twenty-eight boards have submitted all of the data required and an additional seven have submitted much of their data, for a total of thirty-five (57%) boards. Another nine boards have submitted one to three tools only.

This exciting and groundbreaking project (no other regulatory group has approached performance evaluation in this manner or to this extent) will clarify the important work of boards of nursing, demonstrate value, and identify best practices.

Highlights of FY02 Activities

- The project advisory group provided consultative assistance with development of an evaluation tool for compact states.
- The tool development workgroup met for the final time. Members completed work on the sixth stakeholder tool: nursing program survey. The workgroup also provided feedback to the advisory group regarding the System of Performance Evaluation under development at that time.

Advisory Group Members

Diana Vander Woude, Chair (Member 1999- 2002), SD, Area II

Joan Bouchard, Executive Officer (Member 1999-2002), OR, Area I

Myra Broadway, Executive Officer (Member 1999-2001), ME, Area IV

Donna Dorsey, Executive Officer (Member 1999-2002), MD, Area IV

Polly Johnson, Member (Member 1999-2002), NC, Area III

Marcia Rachel, Member (Member 1999), MS, Area III

Board Liaison

Myra Broadway, Executive Officer (2001-2002), ME, Area IV, Director-at-Large

Pilot State Work Group

Lanette Anderson, Board Staff, WV-PN, Area II

Karla Bitz, Board Staff, ND, Area II

Debra Brady, Executive Officer, NM, Area I

Charlene Kelly, Executive Officer, NE, Area II

Elizabeth Lund, Executive Officer, TN-, Area III

Sue Milne, Board Staff, OH, Area II

Cynthia Morris, Board Staff, LA-RN, Area III

Tawnya Smith, Board Staff, TX-RN, Area III

Calvina Thomas, Board Staff, MO, Area II

Dee Esry, Board President, MO, Area II

Sharon Weisenbeck, Executive Officer, KY, Area III

Sandy Johanson, Credentials, Board Staff, KY, Area III

Jean Lazarus, Consultant

Staff

Lynda H. Crawford, Director of Research Services

Esther White, Research Project Coordinator

Relationship to Strategic Plan

Strategic Initiative 2 – Changing Practice Settings: The National Council will coordinate the identification of effective regulatory outcomes and assist Member Boards to implement and evaluate strategies for sound regulation.

Outcome 1: An articulated relationship demonstrating the benefits of nursing regulation for the public health, safety and welfare.

Meeting Dates

- November 5 & 6, 2001
- January 17 & 18, 2002
- February 15, 2002 (teleconference)
- July 15 & 16, 2002

Attachments

None.

- The advisory group completed development of an ongoing, systematic, organization-wide performance measurement system, the System of Performance Measurement. The NCSBN Board of Directors approved the system in January.
- A System of Performance Measurement manual has been under development for four months. The manual will be distributed to member boards at the 2002 Delegate Assembly.
- The advisory group began development of processes of best practices identification.

Future Activities

- There will be a training and orientation workshop for members prior to the 2002 Delegate Assembly. Manuals will be distributed at that time.
- The project will be completed August 2002. The ongoing System of Performance Measurement will be initiated August 2002.

Report of Disciplinary Curriculum Advisory Panel

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of the Disciplinary Curriculum Advisory Panel

Boards of nursing spend much of their time and resources in resolution of complaints that are received regarding the practice of licensees. The number of complaints and cases is growing. The process of resolution, including investigation, prosecution and decision-making is increasingly complex. Boards monitor more nurses under some form of discipline order, and at the same time, are often faced with decreasing resources and fewer staff to manage these cases.

The Board of Directors first appointed the Disciplinary Curriculum Advisory Panel in 2001. Its charge was to plan an Investigators Summit that was held June 22-23, 2001. The panel members reviewed evaluations from the 2001 event, reviewed notes from the Discipline and Practice "Building Bridges" networking groups at the 2001 NCSBN Annual Meeting, and reviewed results to date of the Regulatory Issues Survey conducted by the Practice, Regulation and Education (PR&E) Committee. The advisory panel members also discussed other current issues and trends affecting disciplinary process as a background for planning the 2002 Summit.

2002 Investigators Summit

In 2002, the advisory panel was again charged to conduct a summit that was held June 20-21, 2002. Program topics included criminal background checks, interviewing skills, pain management (approaches, concerns, and when does it becomes a regulatory issue), and the opportunity to learn from previous discipline cases. Based on comments from the 2001 evaluations, the following changes were incorporated in the 2002 program:

- CEUs were offered.
- Networking opportunities were expanded (two networking lunches provided).
- 2002 audience was expanded to include all staff involved with fact-finding, prosecuting and deciding nursing board discipline cases.
- The summit was held in a more conducive learning environment.
- Communications regarding the summit were improved.

Attorney Summit

The Disciplinary Curriculum Advisory Panel agreed to a proposal by the Arizona Board of Nursing to hold an Attorney Summit in conjunction with the 2002 Investigator Summit. The panel members agreed that having the meetings together would allow Member Board participants to attend two meetings on one trip. They also agreed that holding the events at separate times might negatively affect the attendance at both. Attention was paid to both agendas so topics were not duplicated.

Discipline Resource Plan

In addition to planning a second Investigators Summit in 2002, the Disciplinary Curriculum Advisory Panel was also charged with developing and beginning to implement a plan for updating and creating other types of disciplinary resources.

Advisory Panel Members

Valerie Smith, Board Staff, AZ, Area I, Chair

Anthony Diggs, Board Staff, TX-RN, Area III

Donald Hayden, Board Staff, SC, Area III

Terrie Miller, Board Staff, CO, Area I

Donna Mooney, Board Staff, NC, Area III

Marsha Straus, Board Staff, OH, Area II

Emmaline Woodson, Board Staff, MD, Area IV

Board Liaison
Paula Meyer, WA, Area I, Director-at-Large

Staff
Vickie Sheets, Director of Practice and Regulation

Relationship to Strategic Plan

Strategic Initiative 2 – Regulatory Effectiveness: The National Council will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome 6: New knowledge and research supports regulatory approaches to discipline, remediation and alternative processes.

Strategic Initiative 5 – Governance & Leadership Development and Organizational Capacity: The National Council will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome 1: Member Boards staff and members access multiple levels of educational programs to develop core competencies in regulation.

Meeting Dates

- December 7-8, 2002
- March 18-19, 2002
- April 23, 2002 (Conference Call)
- May14, 2002 (Conference Call)
- June 21-22, 2002 (Investigator Summit)

Attachments

A. Proposed NCSBN Discipline Resources Plan

The panel members reviewed an array of materials, reviewed and made recommendations regarding existing NCSBN resources, and obtained feedback from the 2001 Investigator Summit participants. The suggestions from the discipline-networking group at the 2001 NCSBN Annual Meeting were also considered.

The advisory panel developed a plan for providing additional discipline resources to members in the following categories:
- Discipline Resources.
- Communications/Networking.
- Consultations/Collaborations.
- Education/Training Resources.

To address member needs, the Disciplinary Curriculum Advisory Panel developed the *Discipline Resource Plan* encompassing a wide range of resources to support various points of the discipline process. The plan proposes written, electronic and interactive resources. The plan also includes increased opportunities for Member Board staff and attorney networking and consulting and methods of collaborating with other organizations.

The discipline resources plan is found at Attachment A to this report. The plan presented provides category-specific tactics, a designated priority ranking, the proposed year of implementation and represents a modified version of a more detailed staff/committee work plan. The plan will be implemented in stages according to member priorities and resources available. The Board of Directors approved the plan at its May 2002 meeting. A Discipline Task Force is desirable to implement this plan and to continue to support the critical regulatory work in this area.

Highlights of FY02 Activities

- Planned and implemented a 2002 Investigator Summit.
- Reviewed current NCSBN discipline resources and member needs.
- Developed the *Discipline Resource Plan* approved by the Board of Directors.

Future Activities

- Implement the Discipline Resource Plan as feasible.

Disciplinary Curriculum Advisory Panel – Attachment A

Proposed NCSBN Discipline Resources Plan 2002-2005

Tactic	Priority	Year
Category One – Discipline Resources		
1. Develop guidelines for top violations for investigators, attorneys and members.	High	2003
2. Enhance disciplinary information in Member Board Profiles.	Medium	2003
3. Prepare a series of samples and model reports, order case studies, and legal documents.	Medium	2003-2004
Category Two – Communication/Networking		
1. Track addresses of nurses for document serving and imposter alerts.	High	2004
2. Collect and maintain state contact list for networking.	Medium	2003
3. Provide access to and relevant organizational Web links.	High	2003
4. Initiate quarterly disciplinary staff conference calls.	High	2003
5. Develop and maintain biannual discipline newsletter (alternative: articles in Council Connector).	Medium	2004
6. Track discipline cases specific to Nurse Licensure Compact cases.	Medium	2003
Category Three – Consultations/Collaborations		
1. Explore for possible implementation of a mentoring program for new board staff.	Low	2004
2. Maintain a directory of content experts on various topics.	Medium	2004
3. Consider need for NCSBN Interstate Discipline Coordinator.	Low	2005
4. Consider a member resource program to provide member discipline consultants to boards needing assistance.	Low	2005
5. Explore opportunity for member involvement and collaboration with CLEAR and FARB.	Medium	2003
Category Four – Education/Training Resources		
1. Conduct summits/workshops/seminars.	High	2002
2. Schedule education sessions in conjunction with NCSBN Midyear and Annual Meetings.	High	2002
3. Provide speaking opportunities support for experienced members.	Medium	As available
4. Explore potential for enhanced distance education (video conference and other electronic interactive approaches to increase member participation).	High	2002

Committee Members

Anita Ristau, Executive Officer, VT, Area IV, Chair

Christine Alichnie, Board Member, PA, Area IV

JoAnn Allison, Board Staff, NH, Area IV

Diana Baker, Board Member, UT, Area I (*served on Committee until January, 2002)*

Teresa Bello-Jones, Executive Officer, CA-VN, Area I

Cora Clay, Board Staff, TX-VN,

Area III

Sheila Exstrom, Board Staff, NE, Area II

Mary Kay Habgood, Board Member, FL, Area III

Lorinda Inman, Executive Officer, IA, Area II

Jackie Murphree, Board Staff, AR, Area III

Board of Director Liaison
Marcia Hobbs, Board President, KY, Area III, Vice President

Item Review Subcommittee Members

Cheryl Anderson, Board Staff, CA-VN, Area I

Mary Calkins, Board Staff, WY, Area I

Lois Churchill, Board Staff, IA, Area II

Claire Doody-Glaviano, Executive Officer, LA-PN-, Area III

Sharon Dschaak, Board Member, MT, Area I

Janice Lanier, Executive Officer, OH, Area II

Sandra MacKenzie, Board Staff, MN, Area II

Cynthia Purvis, Board Staff, SC, Area III

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Report of the Examination Committee

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of the Examination Committee

The Examination Committee is charged with providing state-of-the-art, entry-level nurse licensure assessments to NCSBN Member Boards of Nursing. In order to accomplish this outcome, the committee monitors the NCLEX-RN® and NCLEX-PN® examination processes to ensure policies, procedures and standards utilized meet and exceed guidelines proposed by the testing and measurement industry. The Examination Committee investigates future enhancements to NCLEX examinations and monitors all aspects of examination development and administration.

In addition, the committee oversees the activities of the Item Review Subcommittee, which in turn assists with the item development and review process. Further, the committee receives and reviews input from the Test Service Technical Subcommittee concerning technical elements of the NCLEX Test Service Transition. All of these activities combine to produce the psychometrically sound and legally defensible NCLEX examinations. The total number of appointments from Member Boards to the Examination Committee, Item Review Subcommittee and Test Service Transition Subcommittee represents nearly half of the 61 NCSBN Member Boards.

Highlights of FY02 Activities

Evaluated and monitored NCLEX examination policies and procedures.
The committee evaluated the efficacy of Board of Directors-approved examination-related policies and procedures and Examination Committee policies and procedures. As an extension of this quality control process, the committee reviewed and adopted necessary modifications and enhancements to the *NCLEX Member Board Manual* and the NCLEX Evaluation Framework. Revisions were made to pertinent procedures in order to reflect improvements in processes that needed to be changed or refined during the eighth year of the administration of NCLEX via computerized adaptive testing.

Monitored all aspects of examination development.

- *Conducted committee and Item Review Subcommittee sessions.*
  In the interest of maintaining consistency regarding the manner in which NCLEX examination items are reviewed before becoming operational, the committee: (1) reviewed RN and PN Chauncey items and RN and PN NCS Pearson items prior to pretesting, (2) recommended that at least two Examination Committee members lead each Item Review Subcommittee meeting, and (3) made final decisions addressing revisions to coding, Operational Definitions for Client Needs, NCLEX Style Manual, Operational Definitions for Integrated Concepts/Processes and Guidelines for Currency Review.

  Under the direction of the Examination Committee, RN and LPN-VN pretest questions were also reviewed (see charts next page). Item review panels reviewed NCLEX-RN and NCLEX-PN pretested items plus Master Pool items.

In addition, the Item Review Subcommittee reviewed real examinations for face validity at its February 2002 meeting and provided a detailed report to the Examination Committee. Assistance from the Item Review Subcommittee continues to reduce item review workload, facilitating the efforts of the Examination Committee toward achieving defined goals.

- *Monitored item production.*
  The Examination Committee has continued to emphasize to test service the importance of writing items that address higher levels of cognitive processing, such as application and analysis. Since the October 1999 pool, both the RN and LPN/VN pools have seen an increase in the total number of items at higher cognitive levels of application and analysis. A significant outcome of this increase is that examinations of different lengths and estimated ability levels have less variability in the percentages of items in the higher cognitive levels. Furthermore, Chauncey has met contractual item production schedules for the current fiscal year, therefore, achieving the goal of developing sufficient numbers of items to maintain the requisite number of high quality operational item pools.
- *Evaluated item development process and progress.*
  The committee evaluated Item Writing and Item Review sessions conducted by both test services. Committee representatives attended and monitored each of the item development sessions and provided feedback to the committee and to the test service. Overall, each of the sessions was rated favorably.
- *Monitored the development of operational NCLEX item pools.*
  The Examination Committee and NCSBN staff monitored the configuration of RN and LPN/VN operational item pools. The criterion for splitting and sculpting item pools includes many clinical and psychometric variables. The resulting operational item pools were evaluated with regard to these variables and were found to be within tolerance.

  To ensure that the operational item pools and item selection algorithm were functioning together as expected, simulated examinations were evaluated. Using these simulated examinations, the functioning of the algorithm was scrutinized with regard to the distribution of items by test plan subcategory; it was concluded that the operational item pools and the item selection algorithm were acting in concert to produce tests that were within NCSBN specifications and were comparable to tests from previous administrations. These conclusions were re-enforced by replicating the results later using actual candidate data. Examination Committee will continue to monitor performance of the NCLEX examinations through these and other psychometric reports and analyses.

Donna Roddy, Board Member, TN, Area III

Patty Shutt, Board Member, NV, Area I

Ellienne Tate, Board Staff, LA-RN, Area III

Board of Director Liaison

Iva Boardman, Executive Director, DE, Area IV Director

Test Service Technical Subcommittee

Donna Aversa, Board Staff, MD, Area IV

Bobbye Hicks, Board Staff, NV, Area I

Sandra MacKenzie, Board Staff, MN, Area II

Renee McClellan, Board Staff, CA-RN, Area I

Lori Scheidt, Executive Officer, MO, Area II

Carol Silveira, Board Staff, MA, Area IV

Staff

Casey Marks, Director of Testing Services

Kristin Garcia, Testing Services Operations Manager

Susan Gawel, Statistician

Fay Green, NCLEX® Administration Coordinator

Lenore Harris, NCLEX® Content Associate

Lorraine Kenny, NCLEX® Content Associate

Harlene Pearlman, NCLEX® Content Associate

Kathy Potvin, NCLEX® Senior Administration Coordinator

Thomas O'Neill, Psychometrician

Michael Tomaselli, NCLEX® Administration Manager

Anne Wendt, NCLEX® Content Manager

Relationship to Strategic Plan

Strategic Initiative 1 – Nursing Competence: National Council will assist Member Boards in their role in the evaluation of nurse and nurse aide competence.

Outcome 1: NCLEX® is state of the art entry-level nurse licensure assessment.

Outcome 2: NCLEX® is administered at international sites for purposes of domestic licensure.

Outcome 3: International testing exams are explored for foreign nurse licensure.

Outcome 5: Targeted constituencies utilize NCLEX® programs and related products/services.

NCSBN Item Development Sessions Held at Chauncey Group International

RN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed	Items Approved	Survival Rate
4/96 - 3/97	10	134	3,815	11	3,225	2,952	92.0%
4/97 - 3/98	8	90	2,929	11	3,326	3,252	97.7%
4/98 - 3/99	5	73	2,060	4	1,414	1,378	97.4%
4/99 - 3/00	3	47	1,289	6	1,834	1,787	97.4%
4/00 - 3/01	3	43	1,265	5	1,449	1,409	97.2%
4/01 - 3/02	0	0	0	3	1,053	1,032	98.0%

LPN/VN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed	Items Approved	Survival Rate
4/96 - 3/97	8	92	2,503	8	2,417	2,001	83.0%
4/97 - 3/98	7	83	2,362	7	2,439	2,419	99.0%
4/98 - 3/99	4	56	1,636	5	1,520	1,499	98.6%
4/99 - 3/00	4	56	2,125	4	1,180	1,152	97.6%
4/00 - 3/01	4	54	2,002	6	1,299	1,284	98.8%
4/01 - 3/02	0	0	0	3	1,115	1,098	98.5%

NCSBN Item Development Sessions Held at Pearson Professional Testing

RN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed	Items Approved	Survival Rate
4/01 - 3/02	3	35	1,593	1	323	323	100%

LPN/VN Item Development Productivity Comparison

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed	Items Approved	Survival Rate
4/01 - 3/02	3	36	1,700	1	328	327	99.69%

- *Initiatives prior to consideration of anticipated changes to the NCLEX-RN® Test Plan.*
  In advance of the triennial RN practice analysis, the committee formulated additional criteria for use in the evaluation of the upcoming *NCLEX-RN® Test Plan*.

- *Time length for the NCLEX-RN.*
  The committee formally endorsed a recommendation to extend the time limit for the NCLEX-RN examination from the current limit of five hours to six. A recommendation to change the NCLEX-RN time limit will prevent an increasing number of RN candidates from running out of time for test administration. Presently, the committee does not recommend a change to the NCLEX-PN time limit due to the substantially shorter maximum length examination (205 for the NCLEX-PN in contrast to 265 for the NCLEX-RN).

- *Responded to Member Board inquiries regarding the NCLEX examination items.*
  As part of its activities, the committee responded to Member Boards' questions and concerns regarding NCLEX examination items and simulated examinations.

- *Practice analysis updates.*
  The Examination Committee provided direction on modifications to the biannual survey of nurses (previously known as the quarterly trend analyses studies) and the triennial *RN Practice Analysis*. The Examination Committee uses the results of these surveys for NCLEX examination content decisions.

Monitored all aspects of examination administration.

- *Monitored Procedures for Candidate Tracking: Candidate Matching Algorithm.*
  The Examination Committee continued to monitor the status and effectiveness of the candidate-matching algorithm. Chauncey conducts a weekly scan of the database, using additional matching criteria, to detect records received during the past week that appear to match a previously received record, yet did not combine during initial processing. Staff resolved all suspect cases. The most recent scan covered the period for January 1, 2001, through December 31, 2001, and reviewed more than 154,000 candidate records. The scan yielded 17 instances where the same person tested more than once and was treated by the system as two separate individuals. In four instances, the candidate succeeded in passing the examination after a prior failure. The results of the analysis were consistent with similar analyses conducted in previous years.

  In no case, however, was the 91-day rule violated. The scan results serve as a reminder of the importance of each board of nursing carefully checking candidate records for accuracy at the time of eligibility declaration. Cumulated records are required in order to properly enforce the waiting period between examinations and to provide blocking files of previously seen items.

- *Monitored the security of the NCLEX examination administrations and item pools.*
  The Examination Committee monitored investigations of potential security incidents, reviewed final reports from the ETS Office of Test Security and made determinations and recommendations regarding security of the NCLEX examination administrations and item pools. Although potential security incidents were identified during the past year, no incident was determined to compromise the NCLEX examination item pools.

- *Compliance with the 30/45-day scheduling rule.*
  The Examination Committee, Board of Directors and staff monitor compliance with the 30/45-day scheduling rule. Prometric maintained sufficient capacity on a site-by-site basis to provide compliant seating to all of the

Meeting Dates

- October 24-26, 2001 (Examination Committee Business Meeting)
- December 3-8, 2001 (Item Review Subcommittee Meeting)
- January 16-18, 2002 (Examination Committee Business Meeting)
- February 11-15, 2002 (Item Review Subcommittee Meeting)
- April 17-19, 2002 (Examination Committee Business Meeting)
- April 30, 2002 (Examination Committee Conference Call)
- May 8, 2002 (Examination Committee Conference Call)
- June 12-14, 2002 (Item Review Subcommittee Meeting)
- July 2002 Conference Call – To Be Determined (Examination Committee)
- July 15-19, 2002 (Item Review Subcommittee Meeting)

Attachments

A. Annual Report of The Chauncey Group International and Prometric, a division of Thomson Learning for the National Council Licensure Examinations (NCLEX®)
B. Annual Report of Pearson Professional Testing, an NCS Pearson Business for the National Council Licensure Examinations (NCLEX®)
C. NCSBN Member Board International Testing Survey

142,967 NCLEX examination candidates who tested during April 2001 to February 2002. A dedicated department at Prometric continues to analyze center utilization levels in order to project future testing volumes and meet the testing needs of all of their testing clients. Additionally, Prometric reports to NCSBN staff on a monthly basis all sites that have 10 or fewer blocks available for NCLEX examination candidates within the next 30 days.

- *Uniformity of the Process and Request Form for Special Needs Candidates.*
  To enhance the uniformity of the special accommodations process for candidates, committee reviewed the current NCLEX procedures and Member Board request form. Although the request form met the strategies for test accommodations endorsed in the 1999 *Standards for Educational and Psychological Testing*, it was found that a wide variance exists in the interpretation of the accommodations requested by Member Boards.

  The first step undertaken by committee to standardize this process was to simplify the accommodation request form and make it available for use by both Member Boards, and professionals conducting the evaluation of the candidates. The second step, to occur in FY03, will be to educate Member Boards on the American with Disabilities Act (ADA), the new NCSBN form, the NCLEX procedures and their potential effect on the administration of the NCLEX examinations. Furthermore, a new feature will be implemented as of October 2002: Member Boards will have the ability to process special needs candidates electronically via the NCS Pearson developed NCLEX Administration Web site.

- *Responded to Member Board Inquiries Regarding NCLEX Examination Administration.*
  As part of its activities, the committee responded to Member Boards' questions and concerns regarding administration of the NCLEX examinations in Member Board jurisdictions.

  Additional information detailing NCLEX operations is presented in the Annual Report of The Chauncey Group International and Prometric, a division of Thomson Learning for the National Council Licensure Examinations (NCLEX®) (Attachment A).

Monitored all aspects of the NCLEX Test Service Transition.

- *NCLEX test service transition activities.*
  The Examination Committee, Board of Directors, NCSBN staff and NCS Pearson staff have accomplished significant milestones pertaining to implementation of the NCLEX Test Service Transition Plan during FY02. The NCLEX Transition Plan, based on the NCLEX Testing Services Contract, ratified by the Delegate Assembly of the NCSBN at the 1999 Annual Meeting, represents the documentation of the process that has be used to guide the transition of the NCLEX examination program from Chauncey to NCS Pearson, since its creation in October 2000.

  From August 1999 to October 2000, NCSBN and NCS Pearson staff, under the guidance of the NCSBN Board of Directors, developed this plan to delineate the numerous timelines and requirements specified in the NCLEX Test Services Contract. In November 2000, the Examination Committee, assisted by the newly formed Test Service Technical Subcommittee, was charged with the task of overseeing the implementation of this plan.

  To accomplish its oversight responsibility, the Examination Committee has reviewed quarterly updates to the NCLEX Test Service Transition Plan and provided direction and feedback to NCSBN and NCS Pearson Staff. Also in

this role, committee has fulfilled its charge by acting as a sounding board for new ideas as well as act as an agent to solicit feedback from Member Boards on issues as required. With the Board of Directors, Examination Committee and Test Service Technical Subcommittee active in the oversight of the implementation of this plan, over one-third of the Member Boards are involved in the NCLEX Test Service Transition process.

Throughout FY02, the committee has continued activities which originated in FY01 including: monitoring plan implementation progress, receiving information from staff and meeting with both test services for purposes of monitoring the test service transition. Updates to The NCLEX Transition Plan were presented and discussed at the October, January and April committee business meetings. Additionally, committee presented a status update on the test service transition at the 2002 NCSBN Midyear Meeting. Although the committee monitors all aspects of the transition, particular focus has been accorded to:

Item development timelines – Committee and staff have constructed test development plans to ensure that item production with NCS Pearson is sufficient for operations and meets contractual obligations. To date, six item writing workshops have been held and item production has progressed as expected. Pretest items produced in assistance with NCS Pearson staff will be field tested by candidates beginning with NCS Pearson NCLEX administration beginning October 1, 2002.

Transfer of test items from Chauncey – Committee has and continues to monitor the transfer of NCLEX items from Chauncey. A remittance schedule for item delivery has been established, with the first three installments being successfully completed. The items seen by candidates as part of the 2002 NCLEX Beta Test were operational items imported from Chauncey databases.

Construction of the NCS Pearson item banking system (CERTS™) – Although the construction of the item banking system for the NCLEX examination was behind schedule as of last year's report, the NCS Pearson acquisition of the company that develops the item banking product, has accelerated the production schedule to keep the project on track for the alpha test. Items imported from Chauncey and items constructed in the six initial item development sessions have been successfully imported in to the CERTS™ database. Committee continues to monitor the functionality of the CERTS™ product to ensure that the needs of the NCLEX item development program are met.

Test center locations – Although final decisions on center location are the contractual right of NCS Pearson, Member Boards have given considerable input as to the location of centers. Additionally, the committee continues to monitor the progress of the center build out to ensure that the appropriate number of centers (as specified in contract) are operational for the alpha and beta tests as well as for the testing service cut over in October 1, 2002. All six alpha and 23 beta sites were constructed, staffed and operational by contractual due dates. The June contractual requirement of 80 test centers will be met, with over 105 centers in a current state of construction. No impediments are anticipated for the full build out of 200 Pearson Professional Centers by September 1, 2002.

NCS Pearson staffing – Committee continues to monitor the assembly of the NCS Pearson project team for the NCLEX examination program. To date, NCS Pearson has met contractual specifications for the number of staff required for the NCLEX program, save for one position. The position of senior psychometrician has not been filled, however, additional psychometric resources have been applied by NCS Pearson to mitigate the effects of this

open position. NCS Pearson expects to fill this position before the test service cutover.

Staffing needs of the Pearson Professional Centers were met for the alpha and beta tests; all required regional managers were trained and hired, as obligated by contract. No impediments are anticipated for the full staffing of 200 Pearson Professional Centers by October 1, 2002.

The alpha-beta test process – Throughout FY02, Committee received and monitored plans, progress and results for the alpha and beta tests. Although they are described more fully in the next section, committee was active in ensuring alpha-beta test participant selection was based on empirical criteria and that candidate recruitment for the beta test was sufficient such that the requisite candidate volume for the beta test was met. Additionally, the committee monitored the planning process to ensure that the burden of the alpha and beta tests was not excessive for Member Boards who were selected and agreed to participate; all of these objectives were meet in FY02.

Communication – A chief concern for the committee that permeates all aspects of the transition process is the communication between Member Boards, NCSBN and NCS Pearson. The goal of the communication component of the test service transition plan is to provide complete information to the NCSBN Board of Directors, Examination Committee and the Member Boards on relevant aspects of the transition process. To accomplish this goal, a number of initiatives have been continued in FY02 including: the test service transition Web page on the NCSBN web site, a newsletter produced for Member Boards (the *NCLEX® Transition Update*), communiqués to Member Boards, development of an informational video for NCLEX candidates, and establishment of conference calls and presentations at the Midyear and Annual Meetings.

Test service transition contractual amendments – As a requirement of the transition plan, NCSBN has identified materials necessary to obtain from Chauncey for purposes of transitioning the NCLEX program. To efficiently obtain these materials for transition purposes, an amendment to the current test services agreement was agreed to by Chauncey and NCSBN.

Additionally, as part of a worst-case planning scenario, Chauncey, Prometric and NCSBN, as obligated by the aforementioned transition plan, agreed to a contingency plan. The contingency plan is designed to ensure that the NCLEX program remain operational in the event NCS Pearson is unable or unwilling to deliver the NCLEX examinations, as contractually specified, beginning October1, 2002. Based on the NCS Pearson quarterly updates and the results of the alpha and beta tests, it is not expected that the Contingency Plan will be invoked.

2001 NCLEX Alpha Test – Beginning December 3, 2001, and lasting through January 15 2002, NCSBN and NCS Pearson, in coordination with Member Board staff, conducted a 'stress test' to ensure the integrity of the computer networks, applications and operational processes that have been developed for the transition of the NCLEX examination program.

The jurisdictions selected for inclusion in the 2001 NCLEX Alpha Test were: Alabama, California (RN and VN), Kentucky, Maryland, Missouri and as an alternate jurisdiction, Minnesota. Board selection was based on a number of criteria including: willingness and ability to participate, candidate volume during the NCLEX Beta Test period, Member Board Office System (MBOS) user status, geographic and NCSBN area representation and concordance in location between the Member Board office and Nursing Education programs

within jurisdictions. Additionally, a sixth NCLEX Alpha Test jurisdiction, Guam, was engaged in early 2002 (prior to the NCLEX Beta Test) to test system readiness for an island jurisdiction.

The purpose of the alpha test was to check the functionality of the NCLEX examination system that NCS Pearson is building. Member Boards participating in the alpha test exercised various aspects of the NCLEX Administration Web site and NCLEX administration processes. Each piece of the system was tested individually including registration, scheduling, and taking the examination. Throughout the alpha test period, Member Boards interfaced with the Member Board web site to assure that the system functions as designed. The alpha test version of the NCLEX examination item pools had approximately the same number of items as the current NCLEX examination; however, they utilized test items that had been previously disqualified from use on operational NCLEX examinations.

All boards participating in the alpha test were provided high levels of support from NCSBN and NCS Pearson during their participation, including instruction on how to send board staff participants to the Pearson Professional Centers. Member Board participants registered for the examination and followed procedures that would be expected of actual nurse licensure candidates.

At the conclusion of the alpha test, NCS Pearson summarized the testing process and issued a full report. Provided to committee at the April business meeting, this report included the alpha test objectives, processes, and results. From the perspective of the Examination Committee, NCSBN staff, and NCS Pearson Staff, the alpha test was a successful trial of the systems and processes that Pearson is developing to administer the NCLEX examination beginning October 2002.

A total of 190 examinations were delivered for the alpha test. In particular results of this test indicated two things; (1) For the most part, NCLEX examinations could be administered successfully as of January 2002 and; (2) the alpha test provided much rich information about procedure and system enhancements necessary for the beta test and live operations. Throughout the alpha test, process feedback from Member Board participants was collected. These findings will be used to make modifications and revisions to procedures and processes in the NCS Pearson system. All of these revisions to the operational systems will be completed prior to the beginning of the beta test.

2002 NCLEX Beta Test – Beginning March 1, 2002, and lasting through April 5, 2002, NCSBN and NCS Pearson, in coordination with Member Board staff, conducted the 2002 NCLEX Beta Test. The beta test was designed as a total assessment of all the operational aspects of the NCLEX Examination program at NCS Pearson. Every part of the system was tested as an integrated whole, including: registration, scheduling, examination delivery at Pearson Professional Centers, data transmission and results reporting. Live candidates were tested from the first day of the beta testing period to the last day. All candidate results were processed as live results.

The jurisdictions selected for the 2002 NCLEX Beta Test included: Alabama, Arizona, California (RN and VN), Guam, Illinois, Kentucky, Maryland, Michigan, Missouri, Minnesota, New Jersey, New York, Ohio, Oklahoma, Texas (RN and VN) and Utah. Board selection was based on a number of criteria including: willingness and ability to participate, candidate volume during the NCLEX Beta Test period, geographic and National Council area representation and concordance in location between Nursing Education Programs and beta test center locations within jurisdictions. All Member Boards that were

chosen for participation in the alpha test were automatically part of the 2002 NCLEX Beta Test.

The NCLEX-RN and NCLEX-PN beta test examinations consisted of the same operational items, adhered to the same test plans and abided by the same psychometric rules as the regular NCLEX examinations that were administered concurrently at Prometric test centers by the Chauncey Group during the beta test time period. Twenty-three Pearson Professional Centers located in eighteen jurisdictions were used to administer the beta test.

The beta test goal was to test approximately 2000 candidates including: RNs, PNs, repeat candidates and ADA candidates, drawn from all the participating jurisdictions. To this end, a total of 917 candidates registered for the beta test with 853 candidates receiving a valid NCLEX examination. A total of 431 candidates took the NCLEX-RN examination (129 first time testers and 302 repeaters), and 422 candidates took the NCLEX-PN examination (385 first time testers and 37 repeaters). The remaining 64 candidates were either never granted eligibility, eligible but did not schedule or were candidates who did not show up for their administration appointment. By the rules established in the *NCLEX® Beta Test Candidate Bulletin*, these candidates will not be granted examination fee refunds. The results of the beta test indicate that the obtained sample size of 853 appears to be substantial enough to accurately infer system wide performance of the Pearson procedures and technical systems.

Measures of systems performance, contractual Key Performance Indicators (KPIs) and surveys of candidate opinion all indicate that the NCLEX Beta Test was a successful test of the systems and procedures that are designed to deliver the NCLEX examinations beginning October 1, 2002, and Pearson is well positioned to begin operational NCLEX administration. Although there are functional areas that need to be improved by Pearson before October, there is no deficiency identified at this time that requires specific remediation, for purposes of operational implementation, to occur before July 1, 2002 (the deadline for Pearson to correct all NCSBN identified deficiencies or incur potential termination of Testing Services Agreement without penalty to NCSBN).

Once the NCSBN Board of Directors has officially accepted the Beta Report in June 2002, a summary of this report will be sent to Member Boards. The committee wishes to express a very heartfelt thank you to all those Member Boards that participated in the 2001 NCLEX Alpha Test and 2002 NCLEX Beta test; without your collective efforts, the test service transition of the NCLEX Program would be impossible.

Activities of the Test Service Technical Subcommittee – As part of the specifications delineated in the NCLEX Transition Plan, NCS Pearson is required to build a new Web-based Member Board Office System. To build a system that reflects the wide-ranging needs of and uses by Member Board office staff, input from end users is absolutely essential for NCS developers. The Test Service Technical Subcommittee was formed to assist NCS in developing the new Web-based Member Board Office System, and the corresponding procedures and processes that are utilized on a daily basis by Member Boards. The subcommittee has focused on transition timelines, deliverables and Member Board communications. The subcommittee reports its findings and recommendations to the Examination Committee.

Although most of the build out of Web site technical interface features was completed in FY01, feedback has been sought from members of the Test Service Technical Subcommittee regarding functionality enhancements

throughout FY02. The subcommittee will continue to work with committee and NCS Pearson, as needed, through October 2002 to ensure a quality product will be available for Boards of Nursing when the transition of the NCLEX examination program is completed.

Test Service Transition Future Activities – The test service transition of the NCLEX examination program is progressing as delineated in the NCLEX Transition Plan. Furthermore, there are no obstacles identified, at this point, which jeopardize a successful and seamless transition of the NCLEX examination program. Committee will continue to monitor and report on the progress of the NCLEX test service transition until it is completed in October 2002. Significant future activities for FY02 and FY03 include:

2002 NCLEX Beta Retest Candidates – Candidates who have registered with NCS Pearson, for purposes of the 2002 NCLEX Beta Test, will remain within the NCS Pearson system and databases; these candidates will not be retested through Chauncey should candidates fail. NCSBN and NCS Pearson have developed retest procedures for candidates who do not pass the examination during the beta test. *NCLEX® Examination Candidate Beta Test Retake Bulletins* were distributed to Member Boards in March/April 2002 and delineate the procedures by which candidates will receive an NCLEX examination in the NCS Pearson system between June and September 2002. The NCSBN-NCS Pearson NCLEX Transition Team will provide a high level of support to participating Member Boards throughout the beta retest period.

NCLEX Cutover Timelines -–With the cutover of the NCLEX Program slated for October 1, 2002 Member Boards should be aware of the following timelines for NCLEX candidates and the potential impact on Board operations:

Registration: Chauncey/Prometric will not accept NCLEX registrations after 8/15/02; all mail registration received by Chauncey after this date will be returned to sender unprocessed and the current Chauncey NCLEX registration telephone number will instruct candidates whom to contact to register with Pearson.

Pearson will begin accepting Pearson NCLEX registrations via web, paper and phone on 8/16/02.

Scheduling: Chauncey/Prometric will not schedule NCLEX appointments after 9/20/02.

Pearson will begin scheduling NCLEX appointments in the Pearson Professional Centers via web and through the Pearson call center beginning with appointments made eligible on or after 8/16/02.

Test Administration: Chauncey/Prometric will conclude NCLEX Test Administration sessions for candidates scheduled before 9/20/02 at the end of business on 9/30/02.

Pearson will begin conducting NCLEX Test Administration sessions in Pearson Professional Centers for candidates who have registered and scheduled with Pearson on or after 8/16/02 beginning 10/1/02.

To reinforce these deadlines and to ensure that Member Boards are aware of the impact of these dates on their operations and candidate behavior, the committee has established a communication strategy regarding the operational transition of NCLEX Testing Services. In May 2002, a direct communication

was sent from NCSBN to educational programs and Member Boards, with follow-ups anticipated for subsequent months, reminding interested constituencies of these deadlines. Additionally the *NCLEX® Examination Candidate Bulletin* for NCLEX operations between October 1 and December 31, 2002, were distributed to Member Boards in April 2002.

Member Board NCLEX Administration Web site training – For Member Boards that were not educated on the new NCS Pearson-developed NCLEX Administration Web site as part of the NCLEX alpha or beta tests, training will begin in July 2002. The NCLEX Administration Web site replaces the current Chauncey-managed MBOS system for candidates who register as of 8/16/02 and test as of 10/1/02 with Pearson. Although the NCLEX Administration Web site incorporates enhanced functions recommended by the Test Service Technical Subcommittee, it will still retain the batch processing capabilities of the current MBOS system; including the same jurisin and jurisout file formats. The retention of these batch-processing features allows for the same functionality to interface with state licensure computer systems that Member Boards currently have.

Additional information detailing NCLEX operations is presented in the Annual Report of Pearson Professional Testing, an NCS Pearson Business for the National Council Licensure Examinations (NCLEX®) (Attachment B).

Other Strategic Initiatives

- **International Administration of the NCLEX Examinations.** As part of its continuing charge, the Examination Committee is directed by Delegate Assembly to provide a "state of the art" entry-level nurse licensure assessment. As part of that charge, committee continually looks for ways to provide a psychometrically sound and legally defensible examination with the fewest hindrances possible to candidates. One method of doing this is to provide administration of the NCLEX examinations outside current Member Board jurisdictions.

  On a regular basis, NCSBN receives a number of requests to administer the NCLEX examination outside the current Member Board jurisdictions. This is due to numerous factors, including the present nursing shortage. It is important to note that while there has been a recent surge in requests to administer the NCLEX examinations in foreign markets, it is not a new phenomenon. In 1994, the Examination Committee and the Board of Directors brought before the Delegate Assembly a list of stabilization criteria that was to be achieved prior to administration of the NCLEX examinations in Canada. This list was not successfully achieved, and the Board of Directors voted in November 1995 not to allow NCLEX administration in Canada.

  Due to the substantial impact international administration of the NCLEX examinations will have on the nursing community worldwide, a planning and explicit decision making process has been undertaken by NCSBN. To date, the committee has engaged in an investigation of the operational feasibility regarding the international administration of the NCLEX examinations for purposes of domestic licensure. It is important to note that this investigation assumed that any implementation of international testing in no way subvert the current licensure determination process in place in Member Boards of nursing nor does it make available the NCLEX examination to licensure bodies other than current Member Boards. The intent, however, is to provide an opportunity for foreign educated candidates to apply and take the NCLEX prior to moving to a Member Board jurisdiction.

In its investigation of operational feasibility, the committee focused on two major factors: examination security and impact on Member Boards. To mitigate security concerns, the committee decided to extend all current security policies and procedures to any and all international administration processes. This condition eliminated a few administration models and limited the venues where test service would propose offering test administration to NCSBN, however, it allowed for limited international testing in conditions equivalent to current Pearson Professional Centers.

Regarding the second concern, the committee surveyed Member Boards to assess the potential impact of international administration on board processes. Results were received from 45 of 61 Member Boards and indicated that individual board operations would not be adversely impacted by international administration. In the instances where impact was indicated, it was described as a positive impact. Generally speaking, comments reflecting negative impact were not considered germane because specific points referenced in comments reflected a process for international testing that was not being contemplated by committee. A copy of the international testing survey and the results, including all comments are provided in Attachment C.

Examination Committee Criteria – Resultant from this investigation committee established the following criteria for international administration of the NCLEX examination for purposes of domestic licensure:

> **Definition:** To administer current NCLEX-RN and -PN examinations in testing centers located outside Member Board jurisdictions, for purposes of licensure within Member Board jurisdictions. No part of this specific recommendation regarding international administration will contradict or circumvent any current Member Board licensure processes or requirements. This specific recommendation regarding international administration does not address the administration or modification of the NCLEX examinations for purposes of licensure, or any other purpose, for Boards of nursing, or any similar regulatory body, outside current Member Board jurisdictions. The candidate examination fees will be set to reflect the costs of the examination administration in the specific international jurisdiction. Domestic NCLEX candidate fees will not be increased to accommodate costs associated with international administration.
>
> **Purpose:** To remove potential barriers to nurse licensure in NCSBN Member Board jurisdictions, facilitate global self-determination of nurse employment, establish an international presence commensurate with the NCSBN mission and vision and establish strategic international relationships with foreign nurse regulatory bodies.
>
> **When:** Not before April 1, 2003.
>
> **Where:** Initial country locations to select from include: Australia, Canada, France, Germany, Japan, the United Kingdom and the Netherlands.
>
> **How:** Utilizing all current NCLEX administration policies and procedures, including security procedures, as delineated in NCSBN Policies and Procedures, NCLEX Member Board Manual and the NCSBN-Pearson NCLEX contract, the NCLEX examinations will be administered in VUE/NCS Pearson Authorized Test Centers that are approved by the Examination Committee and meet NCLEX contract specifications.

Committee recommendation – Based on the investigation of current security protocols established for the NCLEX program, starting October 1, 2002, and

the results of the Member Board survey committee recommended to the NCSBN Board of Directors to adopt the proposed criteria in order to proceed with negotiations for a contract amendment with test service to administer current NCLEX-RN and -PN examinations in testing centers located outside Member Board jurisdictions, for purposes of licensure within Member Board jurisdictions no sooner than April 1, 2003. As part of this contractual negotiation for international administration, the Board of Directors will utilize criteria established by the Examination Committee to establish jurisdiction specific candidate examination fees for NCLEX examinations delivered outside current Member Board jurisdictions.

Future activities – Pending a successful adoption by the Delegate Assembly, NCSBN staff at the direction of the Board will begin contract negotiations. Subsequent to successful contract negotiations Examination Committee will establish a plan for operational roll out of international testing utilizing the established criteria, including the development of any policy or procedure modification.

- **Puerto Rico nurse licensure comparison.**
  As part of the FY03 strategic initiatives, the Examination Committee was charged with determining the equivalency of the NCLEX-RN with the Spanish language nurse licensure examination. On behalf of committee, multiple contacts were made with the Board of Nurse Licensure in Puerto Rico by NCSBN staff and information regarding the NCLEX-RN was sent to identified personnel in Puerto Rico. At the conclusion of Committee activities for FY02, reciprocal information, regarding the Puerto Rican nurse licensure examination, had not been received by committee. Upon receiving the relevant information the Examination Committee will conduct a comparative study with authorities in Puerto Rico in a similar style to the comparison done between the NCLEX-RN and the Canadian Nurse Licensure Examination. Committee expects this tactic to continue in FY03.

- **English Proficiency Examinations – Interim Report.**
  As part of FY02 NCSBN Strategic Initiatives the Examination Committee was charged by the Board of Directors to initiate exploration of English-as-a-second language competency as related to the international testing plan; staff has accumulated information regarding existing English language proficiency examinations. Of paramount consideration in this investigation was examination relevancy to the nursing context and availability of examination administration. Presented below is information that preliminarily identifies some existing ESL proficiency examination information.

  United States – Presently, the Immigration and Naturalization Service Department (INS) recognizes the following ESL proficiency exams for aliens seeking employment within certain healthcare industries, including nursing; aliens must meet English language requirements in order to obtain a certificate (see chart on next page).

English Proficiency Exam	Minimum Score for Nurses (RNs)*
Test of English as a Foreign Language (TOEFL)	540 (Paper Based); 207 (Computer Based)
Test of Written English (TWE)	4
Test of Spoken English (TSE)	50
Michigan English Language Assessment Battery (MELAB)	Final Score 79; oral interview +3
English Proficiency Exam	**Minimum Score for Nurses (LPNs, LVNs)***
Test of English as a Foreign Language (TOEFL)	530 (Paper Based); 197 (Computer Based)
Test of Written English (TWE)	4
Test of Spoken English (TSE)	50
Michigan English Language Assessment Battery (MELAB)	Final Score 77; oral interview +3

** Scores developed by Secretary of Health and Human Services (HHS) in consultation with Department of Education and appropriate healthcare organizations (INS Web site).*

As it currently stands, 47 Member Boards of nursing call for English language proficiency; the majority require CGFNS certification. As part of CGFNS certification, foreign-educated candidates must take the Test of English as a Foreign Language (TOEFL) and receive a minimum score of 540 paper-based; 207 computer-based. If a state requires CGFNS Visa Screen, candidates must sit for the TOEFL, TWE and TSE or the MELAB and receive the above referenced scores in the table.

Canada – Four Canadian provinces also have an English proficiency requirement for nurses seeking licensure; interestingly: Saskatchewan, British Columbia, Nova Scotia and Newfoundland/Labrador require at least a minimum TOEFL paper-based score of 550; computer-based: 213.

Australia – Australia has two acceptable ESL examinations for foreign-educated students educated outside of Australia: International English Language Testing System (IELTS) and the Australian Occupational English Test for Health Professionals (OET). The OET assesses English language proficiency within a health care setting.

Other Background Information – CGFNS presented a report to the 1999 Delegate Assembly that explained a 1997 study commissioned to investigate development of a new ESL examination designed to include healthcare terminology. The conclusion from the presentation was that interest was high among regulatory boards, however, not high enough to command the needed financial investment for development. The presentation also concluded, however, that as of 2000, (1) there was an interest and need for a new language examination; (2) a 2000 study suggests the Test of English for International Communication (TOEIC) is interchangeable with the TOEFL; and (3) these language tests can be enhanced with a module of for health-related terminology.

Future Activities

In FY03 it is expected that committee will continue to research other English-as-a-second language competency examinations as it relates to the current strategic initiatives. As an anticipated outcomes for FY03, the committee expects to accomplish the following: (1) for all suitable English proficiency examinations, technical specifications will be gathered and analyzed; with the goal of conducting a study of the validity of examination passing standards; (2) if suitable English proficiency examinations are not found or if valid examination passing standards cannot be ascertained, Member Board interest in the development of an English proficiency examination would be assessed.

- **NCLEX Outreach**
  As part of its ongoing tactic to accurately inform constituencies about the NCLEX examination, the following outreach activities were undertaken in FY02.

  Presentations – NCSBN Testing Services Staff conducted more than 30 NCLEX informational presentations. In FY03 it is expected that this number will increase.

  Video – In FY02, substantial work on a new informational NCLEX candidate video was completed. With candidate focus groups expected to occur in June 2002, the video will be distributed to Members Board and educational programs in August/September 2002.

  Publications – Committee continues to oversee development of various publications that accurately reflect the NCLEX examination process.

  NCLEX Invitational – For the past two years, NCSBN Testing Services staff has coordinated and hosted an NCLEX Invitational in order to provide Member Boards, educators and other stakeholders an opportunity to learn about the NCLEX Program. As part of the FY02 strategic initiatives, committee and staff were charged to improve delivery of the NCLEX Invitational. On September 28, 2001, 110 attendees took part in the 2001 NCLEX invitational in Las Vegas, Nevada. Feedback from attendees was been positive and constructive. For FY03, the NCLEX Invitational is going to be held on September 23, 2002, at the Coronado Springs Resort, Walt Disney World in Orlando, Florida. It is expected that, as in previous years, the FY03 NCLEX Invitational will be a revenue generator for NCSBN.

  NCLEX Program Reports – Committee monitored production of the NCLEX Program Reports. NCLEX Program Reports were distributed to subscribing nursing education programs during the current fiscal year in October 2001 and April 2002. These reports were produced with enhancements such as improved report formatting, inclusion of color, more attention to reader usability, rewording designed to increase utility, precision and consistency of results interpretation and enhanced explanations of all analyses.

- Continue to monitor all administrative, test development and psychometric aspects of the NCLEX examination program.
- Evaluate enhancements to NCSBN NCLEX test service reports.
- Continue to monitor all aspects of the NCLEX Test Service Transition.
- Evaluate the *NCLEX-RN® Test Plan*.
- Establish procedures for administering the NCLEX examination outside current Member Board jurisdictions.

- Monitor closely all item development during the test service transition. In particular, the committee or its representative will continue to review items developed by NCS Pearson in order to provide timely feedback to enhance the item development process during the test service transition.
- Collaborate with the research department in regard to the RN and PN biannual survey, and receive results of triennial RN Practice Analysis.
- Perform approved innovative item research study.
- Establish and implement a plan for operational roll out of international testing utilizing the established criteria.
- Determine the equivalency of the NCLEX-RN with the Puerto Rican Spanish-language nurse licensure examination.
- Research and recommend English-as-a-second language competency examinations and valid passing standards.

Examination Committee – Attachment A

Annual Report of The Chauncey Group International and Prometric for the National Council Licensure Examinations (NCLEX®)

This year represents Chauncey and Prometric's (a division of Thomson Learning) eighth year of providing service to the National Council of State Boards of Nursing (NCSBN). This report summarizes the activities of the past year.

Test Development Activities

Chauncey's staff of masters-prepared nurse test developers, most of whom have been with the NCLEX® examination program for four or more years, have been responsible for the development of quality NCLEX examination items reflecting the higher cognitive levels of application and analysis. The efforts exerted by our staff have grown the item banks to almost three times their original size from six years ago. We are proud to acknowledge that our nurse test developers have worked diligently to meet and exceed the contractual metrics of size, distribution and difficulty of the NCLEX examination item pools, a full year ahead of schedule.

- **Item Review Workshops**
  The three NCLEX-RN® Item Review Panels that met between April 1, 2001, and March 31, 2002, approved 1,032 (98%) of the 1,053 items reviewed, while the three NCLEX-PN® Item Review Panels that met between April 1, 2001, and March 31, 2002 ,approved 1,006 (98%) of the 1,023 items reviewed. All of the meetings were held at Chauncey headquarters in Princeton, NJ. There was one NCLEX-PN and two NCLEX-RN master pool review sessions held between April 1, 2001, and March 31, 2002. There were 2,088 items reviewed at the NCLEX-RN sessions and 955 items reviewed at the NCLEX-PN session.
- **Item Review by the Examination Committee (or designees)**
  Chauncey has been successful in developing quality multiple-choice items to meet test plan and difficulty requirements as specified in our contract with the National Council. Between April 2001 and March 2002, there were 1,578 NCLEX-RN items and 1,169 NCLEX-PN items pretested.

  Between June 2001 and December 2001, the Examination Committee approved 958 (98%) of 981 NCLEX-RN pretest items reviewed and 904 (97%) of 930 NCLEX-PN pretest items reviewed for inclusion in a future operational pool. At the July 2001 Item Review Subcommittee meeting, the Committee reviewed master pool items for currency. The Committee approved a total of 1,022 (96%) of 1,063 NCLEX-RN items reviewed and 944 (99%) of 955 NCLEX-PN items reviewed for continued use in the operational pools. At the February 2002 meeting, the Item Review Subcommittee reviewed NCLEX-RN master pool items only: 954 (93%) of 1,025 master pool items were approved.
- **Construction of 2002 Operational Pools**
  Prior to configuring the April 2002 item pools, a master pool of available items was evaluated. As of December 2001, the master pool for the NCLEX-RN

examination consisted of approximately 10,090 total items, an increase of 906 items from the previous year. For the NCLEX-PN examination, the master pool consisted of approximately 8,346 total items, an increase of 854 items from the previous year.

- **Face Validity Reviews**
  The Chauncey test development staff routinely review actual and simulated examinations based on criteria established by the Examination Committee. In addition to reviewing test specification criteria, Chauncey staff reviews these examinations for additional criteria, including cognitive level, documentation, cultural awareness, geriatrics, emergency procedures and the nursing process. The review also includes the identification of items based on similar content within an actual or simulated examination.

  The actual and simulated candidate examinations reviewed for face validity are generated at five levels: low ability; moderately low ability; borderline (pass/fail) ability; moderately high ability, and high ability. The face validity review of the simulated and actual examinations for the April and October 2001 operational pools indicated that there was some overlap of content areas, which is more apparent in the longer examinations. Items deemed to be similar are noted for future inclusion in separate pools.

- **Fairness Reviews**
  In-house fairness reviews are required for all tests generated at Chauncey. The reviews are based on item-level and test-level concerns and are conducted by trained individuals drawn from across non-NCLEX examination Chauncey staff. Using guidelines developed by Chauncey and reviewed by the Examination Committee, the new items for the NCLEX examination item pools undergo a fairness review as they are processed during item development.

  To address test-level concerns such as gender balance and position of items, fairness reviews are conducted on a selection of the simulated examinations generated for the respective operational pools. The review of the April 2000 and October 2000 operational pools indicated that the pools are in accordance with ETS fairness guidelines, which Chauncey uses as the metric for comparison.

- **NCLEX Examination Differential Item Functioning (DIF) Review Panel Meetings**
  Each NCLEX Examination DIF Review Panel consists of five members, of which there is at least one male, one representative of three of the ethnic focal groups of NCLEX examination test takers, one individual with a general linguistic background and one individual who is currently a licensed registered nurse.

  DIF statistics are computed comparing the performance of males with females and of Whites with other ethnic/focal groups: Blacks, Hispanics, Asian Indians, Native Americans and Pacific Islanders. Items containing moderate to large DIF are reviewed at a DIF Panel Meeting. There were two DIF Panel meetings this past year. The panel reviewed a total of 238 RN and 239 PN items from the operational pools and 92 RN and 71 PN items from the pretest pools. The panel recommended the referral of 7 RN and one PN item from the operational pools, as well as one RN pretest item to the Examination Committee for review and disposition.

  The reasons for referral included access to poison control services, whether bathing/showering terminology is culturally linked, and linguistic style. The Examination Committee reviewed the items from the August 2001 DIF

Review Panel at the October 2001 meeting and retained all but one of the referred items for continued use in the operational pools. The items from the February 2002 DIF Review Panel were reviewed at the April 2002 Examination Committee meeting. Three of the four items were retained.

- **Readability Levels of Operational Pools**
  The Fry method of determining readability levels was used to calculate the reading levels of the operational pools for the NCLEX-RN and NCLEX-PN examinations for October 2001 and April 2002. This method calculates readability based on non-medical terminology. According to the Fry index, the estimated reading levels of the October 2001 and April 2002 RN operational pools are grades 7.4 and 7.2, respectively, and the estimated reading level of both the October 2001 and April 2002 PN operational pools is grade 6.9.

- **Member Board Reviews**
  Each spring and fall, Member Boards have the opportunity to conduct item reviews at Prometric Technology Centers. Member Boards can review newly developed items on-line that are in the pretest pools and/or simulated operational examinations for high, medium, and low achievers for both the NCLEX-RN and NCLEX-PN examinations.

  In the fall of 2001, seven Member Boards scheduled review sessions, while in the spring of 2002, 10 Member Boards have scheduled reviews. All comments from a Member Board review are forwarded from NCSBN to Chauncey test development staff for review. All items referred are re-evaluated for accuracy and currency and brought to the Examination Committee for disposition.

NCLEX Examination Operations

The operations in support of the NCLEX examination program functioned this year much as they have in prior years. The great majority of testing sessions takes place correctly, without any administrative error and on schedule. Occasionally when events do not proceed as planned, such as a server crash or a file delayed, Chauncey staff, with the assistance of our partners at Prometric, make every attempt to resolve the situation promptly and deliver the required results as soon as possible. Events of note are described in detail in the following paragraphs.

Telephone Activity in NCLEX Examination Operations

The following table provides the data for the type of registration by year.

Registration Type	1994	1995	1996	1997	1998	1999	2000	2001	Total
Scanned	122,493	122,814	116,575	113,871	122,449	130,400	118,121	115,226	961,949
Telephone	22,745	26,136	26,281	25,233	26,436	26,506	30,556	33,828	217,721
Electronic	38,435	42,531	41,549	39,894	22,605	10,006	9,359	8,667	213,046
Other	3,017	3,322	3,541	2,475	2,859	2,417	2,679	4,039	24,349
Total	186,690	194,803	187,946	181,473	174,349	169,329	160,715	161,760	1,417,065
Test Sessions	155,111	189,057	181,726	174,793	167,068	161,315	155,248	150,791	1,335,109

Prometric, Inc. Update

As the contract to deliver the NCLEX examination comes to a close, Prometric extends our best wishes to all Member Board and National Council staff. Much change and growth has occurred during our eight-year journey together and we all have learned much.

In April 2002, Prometric began rolling out our Unified Administration System (UAS) to all test sites worldwide. This system, which was originally launched in the United Kingdom in January 2000, boasts numerous features that simplify and streamline test center operations as well as provide planning and statistical information for test center staff. Daily rosters can be printed up to five days before the testing event for advance planning, image capture photographs are automatically initiated during the check-in procedure and the EIR (electronic irregularity report) function has been streamlined so that some EIRs are automatically generated when specific processes are unable to be completed (such as Image Capture.)

In addition to the new UAS system, we have also enhanced our test center video monitoring systems so that videos record continually, day and night for monitoring of the testing lab during testing and when the center is closed.

- **Status of Prometric Test Centers**
  The Prometric Testing Center Network has contracted since the last report in 2001. As of May 1, 2002, the NCLEX examinations are administered in 266 laboratories located in the United States and its territories.
- **30/45-day compliance**
  Prometric maintained sufficient capacity on a site-by-site basis to adequately provide compliant seating to every one of the 65,795 NCLEX examination candidates who tested during the June – August 2001 NCLEX peak testing season. During the last year (May 2001 – March 2002), every one of the 145,618 NCLEX examination candidates was offered an appointment within the compliant period.

Summary of NCLEX Examination Results for the 2001 Testing Year

Tables 2, 4, 6 and 8 provide a technical summary of the NCLEX examination results from January through December 2001. In addition, summaries for the January through December 2000 testing interval are provided. Tables 1, 2, 3 and 4 present results for the NCLEX-RN examination, and Tables 5, 6, 7 and 8 present results for the NCLEX-PN examination. Summary statistics for the total group of candidates and the reference group of candidates (that is, first-time U.S. educated candidates) for 2001 are presented in Table 2 for the NCLEX-RN examination and in Table 6 for the NCLEX-PN examination. Tables 4 and 8 summarize operational and pretest item statistics for the 2001 calendar year while tables 3 and 7 for the 2000 calendar year. It should be noted that the data provided here are intended only to serve as a general summary.

The following bullet points are candidate highlights of the 2001 testing year for the NCLEX-RN examination:

- Overall, 108,471 NCLEX-RN examination candidates tested during 2001, as compared to 108,710 during the 2000 testing year. This represents a decrease of 0.2 percent.
- The candidate population reflected 68,760 first-time, U.S.-educated candidates who tested, as compared to 71,494 for the 2000 testing year, representing a decrease of 3.8 percent.

- The 2001 average passing rate for the total group and the reference group were slightly higher than in 2000. The overall passing rate was 69.4 percent in 2001 compared to 68.8 percent in 2000, and the passing rate for the reference group also was 85.5 percent in 2001, as compared to 83.8 percent in 2000).
- There were 48.9 percent of the total group and 53.3 percent of the reference group who ended their tests after a minimum of 75 items were administered. This is slightly higher than the 2000 testing year in which 47.7 percent of the total group and 51.2 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 12.6 percent for the total group and 11.3 percent for the reference group. This is slightly lower than last year's percentages (14.1 percent for the total group and 12.9 percent for the reference group).
- The average time needed to take the NCLEX-RN examination during the 2001 testing period was 2.44 hours (or two hours, 26 minutes) for the overall group, and 2.20 hours (or two hours, 12 minutes) for the reference group.
- A total of 41.1 percent of the candidates took the mandatory break that occurs after two hours of testing, and approximately 3.7 percent of the candidates chose to take the optional break.
- Overall, 5.2 percent of the total group, and 3.3 percent of the reference group ran out of time before completing the test. These percentages of candidates timing out were similar to the overall cumulative percentages for candidates during the 2000 testing year.
- In general, the NCLEX-RN examination summary statistics for the 2001 testing period indicated patterns that were similar to those observed for the 2000 testing period. These results provide continued evidence that the administration of the NCLEX-RN examination is psychometrically sound.

The following bullet points are item-level highlights of the 2001 testing year for the NCLEX-RN examination:

- The operational item statistics were consistent across the year and with the 2000 testing year. Mean point biserial correlations were generally in the range of 0.20 to 0.21 and mean model-data fit statistics were 0.14 to 0.41 (SD was typically approx. 2.1). Average item times were 64.6 to 69.7 seconds, indicating that candidates took slightly more than one minute, on average, to answer each question.
- Tryout item statistics indicated that 1,596 items were pretested during 2001. The number of tryout items flagged (37.2 percent) was slightly higher than last year (36.1 percent). The number of approved pretest items decreased from 1,031 in 2000 to 1,003 in 2001.
- The mean B-Value of the RN tryout items for the 2001-year was -0.45, compared to -0.34 for the 2000-testing year.

The following bullet points are candidate highlights of the 2001 testing year for the NCLEX-PN examination:

- Overall, 45,804 PN candidates tested during 2001, as compared to 46,347 during the 2000-testing year. This represents a decrease of 1.2 percent.
- The candidate population reflected 33,257 first-time, U.S.-educated candidates who tested, as compared to 34,167 for the 2000-testing year, representing a decrease of 2.7 percent.
- The 2001 average passing rates for the total group and the reference group were slightly higher than in 2000. The overall passing rate was 75.5 percent in 2001 compared to 74.3 percent in 2000, and the reference group was 86.3 percent in 2001, as compared to 84.9 percent in 2000.

- There were 53.5 percent of the total group and 58.3 percent of the reference group who ended their tests after a minimum of 85 items were administered. This is slightly higher than the 2000 testing year in which 52.2 percent of the total group and 56.1 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 16.8 percent for the total group and 14.2 percent for the reference group. This is slightly lower than last year's percentages (18.4 percent for the total group and 16.1 percent for the reference group).
- The average time needed to take the NCLEX-PN examination during the 2001 testing period was 2.36 hours (or two hours, 22 minutes) for the overall group, and 2.15 hours (or two hours, 9 minutes) for the reference group.
- A total of 42.5 percent of the candidates took the mandatory break that occurs after two hours of testing, and approximately 2.3 percent of the candidates chose to take the optional break.
- Overall, 2.5 percent of the total group and 1.5 percent of the reference group ran out of time before completing the test. These percentages of candidates timing out are slightly higher than the 2000 testing year timing out percentages (2.0 percent for overall, 1.2 percent for reference group).
- In general, the NCLEX-PN examination summary statistics for the 2001 testing period indicated patterns that were similar to those observed for the 2000 testing period. These results provide continued evidence that the administration of the NCLEX-PN examination is psychometrically sound.

The following bullet points are item-level highlights of the 2001 testing year for the NCLEX-PN examination:

- The operational item statistics were consistent across the year and with the 2000-testing year. Mean point biserial correlations were 0.21 to 0.22 and mean model-data fit statistics were 0.06 to 0.14 (SD was approx. 2.1). Average item times were 64.9 to 68.0 seconds, indicating that candidates took around one minute, on average, to answer each question.
- Tryout item statistics indicated that 1,242 items were pretested during 2001. The number of tryout items flagged (27.9 percent) was lower than last year (28.5 percent). The number of approved pretest items decreased from 1,079 in 2000 to 896 in 2001.
- The mean B-Value of the PN tryout items for the 2001 year was -0.40, compared to -0.29 for the 2000 testing year.

References

Fry, E.B. (1972). Reading instruction for classroom and clinic. New York: McGraw-Hill.

Table 1. Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for the 2000 Testing Year

RN	Jan 00 - Mar 00		Apr 00 - Jun 00		Jul 00 - Sep 00		Oct 00 - Dec 00		Cumulative 2000	
	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
# Testing	22,734	14,262	24,549	15,644	45,229	36,679	16,198	4,909	108,710	71,494
% Passing	68.2	84.5	68.8	86.3	75.2	83.7	51.7	73.9	68.8	83.8
Ave. # Items Taken	125.9	119.1 1	21.8	115.8	122.9	120.9	136.4	130.6	125.3	120.1
% Taking Min # Items	47.1	51.6	50.0	54.6	49.5	50.8	39.7	42.8	47.7	51.2
% Taking Max # Items	14.0	12.4	12.8	11.5	13.6	13.4	17.4	15.8	14.1	12.9
Ave. Test Time (Hrs)	2.41	2.18	2.28	2.04	2.25	2.15	2.64	2.43	2.35	2.15
% Taking Mand. Break	41.8	34.0	38.0	29.8	37.4	33.8	50.3	43.4	40.4	33.6
% Taking Opt. Break	4.4	2.7	3.8	2.1	3.3	2.5	6.4	4.2	4.1	2.6
% Timing Out	4.8	2.9	4.2	2.4	3.7	2.8	6.7	5.2	4.5	2.9

Table 2. Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for the 2001 Testing Year

RN	Jan 01 - Mar 01		Apr 01 - Jun 01		Jul 01 - Sep 01		Oct 01 - Dec 01		Cumulative 2001	
	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
# Testing	23,001	13,608	23,582	14,144	45,230	35,910	16,658	5,098	108,471	68,760
% Passing	66.0	84.8	69.0	88.1	76.8	86.2	54.4	75.4	69.4	85.5
Ave. # Items Taken	125.3	118.0	119.7	111.4	119.9	117.1	129.8	124.3	122.5	116.6
% Taking Min # Items	47.4	52.4	51.0	57.5	51.0	53.1	42.2	46.1	48.9	53.3
% Taking Max # Items	13.7	11.9	11.5	9.8	12.0	11.5	14.1	12.3	12.6	11.3
Ave. Test Time (Hrs)	2.40	2.14	2.44	2.11	2.36	2.22	2.69	2.46	2.44	2.20
% Taking Mand. Break	42.0	33.1	40.1	29.1	37.8	33.3	50.0	41.8	41.1	33.0
% Taking Opt. Break	4.5	2.5	3.6	2.0	2.9	2.2	5.0	3.5	3.7	2.3
% Timing Out	5.1	3.0	5.4	2.7	4.4	3.3	7.4	6.1	5.2	3.3

**Table 3. Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for the 2000 Testing Year**

RN	Jan 00 - Mar 00		Apr 00 - Jun 00		Jul 00 - Sep 00		Oct 00 - Dec 00		Cumulative 2000	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Operational Item Statistics										
Point Biserial	0.21	0.09	0.20	0.09	0.20	0.09	0.20	0.08	N/A	N/A
Z-Statistic	0.16	2.12	0.38	2.18	0.51	2.40	0.14	1.98	N/A	N/A
Ave Item Time (Secs)	65.2	16.5	63.5	15.4	61.6	14.5	67.7	19.5	N/A	N/A
Tryout Item Statistics										
# of Items	314		497		700		102		1613	
Ave. Sample Size	602		623		560		601		590	
Mean Point-Biserial	0.10		0.08		0.09		0.10		0.09	
Mean P+	0.58		0.58		0.56		0.64		0.58	
Mean B-Value	-0.41		-0.30		-0.26		-0.89		-0.34	
Total Number Flagged	110		192		243		37		582	
Pct. Items Flagged	35.0%		8.6%		34.7%		36.3%		36.1%	

**Table 4. Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for the 2001 Testing Year**

RN	Jan 01 - Mar 01		Apr 01 - Jun 01		Jul 01 - Sep 01		Oct 01 - Dec 01		Cumulative 2001	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Operational Item Statistics										
Point Biserial	0.21	0.09	0.21	0.09	0.21	0.09	0.20	0.09	N/A	N/A
Z-Statistic	0.30	2.15	0.26	2.01	0.41	2.29	0.14	1.95	N/A	N/A
Ave Item Time (Secs)	66.1	18.9	66.6	15.6	64.6	15.0	69.7	18.5	N/A	N/A
Tryout Item Statistics										
# of Items	317		513		650		116		1596	
Ave. Sample Size	602		609		556		545		581	
Mean Point-Biserial	0.10		0.09		0.08		0.10		0.09	
Mean P+	0.58		0.60		0.57		0.64		0.59	
Mean B-Value	-0.36		-0.47		-0.43		-0.77		-0.45	
Total Number Flagged	98		191		275		29		593	
Pct. Items Flagged	30.9%		37.2%		42.3%		25.0%		37.2%	

Table 5. Longitudinal Technical Summary for the NCLEX-PN® Examination
Group Statistics for the 2000 Testing Year

PN	Jan 00 - Mar 00		Apr 00 - Jun 00		Jul 00 - Sep 00		Oct 00- Dec 00		Cumulative 2000	
	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
# Testing	9,739	6,755	8,909	5,749	16,471	13,340	11,228	8,323	46,347	34,167
% Passing	72.1	83.8	69.0	82.2	79.5	87.6	72.9	83.2	74.3	84.9
Ave. # Items Taken	120.4	116.3	121.0	115.4	116.1	113.0	118.9	115.5	118.6	114.7
% Taking Min # Items	50.5	54.4	49.7	55.3	55.3	58.2	51.1	54.5	52.2	56.1
% Taking Max # Items	19.9	17.6	19.2	16.0	16.9	15.0	18.7	16.7	18.4	16.1
Ave. Test Time (Hrs)	2.35	2.17	2.41	2.20	2.16	2.02	2.32	2.16	2.29	2.11
% Taking Mand. Break	43.8	36.1	47.7	39.1	37.3	31.9	44.1	37.5	42.3	35.3
% Taking Opt. Break	2.9	1.7	3.4	1.9	2.3	1.3	2.9	1.9	2.8	1.6
% Timing Out	2.2	1.2	2.7	1.6	1.6	0.9	2.0	1.4	2.0	1.2

Table 6. Longitudinal Technical Summary for the NCLEX-PN® Examination
Group Statistics for the 2001 Testing Year

PN	Jan 01 – Mar 01		Apr 01 – Jun 01		Jul 01 – Sep 01		Oct 01 – Dec 01		Cumulative 2001	
	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
# Testing	9,944	6,803	8,794	5,629	15,758	12,467	11,308	8,358	45,804	33,257
% Passing	73.4	85.4	71.4	84.8	80.1	88.7	73.9	84.3	75.5	86.3
Ave. # Items Taken	118.1	112.1	118.9	113.1	112.8	109.3	119.5	115.6	116.8	112.1
% Taking Min # Items	53.1	59.0	51.4	57.3	57.5	61.2	50.1	54.2	53.5	58.3
% Taking Max # Items	18.2	14.7	17.6	14.4	14.4	12.5	18.4	16.2	16.8	14.2
Ave. Test Time (Hrs)	2.28	2.06	2.50	2.22	2.30	2.12	2.41	2.23	2.36	2.15
% Taking Mand. Break	41.8	33.0	46.9	36.3	38.8	31.9	44.8	37.6	42.5	34.3
% Taking Opt. Break	3.0	1.5	2.8	1.5	1.8	1.1	2.1	1.3	2.3	1.3
% Timing Out	2.2	1.2	3.1	1.7	2.3	1.3	2.7	1.8	2.5	1.5

Table 7. Longitudinal Technical Summary for the NCLEX-PN® Examination Group Statistics for the 2000 Testing Year

PN	Jan 00 - Mar 00		Apr 00 - Jun 00		Jul 00 - Sep 00		Oct 00 - Dec 00		Cumulative 2000	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Operational Item Statistics										
Point Biserial	0.22	0.09	0.20	0.09	0.21	0.09	0.21	0.09	N/A	N/A
Z-Statistic	0.04	2.20	0.15	2.12	0.27	2.28	0.09	2.11	N/A	N/A
Ave Item Time (Secs)	63.7	17.2	65.2	18.4	61.9	17.4	65.7	17.2	N/A	N/A
Tryout Item Statistics										
# of Items	291		255		614		350		1510	
Ave. Sample Size	498		534		472		511		497	
Mean Point Biserial	0.11		0.12		0.12		0.09		0.11	
Mean P+	0.55		0.55		0.58		0.55		0.56	
Mean B-Value	-0.22		-0.29		-0.32		-0.28		-0.29	
Total Number Flagged	93		64		141		133		431	
Pct. Items Flagged	32.0%		25.1%		23.0%		38.0%		28.5%	

Table 8. Longitudinal Technical Summary for the NCLEX-PN® Examination Group Statistics for the 2001 Testing Year

PN	Jan 01 - Mar 01		Apr 01 - Jun 01		Jul 01 - Sep 01		Oct 01 - Dec 01		Cumulative 2001	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Operational Item Statistics										
Point Biserial	0.22	0.09	0.21	0.09	0.22	0.09	0.21	0.09	N/A	N/A
Z-Statistic	0.09	2.10	0.06	2.07	0.14	2.27	0.06	2.18	N/A	N/A
Ave Item Time (Secs)	65.8	17.1	68.0	17.0	64.9	15.9	65.6	16.4	N/A	N/A
Tryout Item Statistics										
# of Items	266		249		448		279		1242	
Ave. Sample Size	619		524		619		643		605	511
Mean Point Biserial	l 0.12		0.14		0.11		0.11		0.12	0.09
Mean P+	0.60		0.60		0.56		0.57		0.58	
Mean B-Value	-0.52		-0.50		-0.25		-0.45		-0.40	-0.28
Total Number Flagged	70		50		129		97		346	133
Pct. Items Flagged	26.3%		20.1%		28.8%		34.8%		27.9%	38.0%

Meetings Attended by Pearson Professional Testing, April 2001 - April 2002

- **Examination Committee**
  April 20, 2001
  October 26, 2001
  January 18, 2002
  April 19, 2002
- **The 2001 NCSBN Annual Meeting**
  August 6 - 11, 2001
- **The 2002 NCSBN Mid-Year Meeting**
  March 4 - 6, 2002
- **NCSBN conference calls with Member Boards participating in the Alpha and Beta testing**
  April 24, 2001 – Alpha
  June 5, 2001 – Alpha
  September 5, 2001 – Alpha
  October 10, 2001 – Beta
  November 13, 2001 – Alpha
  January 15, 2002 – Beta
- **National Council visits to Pearson Professional Testing**
  April 11, 2001 – Test Service Technical Subcommittee
  May 3, 2001 – NCLEX Administration staff
  June 25, 2001 – NCLEX Administration staff
  July 9, 2001 – Executive and Testing staff
  July 16, 2001 – NCSBN Update Meeting
  October 4, 2001 – NCLEX Administration staff
  November 8 - 9, 2001 – NCLEX Testing Staff, Regional Manager Training
  February 21, 2002 – NCLEX Testing Staff

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Examination Committee – Attachment B

Annual Report of Pearson Professional Testing for the National Council Licensure Examinations (NCLEX®)

The past year has been a very busy one for Pearson Professional Testing, an NCS Pearson business. Preparations have focused on test development, software development, quality assurance, test center buildout, the alpha test, the beta test, and training staff for the administration and support of the NCLEX® examination. In November 2001, the first alpha test registrations were processed from Board of Nursing simulated candidates. The alpha test was conducted through mid-January of 2002, then we immediately began processing the registrations for Beta Testing with actual NCLEX candidates. The beta test proceeded very smoothly from the first of March through the first week of April 2002. We are now preparing for full-scale production testing, which will begin October 1, 2002. The progress to date leads us to conclude that no difficulties are anticipated for the cutover of NCLEX examination operations on October 1, 2002.

Alpha Test Outcomes

The alpha test of the NCLEX examination was conducted by Pearson Professional Testing from November 14, 2001, to January 15, 2002. The alpha report was submitted to NCSBN as scheduled on January 31, 2002. Four objectives were addressed: (1) verify that the software and the operational processes were functioning as desired, (2) determine any software issues that needed to be solved or any operational processes that needed to be corrected, (3) make sure that customer service operates at a high level for all NCLEX candidates and Member Boards, and (4) complete all aspects of the Pearson Professional Center buildouts on time. All four objectives were achieved.

Participants from seven boards of nursing, NCSBN staff and Pearson Professional Testing staff were involved in the alpha test, acting as simulated candidates. Each participant registered, scheduled, and completed at least one Alpha examination at a fully outfitted Pearson Professional Center.

There were 190 successful examinations completed. The components of the Pearson Professional Testing system provided successful functionality in virtually all areas. As expected (and as desired in any preliminary functionality test), some exceptions to flawless process and operations were found. These issues were corrected before the NCLEX beta test began.

- CERTS Writer: In the first item writing workshop, CERTS Writer did not function completely as anticipated. Issues related to incorrect functionality ("bugs") were fixed prior to Beta testing. User friendliness issues will be resolved in future staged releases.
- Functionality for Member Board Reviews and Review and Challenge: Both of these functions require the Candidate Simulator tool to be completed. These functions are now available in the system.
- Candidate Web Site: Numerous user friendliness issues were uncovered during the alpha test as participants used the Candidate Web Site for registration and scheduling. Some technical issues also were discovered. Before the beta test registration began, the technical issues were corrected and selected user friendliness issues were addressed.
- Transmission of ATT and other Confirmation Letters: Early in the course of

the alpha testing, there were problems with the transmission of the ATTs and some confirmation letters. These difficulties were corrected before the alpha testing process was completed and they functioned correctly during the beta testing.

- Fingerprinting and Check-In of Candidates: During the alpha testing, the fingerprint reading devices were not functioning exactly as expected. The machinery was recalibrated and standardized instructions were documented to assist the test center staff in using the fingerprinting device. All regional managers and TAs were retrained on these devices during their beta test training. We also put new processes in place to streamline candidate processing and to make check-in more efficient.
- Examination Delivery: The alpha testing uncovered issues with item masking, changes in the CAT algorithm, placement of experimental items, correct information on introductory screens, and misspelled words in items. These were all implemented in the delivery system by February 15, 2002. A simpler form of the calculator also was installed for the beta test.
- Breaks: All procedures for candidate breaks were clearly documented and standardized. Retraining on these procedures was emphasized in the beta test training for Regional Managers and Test Administrators.
- Accommodations: Call Center Program Coordinators, Regional Managers, and Test Administrators all received additional training on the setup, scheduling, and implementation of special accommodations prior to the beta test. More precise documentation was created for reference by all staff.
- Test Center Facilities and Procedures: The test center team addressed a number of issues, before the beta test, including:
  - Making check-in procedures more efficient.
  - Improving the implementation and standardization of break procedures.
  - Revising the candidate rules checklist.
  - Improving security procedures, especially admission to the testing room.
  - Improving signage and directions.
  - Minimizing noise distractions.
- Reports: All reports were functional on the Administrative Web Site by March 1, 2002.
- Ability to Print Candidate Results: Due to a design problem, some Member Boards were not able to print candidate results during the alpha test period. This problem was corrected by March 1, 2002.

Overall, the alpha testing process was an excellent methodology to exercise the entire examination system, and it successfully achieved its objectives. We are indebted to all of the individuals from the boards of nursing that participated in the alpha test and contributed their time and expert knowledge about both the examination and NCLEX candidates.

Beta Testing Summary

We are very pleased to report that the NCLEX beta test went very smoothly, and very few difficulties were encountered. A total of 853 NCLEX-RN and -PN candidates successfully registered for, scheduled, and received their examinations in 23 Pearson Professional Centers. Four hundred and thirty-one took the NCLEX-RN examination (129 first time testers and 302 repeaters), and 422 took the NCLEX-PN examination (385 first time testers and 37 repeaters). The beta test final report was submitted to NCSBN by its scheduled date of April 25, 2002.

- **Pearson Professional Testing visits to National Council**
  January 28, 2002 – Presentation on the CAT algorithm Quality Assurance

  February 21, 2002 – CERTS training for NCLEX staff

  March 18, 2002 – Joint Research Committee meeting

Registration and scheduling for the Beta testing began on January 14, 2002, and testing was conducted from March 1 - April 5, 2002. The seven Member Boards that participated in the alpha testing also participated in the beta testing (Alabama, California-RN, California-VN, Guam, Kentucky, Maryland, and Missouri). An additional 11 Member Boards in Arizona, Illinois, Michigan, Minnesota, New Jersey, New York, Oklahoma, Ohio, Texas-RN and Texas-VN, and Utah also participated in the beta test. All participating boards were trained on the use of the NCLEX AdministrationWeb Site, and most used this tool to declare eligibilities, run reports and access candidate results. California-RN, California-VN, New York, and Minnesota worked with Pearson Professional Testing to implement batch processing using the jurisin and jurisout file methodology.

The beta test exercised the system in a total production environment and focused on six primary objectives: (1) ensure that the NCLEX examination is psychometrically sound, (2) meet the examination needs of actual NCLEX candidates, (3) provide information and services needed by boards of nursing, (4) appropriately handle special NCLEX processes, (5) complete the construction of 23 testing centers and have them ready for beta testing, and (6) handle a level of increased volume to test the system scalability. All six objectives were achieved in the beta test.

As a result of the data gathered and feedback obtained from the beta testing, all but five of the 28 functional areas (as defined in the Beta Functional Questions) were determined to be in a state of readiness for NCLEX production activity. That is, the basic functionality has been proven by the beta test, and the function is ready for the full-scale program launch. The five areas targeted for special attention before production begins in October 2002 are:

- Modify the registration and scheduling system to allow better system management of and access to jurisdictions located in U.S. territories (our system currently considers Guam and other U.S. territories not in the U.S.).
- Provide a reliable method for verifying the identity of each candidate that enters the testing room, either through enhanced fingerprinting capabilities or alternative techniques.
- Ensure that all nine batch processing Member Boards are ready to process eligibilities by the opening of registrations in August 2002 (we need to be sure that the Member Boards and NCS Pearson have a common understanding of all the jurisin/out data elements and their function).
- Implement the new requirements for examination “breaks” that NCSBN has defined and fix three related bugs that were identified during the beta testing.
- Complete the Security and Quality Assurance Plan.

In many of the other functional areas, ideas for software enhancements and improvements to processes have been generated as a result of the beta testing. These will be prioritized and implemented as resources and timing allow.

Pearson Professional Testing is looking forward to the production phase of the NCLEX examination program. Permanent testing center staff will be hired and trained in Summer 2002 and 200 Pearson Professional testing centers will be operational by September 1, 2002. With the completion of a few software modifications in Summer 2002, all systems will be completely ready to go and very able to handle the NCLEX volume of candidate registrations, scheduling, and test administration.

Pearson Professional Center Update

The rollout of the Pearson Professional Centers started more than a year ago. We built two testing center prototypes in Spring and Summer 2001and improved our original site design based on the input provided by National Council.

- Six alpha test sites were built by early November 2001 and were operational for the alpha test in December 2001 and January 2002.
- We built an additional 17 sites in early 2002. All 23 beta test sites were operational for the beta test from March 1, 2002, through April 5, 2002, (with the exception of our site in Guam, which opened on March 6, 2002). We successfully tested almost 900 Beta candidates throughout the five-week beta test period.
- We are progressing to be on target for the completion of the next contractual milestone. 80 sites (including the 23 beta test sites) will be operational by June 1, 2002. Those sites will be ready for test delivery, but might not be fully staffed at that time. The only sites that will be staffed starting in June 2002 will be the 23 beta test sites that will be open for Beta re-take candidates starting on June 3, 2002.
- Our most important milestone is to be ready for the nationwide rollout of the NCLEX examination program in all 200 Pearson Professional Centers on October 1, 2002. We are targeting the last 120 sites to be operational by September 1, 2002. As of April 19, 2002, we have made significant progress towards this milestone. There are only 15 locations remaining where we have not identified preferred real estate. Currently, 105 locations are in the leasing process. Buildout of those locations will be completed in May-August 2002.

Site Staffing Update

The network of 200 Pearson Professional Centers will be managed by a team of 20 Regional Testing Center Managers (RTCMs) and staffed with 400-600 Test Administrators (TAs) at the time of NCLEX launch in October 2002.

- Ten RTCMs were hired between August 2001 and November 2001. Those managers were trained and certified as TAs in November 2001. They staffed the alpha test sites during the alpha test in December 2001 - January 2002.
- An additional 10 RTCMs were hired between December 2001 and early February 2002. Those 10 managers were also trained and certified as TAs in February 2002. The original group of managers was retrained and recertified at that time as well, as we have updated our operational procedures since the alpha test. All 20 RTCMs served as TAs during the beta test in March - April 2002. In addition, the managers have hired, trained, and certified temporary TAs for the 23 beta sites. Each beta site was staffed with an RTCM (or corporate staff member) and one temporary full-time TA. We also had one temporary guaranteed back-up TA per site on stand-by.
- The RTCMs are starting hiring of TAs in April 2002 to staff the 23 beta test sites for beta retake candidates, as retakes can occur starting in June 2002.
- At least 80 sites (including the 23 Beta sites) will be staffed by end of June, as we are launching another professional licensure program in those 80 Pearson Professional Centers on July 1, 2002.

By the NCLEX launch on October 1, 2002, staffing levels at all 200 sites will be such that at least two certified TAs will be present at each testing center during all testing hours.

Test Development

During the past year, NCS Pearson has built an in-house Test Development organization to support the NCLEX examination program's psychometric and test development needs. Staff members are in place to manage the item and candidate database, to perform psychometric and statistical analyses of the data and conduct program-related research, and to develop, edit, and review new test items – all with the goal of maintaining the integrity of the NCLEX examination program and delivering examinations of the highest possible quality to nursing candidates.

The NCS Pearson Test Development group has conducted its first set of item development workshops, enhanced and populated the NCLEX item and candidate database, participated in extensive quality assurance of the adaptive testing and scoring algorithms, and produced and published the beta test examinations for delivery to nurse candidates. Specific information concerning these activities is presented below.

CERTS™ Database

The CERTS™ item and candidate database tool has undergone many enhancements since NCS Pearson acquired it in early 2001. CERTS is a full-fledged relational database that stores information about item pools, exams, and individual items; it also tracks and maintains a history of all item revisions. CERTS is also configured to store all candidate results, from the individual item responses to final test scores.

Over the past year, CERTS' underlying database structure was enhanced to accommodate the extensive information and development history that is required for each item. We designed and implemented additional functionality for queuing and tracking items through the development cycle to enhance the efficiency of the process. Moreover, the user interface was enhanced to permit easier and more extensive querying of the database information. NCSBN staff has access to the CERTS database and the ability to query its contents.

Items were successfully exported from the CERTS database for publication in the beta test. Candidate responses and test results from the beta test were imported into CERTS at the conclusion of the beta test and that data will form the basis for many of the beta test reports.

NCLEX Item Pools

In January 2002, the current test service provided a download of the current NCLEX item database, and these items and accompanying data were imported into CERTS. The items and content coding for the beta items were reviewed by the NCS Pearson NCLEX content staff prior to the implementation of the beta test.

We received a subsequent download of items from the Chauncey Group in mid-April 2002; as of this writing, the item text and accompanying data were being prepared for import into CERTS. Items for the October 2002 item pools are scheduled to be selected by mid-summer. As for the beta test item pools, the publication process is started with their export from CERTS and their subsequent extensive review prior to publication.

The Chauncey Group's final download of the NCLEX item pools is scheduled to be delivered to NCS Pearson in the fall of 2002. These items will then be imported into the CERTS database, and all item text and coding (i.e., for the entire set of active items) will be reviewed and updated as appropriate.

Development of New Items

Item writing and item review workshops have been conducted since January of this year; all workshops take place in the Chicago office of NCS Pearson. A total of 29 workshops have been scheduled for 2002: 15 item writing workshops and 14 item review workshops.

As of May 1, 2002, six item writing workshops have been held. These workshops have been extraordinarily productive, far exceeding the estimated number of items we expected to produce. The numbers of items produced at the first three RN item writing sessions held this year were 357, 619, 626, respectively, for a total of 1602 items. For the PN sessions, these figures were 421, 675, and 608, for a total of 1704 items. After editing and review by the content staff, most of those items are surviving through the review workshops. All 619 of the RN items reviewed as of this writing have been approved, and 625 of the 634 PN items reviewed so far have been approved.

A focus for the remainder of this year and into following years is the development of innovative items. These new items may present information to candidates in a way that differs from the current all-verbal items. Alternatively (or additionally), these items may require candidates to respond in a way other than selecting from among a set of response alternatives. Once developed, these items will be subjected to the same rigorous content and statistical standards as current items before they are deployed in operational pools.

Staffing

NCS Pearson's NCLEX Test Development team is nearly complete. The director, Kathi Gialluca, PhD, has hired the following individuals:

- Marcia Crowell, MS, RN, NCLEX Content Manager, manages a staff of content developers and is responsible for the development and revision of all new test items. Her staff of content developers includes:
  - Susan Ford, RN
  - Michelle Glass, RN
  - Marjorie Roche, RN
  - Nadia Sperry, RN
  - Julie White, RN
  - Lynn Shine is the Program Assistant who reports to Marcia and who coordinates the travel arrangements and other workshop-related activities
  - Adisack Nhouyvanisvong, PhD, is the Psychometrician on the project, and is responsible for working with National Council staff to maintain the technical/psychometric integrity of the NCLEX examinations.
  - Stephan Madsen is the Application Data Administrator responsible for maintaining the integrity of the item and candidate database, importing newly written items into the database, exporting item and candidate data for further analysis, and querying and reporting on project status and progress as necessary.

As of the time of this report, interviews were being conducted for the editor position(s). Recruiting and interviewing continues for the senior psychometrician position, which has proved to be an exceptionally difficult position to fill. More than three dozen applicants have applied, and most of those have been interviewed in person and/or by telephone. The search has included postings on professional websites and listservs, on general career/job Web sites, and in professional newsletters. Unsolicited contacts have also been made, though none have been successful to date.

Pearson Professional Testing Organizational Change

This year marked a change in the NCS Pearson organization. The market for education solutions is increasingly becoming a global one with NCS Pearson an important player in this business (a big reason why Pearson acquired NCS last year). In particular, our testing business in the professional, information technology and K-12 markets is increasingly global in scope. To position NCS Pearson to fully realize this global opportunity we formed a worldwide Assessments & Testing organization beginning January 1, 2002. The business, headquartered in London, is headed by Clive Hay-Smith. Mr. Hay-Smith has the responsibility for leveraging our core strengths in the professional, information technology and K-12 testing markets and expanding these services worldwide.

To accommodate this new opportunity, NCS Pearson's structure also changed with the outcome being a new organization that is a formidable player in the domestic U.S. school testing business, a growing force in the international professional and certification business, and the leader in establishing testing and scoring service capabilities in countries around the world. Gary Mainor reports to Mr. Hay-Smith and leads the State Assessments' business development and proposal management for the North American K-12 testing business. Gary will also manage the Professional Assessments businesses, including IT Certification, Professional Licensure, Clinical Assessments and Reid London House. Eventually North American responsibilities will be divided between two executives with one responsible for State Assessments account and proposal Management and one responsible for Professional and IT Licensure and Certification. Neil Crocker becomes General Manager, IT Certification and Bob Whelan becomes General Manager of Professional Licensure (including the Pearson Professional Centers)

Again, the reason for this organizational change is the tremendous worldwide market opportunity for the assessments and testing services that NCS Pearson offers. We will position ourselves to meet this demand in the best manner possible. In the U.S., we are leaders in this arena and we have demonstrated our ability to open selective international markets. The changes are to effectively meet the challenge to extend our capabilities globally.

Future Activities

NCS Pearson is fully committed to completing the work necessary for an on-time NCLEX examination program launch on October 1, 2002. The effort needed to be ready will be focused on the operational areas already outlined in this report (PPC testing centers, PPC staff hiring and training, test development, Member Board data sharing, Member Board Administrative Web site training, a bit of software development, and process improvement based on learning from the beta test). Given the timely progress to date and our good working relationship with NCSBN and its Member Boards, NCS Pearson is extremely confident that the full-scale NCLEX examination program launch will occur on time and be well executed.

Examination Committee – Attachment C

NCSBN Member Board International Testing Survey

This letter was printed on NCSBN letterhead.

February 4, 2002

Dear Executive Officer,

As part of the National Council State Boards of Nursing (NCSBN) Strategic Initiatives and Outcomes for FY 2002, the Examination Committee has been charged with investigating the administration of the NCLEX-RN® and -PN® examinations at international sites for purposes of domestic licensure.

For clarity, international testing is defined as, "The administration of current NCLEX-RN® and -PN® examinations in testing centers located outside Member Board jurisdictions, for purposes of licensure within Member Board jurisdictions." No part of this plan is designed to be a contradiction or circumvention of any current Member Board licensure processes or requirements. This plan does not address the administration or modification of the NCLEX® examinations for purposes of licensure, or any other purpose, for Boards of Nursing, or any similar regulatory body, outside current Member Board jurisdictions.

To assist NCSBN in researching the feasibility of internationally administrating NCLEX® examinations, the Examination Committee asks for your assistance in identifying any unforeseen potential problems that would be encountered by your Member Board should NCSBN offer administration the NCLEX® examinations outside current Member Board jurisdictions.

To have your input included as part of the 2002 NCSBN Delegate Assembly Examination Committee Report, please take a moment to answer the brief survey on the following page and email or fax your response to Kristin Garcia, Testing Services Operations Manager, at kgarcia@ncsbn.org or 312.787.6898. If you have any questions about the survey please contact me directly at cmarks@ncsbn.org or 312.787.6555, ext. 172. Your opinion is important.

On behalf of the Examination Committee, thank you for your assistance,

Casey Marks
Director of Testing Services
NCSBN, Inc.

Enclosure

International Survey Responses

Total Number of Boards of Nursing Responding: 45

1. Question One: If NCSBN undertakes administration of the NCLEX Examination outside current Member Board jurisdictions, as previously defined, will the operations of your Board be impacted?
   Yes = 15
   No = 28
   Possibly = 2

   If Yes, How?

Tennessee	Y	Communication will be limited to email as overseas calls are restricted. Also, international time lines will impact us.
Rhode Island	N	
Florida	Y	It may speed up licensing of foreign graduates in Florida.
Oklahoma	Y	It's difficult to answer this without additional information. If the NCLEX is administered in other languages, it is possible that the operations of our Board will be impacted. The Board would have to determine whether the NCLEX that is administered in another language would be accepted for licensure.
N. Dakota	N	
Texas-RN	N	Texas eligibility requirements have not changed.
New Jersey	Y	The number of foreign graduates testing in New Jersey would decrease.
Maine	N	
Minnesota	N	
Montana	N	
PA	Y	Each candidates' educational credentials will have to be evaluated on an individual basis. Commission of Graduates of Foreign Schools (CGFNS) will also review credentials before materials are reviewed by us. Graduate may apply for licensure but we must wait for evaluation of education. Our assumption is that the NCLEX being offered is a mirror of the one offered in the U.S. That is in terms of items, security, etc., are unchanged.
Kentucky	N	
Mississippi	Y	Would probably be unable to be directly involved in the testing process for candidates with accommodations.
Nevada	Y	There does not appear to be any conflict with the Nevada statutes and regulations. Any impact will be related to internal board procedures for processing license applications. It is anticipated these would be minor in nature.
Hawaii	Y	It will cut down on phone inquiries from foreign school graduates. This is good for us. Not certain if it would have an affect on licensing. If it does than we would lose fees.
Idaho	N	
LA-PN	N	No- I do not see how it would impact…of course the Board would have concerns about security of test and the sites adherence to standards…but I don't think we would look at international test sites any differently than the cases where someone applies for licensure in LA and sits in Alaska or Timbuktu…
Connecticut	N	
Iowa	Y	The number of applicants and inquiries would increase. Costs related to mailing materials, staff time and phone calls would increase. Licensure fee payment by personal check would require review. Application forms would require review (e.g. high school/equivalency data) Online licensure programming would require review (eg address fields) Procedures related to CGFNS certification (RN)/credential evaluation(LPN) would require review. Procedures related to individuals with past criminal convictions would require review. The requirement for a Social Security number prior to licensure would require resolution. Annual site visits to the test centers by board staff would be impacted. The process for test modifications (documentation from diagnosticians and nursing programs) would require review. ADA implications/selection of readers would need to be addressed. The timeframe for licensure might be impacted.

Nebraska	Y	It would seem that administration of NCLEX outside of current MB jurisdictions might increase the number of application. There might also be some impact on postage costs due to increased mailing outside the US.
W. VA-RN	N	
Indiana	N	
W. VA- LPN	N	
New York	N	Not significantly. However, currently we will not license an applicant unless they have a domestic address. That requirement might need to be reconsidered when the NCLEX exam is administered abroad.
Wyoming	N	
Colorado	N	
Alaska	N	
Utah	N	
Kansas	Y	Evaluations of education and licensure are required before approval for testing. Unclear in letter who would give approval to write examination. Where would records be maintained? KS licensure restrictions on felony convictions against persons and English Competency requirements.
Georgia	N	
Arkansas	Y	That depends. If the applicants is taking the exam for licensure in a U.S. jurisdiction, he/she could endorse into our state.
Maryland	N	
Vermont	N	
Arizona	Y	For the better! Will have a positive impact on foreign-educated applicants who have constant frustrations in obtaining CGFNS certification prior to us approving them to take the NCLEX. Would also prevent applicants from moving to U.S.A. and then finding out they can't pass the NCLEX.
Texas-VN	N	
Virginia	N	
Ohio	N	
NH	Y	The New Hampshire Board of Nursing believes that International NCLEX administration by NCSBN may be a valuable tool which certainly could save various institutions money who forge ahead, bring candidates to the States only to have them fail the exam. The Law, Rules and Regs of this state's NPA would need to change to meet the caveats in place for foreign educated candidates so this would be an impact. Over and above all, the NHBON is very concerned with regards to the integrity and security of the system as we move outside the walls of our US jurisdiction.
Alabama	Possibly	It is hard for me to determine, based on the information given, whether it will or not. I would be concerned about security measures in some third world countries. We would still require CGFNS for foreign educated nurses because, as you know, NCLEX is only one piece of the requirements for licensure. I would also be concerned about the tremendous costs to NCSBN to do a thorough, secure administration in another country and establish appropriate quality control measures. Who will pay for it? How much will it cost? Will it raise our fees or those of our candidates? All those concerns are why I can't respond either way. Need more info.
Washington	Possibly	Would our jurisdiction contract cost increase? Would individual exam fee increase?
CA-VN	Y	The Board would have no means of identifying approved readers in the event that an applicant requiring special accommodations were to test in another country. Additionally, the law in California currently requires a valid US social security number in order to process an application for licensure. It is possible that if the exam is offered in other countries, the Board will experience an increase in potential applicants that will not be eligible for examination due to their not having a US social security number.
Georgia	N	
N. Carolina	N	
LA- RN	N	
Wisconsin	N	

2. Do you believe international administration of the NCLEX Examinations would affect how your Board licenses, by endorsement, candidates educated outside current Member Board jurisdictions?
Yes = 10
No= 32
Possibly= 3

If Yes, How?

Tennessee	N	
Rhode Island	N	
Florida	N	Procedures and requirements in Florida would not change.
Oklahoma	N	We would continue to require the candidate submit an application for endorsement, have a visa, be licensed in their country of graduation, meet CGFNS requirements and successfully pass TOEFL, TSE and the CGFNS qualifying examination, prior to approving the candidate to take the NCLEX. The issue of where the NCLEX was given would not matter, unless it was administered in another language.
North Dakota	Y	Would expedite the process for licensee. We are currently issuing 90 work authorization until the candidate can test.
Texas-RN	N	However, the fee for endorsing is $125.00 or $65.00 for initial licensure.
New Jersey	Possibly	Hmmm…possibly, we would be concerned that the minimum standard for eligibility for licensure by examination would be consistent with New Jersey's requirements. If they are/would be, then endorsement would not be a problem.
Maine	N	It will not affect HOW…but I think it will make endorsement process smoother- for example, after taking CGFNS (Maine requires), individual can write NCLEX without cost of travel, etc., Also, it prevents the situation of "foreign nurse who has failed exam" being utilized by health care facilities in "creative" or unusual ways …Therefore, I believe this will contribute to better protection of the public.
Minnesota	N	
Montana	N	
Pennsylvania	Y	See response #1.
Kentucky	N	
Mississippi	N	No- We would still require CGFNS certification.
Nevada	Y	See response #1.
Hawaii	N	
Idaho	N	
LA-PN	N	No –Currently and endorsement applicant can have passed the exam and not be eligible in LA because of educational requirements….that won't change based on overseas testing sites
Connecticut	N	
Iowa	Possibly	Unsure at this time. No changes in Iowa licensure requirements for individuals previously licensed in another U.S. jurisdiction are anticipated at this time. If record (background) checks become a condition of licensure in Iowa, international testing would impact licensure rules.
Nebraska	N	It won't impact how we license. However, I would anticipate that states that do not require CGFNS will become an even greater conduit for licensure in the US. In the absence of CGFNS transcript evaluations, it takes more staff time to evaluate applicant educational credentials.
W. VA-RN	Y	It could: Will the test be in the English language? Will ability to speak and converse in English language be part of the pre-requisite to take NCLEX-RN? Indiana N West Virginia- LPN N We do very little of this.
New York	N	
Wyoming	N	
Colorado	N	
Alaska	N	
Utah	Y	Improve - Canadian nurses could take the exam before coming here!

Kansas	Y	Currently experiencing difficulty with other jurisdictions licensing without evaluating educational and licensure evaluation or licensing individual that KS has determined does not meet requirements.
Georgia	N	
Arkansas	Y	We do not endorse candidates from outside member board jurisdictions. Security of the exam and continued integrity of the exam would be questioned. Would like to have information regarding other licensure examinations given internationally.
Maryland	N	
Vermont	N	
Arizona	Y	They would still need to provide CGFNS general report to validate their education is equal to a Board-approved program.
Texas-VN	N	
Virginia	N	Applicants by both endorsement and exam would still have to meet the education requirements of Virginia.
Ohio	N	
NH	Y	See response #1.
Alabama	Possibly	See response #1.
Washington	Y	Who would approve them to take the NCLEX? Currently the jurisdiction approves the paperwork.
California-VN	N	No, the location of the examination would not have any affect on how the board processes applications by endorsement.
Georgia	N	
N. Carolina	N	NOTE: Our requirement for criminal background checks become problematic for foreign grads-regardless of where the testing is done.
Louisiana-RN	N	
Wisconsin	N	

3. Do you believe international administration of the NCLEX Examinations would affect how your Board licenses, by initial licensure, candidates educated outside current Member Board jurisdictions?
   Yes= 11
   No= 32
   Possibly= 2

   If Yes, how?

Tennessee	N	Security as related to exam and examiners is a major concern for many countries. What mechanisms are in place to ensure identity, eligibility, come to us.
Rhode Island	N	
Florida	N	
Oklahoma	N	Currently, our statutes only initially license individuals who have graduated from a state board approved program of nursing. Foreign-educated candidates have been licensed through the endorsement process and have been required to be licensed in their country of graduation.
North Dakota	Y	See response #2
Texas-RN	N	
New Jersey	N	Not if the RN applicant was CGFNS certified and the PN applicant graduated from an approved practical nurse program, passed TOEFL, and held a valid unencumbered license from their country of education.
Maine	N	
Minnesota	N	
Montana	Y	We require CGFNS prior to making a candidate eligible, so it depends upon how it is set up. We may end up requiring the TOEFL as well- depends.
Pennsylvania	Y	See response #1.
Kentucky	N	
Mississippi	N	We would still require CGFNS certification.

Nevada	Y	See response #1.
Hawaii	Y	Fees would decrease if candidates bypass Hawaii and go to other states.
Idaho	N	
Louisiana-PN	N	We won't change our requirements for initial licensure and test site location won't have an impact.
Connecticut	N	
Iowa	Y	Yes No changes in initial Iowa licensure requirements are anticipated at this time. See comment re: background checks. The requirement for a SSN at the time of application would require resolution. The requirement to inform the board that the primary state of residence is Iowa or a compact state, and provide a street address at the time of application, would require resolution. See Question #1 re: CGFNS, test accommodations, test centers, prior felony convictions, etc
Nebraska	N	Won't affect how we license. I would anticipate the number we license might increase. I think there is also the potential that a greater number of foreign nurses we license may never come to the US.
W. VA-RN	Y	See response #2.
Indiana	N	
W. VA- LPN	N	See response #2.
New York	N	
Wyoming	N	
Colorado	N	
Alaska	N	
Utah	N	
Kansas	Y	Determining if candidate meets our requirements. See Response to Question #1 & 2.
Georgia	N	Arkansas Possibly Need more information to be able to answer this question. Will the exam be given following CGFNS? Is the proposal for "English speaking countries" or all countries? Our statutes have other requirements (such as substantially similar education) that must be met before the candidate is deemed eligible to sit for the exam so I'm not sure at this point how that would be accomplished.
Maryland	N	
Vermont	N	
Arizona	Y	Initial license can be by examination or endorsement into Arizona. I believe we address examination candidates in question #1 and endorsement applicants in question #2.
Texas-VN	N	
Virginia	N	Applicants by both endorsement and exam would still have to meet the education requirements of Virginia.
Ohio	N	
NH	Y	
Alabama	Possibly	See response #1.
Washington	Y	Transcript evaluation may be affected and we use (Washington State) CGFNS-
California-VN	N	No, the current process for licensing candidates educated in other countries would not change if the exam is administered in other countries. However, as mentioned above, it is possible that the board would be impacted by the administration of the exam in other countries because it would be more likely that those applicants will not have a US social security number, so the Board would not be able to approve them to test.
Georgia	N	
N. Carolina	N	See response #2
Louisiana-RN	N	
Wisconsin	N	

Additional Comments

Iowa – The exploration of international NCLEX testing is relevant and timely. The larger issues of written and spoken English competency testing for nurses, prior criminal records, minimum requirements for theory and clinical experience in medical, surgical, obstetric, pediatric (PN), and psychiatric and community health nursing (RN), test security and related issues require in-depth study. Pilot testing in selected countries (Canada, Mexico) would provide valuable information.

Kansas – Maintaining security of examination after hearing about GRE problems with miniature TV cameras carried into testing centers and trucks lined up outside center to record broadcasts of test materials.

Ohio – Currently some Boards of Nursing require reports from outside agencies, such as CGFNS or ETS prior to making an applicant eligible to take the NCLEX. If an increased number of testing locations that are not located within an NCSBN jurisdiction would result in a larger number of applicants using these outside sources, would these organizations be able to handle an increased number of applicants without long delays in receiving reports? It is important for state boards of nursing to look at ways to eliminate barriers to licensure while maintaining their standards for state licensure. Delays in licensure as a result of not receiving necessary reports from outside agencies may be perceived as a barrier to licensure, thus creating a barrier by eliminating another. We recommend discussing with CGFNS and ETS what preparations they may make to accommodate any additional work load this may create, and have the ability to provide Boards with timely reports.

Washington – Who would pay for the sites? Would NCLEX test rates go up?

Committee Members

Barbara Morvant, Executive Officer, LA-RN, Area III, Treasurer and Chair

Sandra Evans, Executive Officer, ID, Area I

Nancy Bafundo, Board President, CT, Area IV

N. Genell Lee, Executive Officer, AL, Area III

Charles Meyer, Board President, NE, Area II

Ruth Ann Terry, Executive Officer, CA-RN, Area I

Staff
Robert Clayborne, Director of Finance

Relationship to Strategic Plan

Strategic Initiative 5 – Governance & Organizational Capacity: The National Council will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome 3: A sound organizational governance and management infrastructure advances the National Council's mission and vision.

Report of the Finance Committee

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of the Finance Committee

The Finance Committee advises the Board on the overall direction and control of the finances of the organization. The committee reviews and recommends a budget to the Board. The committee monitors income, expenditures, and program activities against projections, and presents quarterly financial statements to the Board.

The Finance Committee oversees the financial reporting process, the systems of internal accounting and financial controls, the performance and independence of the independent auditors, and the annual independent audit of NCSBN financial statements. The committee recommends to the Board the appointment of a firm to serve as independent auditors.

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

Highlights of FY02 Activities

- Reviewed and discussed with the independent auditors the financial statements for the fiscal year ended September 30, 2001. Based on the review and discussions, the Finance Committee recommended to the Board of Directors that the financial statements and the Report of the Auditors be accepted and provided to the Membership (Attachment A).
- Reviewed and discussed the financial statements and supporting schedules quarterly, and made recommendations to the Board to accept the reports and post them to the members-only section of the NCSBN Web site.
- Reviewed and discussed the performance of NCSBN investments with representatives from Becker Burke (consultant) and Richmond Capital Management (investment manager). The committee approved the performance of the investment manager and reaffirmed the current investment policy.
- Reviewed and discussed financial policies and procedures with management staff. Based on the review and discussions, the committee forwarded the policies to the Board for final approval.
- Reviewed and discussed the liability insurance coverage for NCSBN with the account manager from USI Midwest Insurance Brokers. Based on the review and discussions, the committee advised the Board that liability insurance coverage for NCSBN was adequate.

- Reviewed and discussed the pending expiration of the corporate office lease, and the advantages, disadvantages, and cost of moving to a new location. The committee members made a site visit to the building being considered for possible relocation. The committee recommended to the Board to approve going forward with the negotiation for the lease of office space on the 29th floor at 111 E Wacker Drive in Chicago.
- Advised the Board and made recommendations related to the finances of program activities:
  1. Resource Network Fund
     a. Endorsed the revised policy.
  2. The 25th Anniversary Commemoration
     a. Recommended to the Board approval of the proposed budget.
  3. Nursys
     a. Recommended to the Board approval of public access to certain data, and the assessment of a fee for information searches.
     b. Recommended to the Board approval of the negotiation with Donnelley Marketing for a new contract to provide data collection services for NCSBN.
  4. Educational Products (on-line courses and video)
     a. Recommended to the Board approval of the business plan and budget.
  5. Compact States fee for secretariat services
     a. Recommended to the Board approval of a fee assessment for secretariat services provided to NLCA members.

Future Activities

- Review preliminary budget for the fiscal year beginning October 1, 2002.

Meeting Dates

- September 14, 2001 (Conference call)
- September 25, 2001 (Conference call)
- November 27-28, 2001
- January 22, 2002 (Conference call)
- February 15, 2002 (Conference call)
- April 28-29, 2002
- July 9-10, 2002

Attachments

A. Report of the Independent Auditors
B. Statement of Revenue and Expenses

Finance Committee – Attachment A

Report of Independent Auditors

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

We have audited the accompanying statements of financial position of National Council of State Boards of Nursing, Inc. (National Council) as of September 30, 2001 and 2000, and the related statements of activities and of cash flows for the years then ended. These financial statements are the responsibility of the National Council's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of National Council of State Boards of Nursing, Inc. as of September 30, 2001 and 2000 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.

November 16, 2001

National Council of State Boards of Nursing, Inc.
Notes to Financial Statements

September 30, 2001 and 2000

Note 1. Description of the Organization

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

The program services of the National Council are defined as follows:

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

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

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

Note 2. Summary of Significant Accounting Policies

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

Basis of Presentation – Financial statement presentation follows the recommendations of the Financial Accounting Standards Board in its Statement of Financial Accounting Standards (SFAS) No. 117, *Financial Statements of Not-for-Profit Organizations*. Under SFAS No. 117, the National Council is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets and permanently restricted net assets. The National Council does not have any temporarily or permanently restricted net assets.

Investments – Investments are carried at fair value which generally represents quoted market price as of the last business day of the year.

Property and Equipment – Property and equipment are carried at cost. Major additions are capitalized while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation is computed over the estimated useful lives of the related assets by the straight-line method. Furniture, and leasehold improvements have estimated useful lives ranging from three and one half to ten years, and equipment and computer hardware and software have estimated useful lives ranging from three to five years.

Inventory – Inventories are valued at lower of first-in, first-out cost or market. Inventory is comprised of merchandise held for resale.

Statement of Cash Flows – For purposes of the statement of cash flows, the National Council considers all marketable securities as investments. Cash includes only monies held on deposit at banking institutions and petty cash.

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.

Reclassification – Certain reclassifications have been made to the prior year amounts to conform to the presentation for the current year.

Note 3. Tax Status

The National Council is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (Code) and is exempt from federal income taxes on income related to its exempt purpose pursuant to Section 501(a) of the Code and has been classified as an organization which is not a private foundation under Section 509(a).

Note 4. Cash Concentrations

The cash balance as of September 30, 2001 and 2000 consisted of the following:

	2001	2000
American National Bank:		
Checking account	$202,731	$213,760
Money market account	481,735	1,873,059
SunTrust Bank:		
Checking account	123,842	106,687
Petty cash	250	250
Total	$808,558	$2,193,756

The National Council places its cash with financial institutions deemed to be creditworthy. Cash balances may at times exceed the insured deposit limits.

Note 5. Operating Lease

Effective May 29, 1997, the National Council entered into a lease agreement for office space expiring April 30, 2004. The following is a summary by year of future minimum lease payments required under the office lease as of September 30, 2001:

Year ending September 30,	
2002	$314,934
2003	321,243
2004	189,560
Total	$825,737

Rent expense for the years ended September 30, 2001 and 2000 were $311,127 and $318,759, respectively.

Note 6. Investments

The composition of investments at September 30, 2001 and 2000 is as follows:

	2001	2000
U.S. Government and Government Agency obligations	$2,692,113	$2,685,175
Corporate bonds	3,842,086	3,582,683
Mutual fund	999,450	1,364,662
Money market fund	878,486	133,590
Total	$8,412,135	$7,766,110

Note 7. Retirement Plan

The National Council maintains a defined contribution pension plan covering all employees who complete six months of employment. Contributions are based on employee compensation. The National Council's policy is to fund accrued pension contributions. Pension expense was $237,363 and $247,544 for the years ended September 30, 2001 and 2000, respectively.

Finance Committee – Attachment B

National Council Statement of Revenue and Expenses

	Year to Date 3/31/2002		12 month		
	$	% of Annual Budget	Projected Actual	Annual Budget	Variance Favorable/ (Unfavorable)
Revenue					
NCLEX revenue	$11,462,941	37.86%	$30,506,000	$30,280,000	$226,000
NCLEX program reports royalty	78,828	157.66%	80,000	50,000	30,000
NCLEX 900#	59,981	74.98%	150,000	80,000	70,000
NNAAP royalty Income	121,458	67.48%	200,000	180,000	20,000
Educational products revenue	264,295	35.43%	635,000	745,872	(110,872)
License production fees	180,725	60.85%	297,000	297,000	0
License verification fees	421,611	60.23%	800,000	700,000	100,000
Meeting revenue	27,585	20.72%	112,000	133,164	(21,164)
Other Publication sales	6,763	27.05%	25,000	25,000	0
Membership fees	0	0.00%	183,000	183,000	0
Investment Income	177,504	30.87%	575,000	575,000	0
Refund-JRC Funds	0	0.00%	250,000	250,000	0
Other revenue	1,148		1,148	0	1,148
	12,802,839		33,814,148	33,499,036	315,112
Expense					
Salaries	1,769,351	43.46%	3,685,000	4,071,078	386,078
Contracted Temp help	70,236	62.51%	105,236	112,356	7,120
Fringe Benefits	408,741	42.84%	905,000	954,052	49,052
NCLEX Processing Costs	4,993,711	37.47%	13,336,611	13,328,099	(8,512)
Other Professional Service Fees	1,036,388	35.13%	2,705,000	2,950,284	245,284
Supplies	38,701	38.40%	101,000	100,776	(224)
Meetings & Travel	439,702	29.53%	1,452,000	1,488,876	36,876
Telephone & Communications	127,804	38.81%	329,000	329,304	304
Postage & Shipping	95,288	37.39%	255,000	254,868	(132)
Occupancy	208,956	55.59%	376,000	375,888	(112)
Printing, copying & Publications	66,289	45.18%	147,000	146,724	(276)
Library/Memberships	11,389	30.14%	37,800	37,788	(12)
Insurance	47,157	90.69%	50,000	52,000	2,000
Equipment Rental & Maintenance	275,253	41.25%	667,000	667,200	200
Depreciation & Amortization	645,816	47.71%	1,353,648	1,353,648	0
Other Expenses	54,911	38.98%	140,900	140,876	(24)
Total Expense	10,289,693	39.03%	25,646,195	26,363,817	717,622
Surplus/(Deficit)	$2,513,146		$8,167,953	$7,135,219	$1,032,734

Statement prepared on an accrual basis and accordingly does not include expenditures for capital. This statement has not been audited. Projected amounts are estimates.

Summary for the First Six Months of Fiscal Year 2002

Revenue

- **NCLEX®** – A total of 59,792 NCLEX® paid test applications were processed compared to 61,229 for the first six months of the previous fiscal year. The budgeted volume for this period was 55,649. A number of applications (8,129) were processed at the old fee of $120. The budget assumed a $200 fee for all FY02 applicants. The FY02 budget assumed an $80.80 cost per applicant. We are paying at the $78 price point. The higher (than budget) actual candidate counts and a savings in NCLEX processing costs continue to offset the revenue shortfall for the difference between the $200 and the $120 rate for these 8,129 applicants. Assuming that candidate applications will equal the budgeted counts for the remaining six months of the year, the projected net revenue (after vendor processing) from NCLEX will total $17.2 million compared to a budgeted amount of $17 million.
- **NCLEX Results by Phone and Program Reports** – Three new states have been added to the NCLEX 900 number program during this fiscal year. The 900 number revenue is projected ahead of budget. Revenue for Program Reports has already exceeded budget for the year.
- **NNAAP** – NNAAP royalty income is projected to exceed budget. The revenue budget was compiled with the assumption that the Florida Board would not be participating at any time during fiscal year 2002. Florida was a participant during the first quarter. Test volume from other states is on budget. The projection is based on the assumption that actual revenue will equal budget for the remaining six months of the year.
- **Educational Products** – Sales of NPA courses are slightly ahead of the first six months' numbers for last year, but are significantly under budget. Based on projections from sales data for the first half of the fiscal year, we will only obtain 54% of the annual sales goal. More targeted marketing to states is planned for the third quarter. Student enrollments for the "NCLEX Review" and the "Assessment Strategies" on-line courses are ahead of prior year actual as well as this year's sales goal. Video sales continue to be disappointing. We are hopeful that a change in the third quarter marketing strategy will help the sales numbers. We have revised dates for new products scheduled to launch during FY02. The "Delegation" video is scheduled for July 2002, and four other courses are planned for the end of the fiscal year.
- **Nursys License Verification** – Seventeen Boards are currently using Nursys. Ten other boards have expressed an interest. The plan for the year is to add as many of those 10 boards as possible. This year, 14,480 verifications have been processed. The budget assumed 23,161 for FY02. The projected volume for the 12-month period is 27,000 verifications.
- **Other Revenue** – Midyear Meeting revenue was under budget as registrations were down by 27% from prior year.

Expense

NCSBN is projected to save over $400,000 salary and benefits as a result of not filling all of the new positions on October 1, 2001. No turnover allowance was included in the budget. A few positions remain unfilled at the end of the first six months. There will also be a significant savings in contracted professional services expenses as the actual need for Information Technology (IT) and management consultants has been less than anticipated. The meetings and travel line is projected to have a favorable budget balance for the year. The Midyear Meeting expenses were less than planned. Testing Department staff has not needed to travel as much for IT and management consultants has been less than anticipated. The meetings and travel line is projected to have a favorable budget balance for the year. The Midyear Meeting expenses were less than planned. Testing Department staff has not needed to travel as much for vendor transition. The combined expense savings for the National Council from all areas is expected to equal approximately $700,000.

Capital

The IT Department will not need $150,000 of the funds budgeted for internet access, fault tolerance and security enhancement projects in this year's budget. There will also be a $70,000 savings on the replacement of laptops for Board and staff, and a $45,000 savings on Accounting software upgrades. The implementation of VLANs and other network performance enhancements is expected to be completed for 37,000 less than budget. The content software evaluation project budgeted at $150,000 for this year will be deferred to next year. The combined savings in the IT capital budget equals $450,000.

Task Force Members

Marcia Rachel, Executive Director, MS, Area III, Co-Chair

Maris A. Lown, Board President, NJ, Area IV, Co-Chair

Shirley Brekken, Executive Director, MN, Area II

Kim Glazier, Executive Director, OK, Area III

Richard Sheehan, Board President, ME, Area IV

Board Liaison
Iva Boardman, Executive Director, DE, Area IV Director

Staff
Alicia Byrd, Member Relations Manager

Rosemary Gahl, Member Relations Assistant

Relationship to Strategic Plan

Strategic Initiative 5 – Governance & Leadership Development and Organizational Capacity:
The National Council will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.

Outcome 1: Member Board staff and members access multiple levels of educational programs to develop core competencies in regulation.

Meeting Dates

- November 27-28, 2001
- January 17, 2002 (teleconference call)
- April 16-17, 2002
- June 14, 2002 (teleconference call)

Attachments

None.

Report of Member Board Leadership Development Task Force

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of the Member Board Leadership Development Task Force

The Member Board Leadership Development Task Force is charged with facilitating the leadership development of the Member Board executive officers and presidents. The charge encompasses clarification of the relationship and role expectations between executive officers and presidents, and orientation and mentorship resources for new executive officers. The task force was charged to devise a method to orient new Member Board presidents, develop programs for Member Board presidents at the midyear and annual meetings, and enhance communication between the membership and NCSBN.

Highlights of FY02 Activities

- Developed and implemented the second leadership program for executive officers and board presidents at the 2002 Midyear Meeting in March.
- Offered continuing education credits for executive officers and presidents at the midyear leadership program.
- Developed and implemented a program for board presidents at Delegate Assembly in Pittsburgh, PA, in August 2001.
- Developed and implemented the mentorship program for new executive officers/contact persons.
- Collaborated with the managing editor and technology department to implement the Web-based NCSBN orientation program, "NCSBN 101."
- Developed the 2002 orientation program for new executive officers/contact persons scheduled for June 19, 2002.
- Designed a regulatory curriculum for the membership with core courses and electives that was transitioned to the Regulatory Credentialing Development Task Force as being part of their charge.

Future Activities

In May 2002 the Board of Directors approved an advisory group that will be assembled early in FY03 to plan the leadership program for executive officers and Member Board presidents at the midyear and annual meetings. The advisory group will teleconference.

Report of the National Nurse Aide Assessment Program (NNAAP™)

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Highlights of FY02 Activities

- Jointly owned and operated by NCSBN and CAT*ASI (formerly known as Assessment System Inc.), the National Nurse Aide Assessment Program (NNAAP™) is a nationally administered certifying examination program based on the activities performed by nurse-aids in long-term, acute and home health care settings.
- The current examination is the product of the combination of the Nurse Aid Competency Evaluation Program (NACEP™) and the National Nurse Aide Examination (NNAE) nurse aid certification programs. The complete integration of written and skill components from NACEP and NNAE into the NNAAP was completed in 1999 with the NNAAP examination being administered exclusively for the first time in FY01.
- The NNAAP is offered in two parts: a written portion and a skills (performance) portion. The written examination is available in English, English with audiotape, and Spanish with audiotape. The skills portion is conducted only in English. For testing year 2001, 116,029 candidates took the written portion of the NNAAP examination with a pass rate of 81.2% and 95,916 candidates took the skills
  portion of the NNAAP examination with a pass rate of 74.7%.
- Additional information detailing NNAAP operations is presented in the Annual Report of CAT*ASI for the National Nurse Aide Assessment Program (NNAAP).

Future Activities

- Continue to monitor all test development and psychometric aspects of the NNAAP Examination program.

National Nurse Aide Assessment Program

Staff

Casey Marks, Director of Testing Services

Lenore Harris, NCLEX® Content Associate

Thomas O'Neill, Psychometrician

Anne Wendt, NCLEX® Content Manager

Relationship to Strategic Plan

Strategic Initiative 1 – Nursing Competence: National Council will assist Member Boards in their role in the evaluation of nurse and nurse aide competence.

Outcome 4: Nurse aide competence is assessed.

Meeting Dates

- April 26-28, 2002
  (Skills Evaluation Review Meeting)
- May 31, 2002
  (Contract Review Meeting)

Attachments

A. Annual Report of CAT*ASI for the National Nurse Aide Assessment Program (NNAAP).

National Nurse Aide Assessment Program – Attachment A

Annual Report of CAT*ASI for the National Nurse Aide Assessment Program™

Company Overview

In December 2001, Computer Adaptive Technologies, Inc. (CAT) a Houghton Mifflin Company, acquired Assessment Systems, Inc. (ASI). The move added the test delivery capabilities of ASIs nationwide network of high-stakes test centers to CAT's superior testing software technology. The two companies are now known as CAT*ASI.

The resources of the two separate companies form an ideal combination of the best testing technologies with the best test delivery network. CAT's suite of products offers a powerful, scalable, and flexible solution that facilitates content creation, management, deployment and delivery, and data and reporting. Clients can choose from options that include rich graphics and question types, and the full complement of testing modes. CAT clients meet their goals with the ultimate array of tools, technology, and services for content management and deployment.

ASIs nationwide network of test centers accommodates paper and pencil testing as well as on-line and off-line computer based testing for high-stakes examinations. Highly trained proctors and well-defined procedures at ASI centers administer tests that meet clients' needs for a wide variety of testing practices. These include systems for Internet or telephone test reservations, special testing sessions, registration procedures requiring multiple forms of identification, and on-site, photo-bearing score reports or credentials.

About Houghton Mifflin

Boston-based Houghton Mifflin Company, a unit of Vivendi Universal Publishing (the third leading worldwide publisher), is one of the leading educational publishers in the United States, with more than $1 billion in sales. Houghton Mifflin publishes textbooks, instructional technology, assessments and other educational materials for elementary and secondary schools and colleges. The Company also publishes an extensive line of reference works and fiction as well as award-winning non-fiction for adults and young readers. Additionally, Houghton Mifflin offers computer-administered testing programs and services for the professional and certification markets. With its origins dating back to 1832, Houghton Mifflin today combines its tradition of excellence with a commitment to innovation.

CAT*ASI Nurse Aide Testing and Registry Services

Since 1986, CAT*ASI has been a leading provider of nurse aide testing and registry services. Currently, CAT*ASI manages 25 nurse aide client testing contracts and 8 nurse aide client registry contracts. CAT*ASIs nurse aide testing services include: registration, eligibility screening, scheduling, test administration (test site and Registered Nurse evaluator management), scoring, and reporting. The registry services CAT*ASI offers include initial certification, recertification and reciprocity management, as well as public access Registry verifications through the Internet and through an Interactive Voice Response (IVR) system, accessible via a toll-free telephone number.

Program Highlights and Test Development Activities

- **Skills Cut Score Study**
  In February 2001, representatives from CAT*ASIs Test Development, Program Direction and Psychometric Services Departments facilitated a three-day meeting, which included fifteen Registered Nurse Subject Matter Experts (SMEs) and two Certified Nurse Aides. The purpose of this meeting was to evaluate the current passing standard for each skill on the skills portion of the National Nurse Aide Assessment Program (NNAAP™). The population of nurse aides changed significantly over the past several years, and the SMEs were asked to determine whether or not the passing standard for each skill reflected the abilities of today's minimally competent candidate.

  Using the modified Angoff method, the SMEs determined that it was necessary to lower the passing standard (or number of steps necessary to pass each skill). The new passing standard requires candidates to pass approximately 75% of the steps in each skill scenario, as opposed to the former passing standard, which required candidates to pass approximately 80% of all the steps in each skill scenario.

- **Skills Cut Score Study Item Review Workshop**
  Representatives from CAT*ASIs Test Development Department facilitated a two-day meeting in Philadelphia in April 2001. The meeting, which included nine Registered Nurse SMEs, was held to review previously developed items from the NNAAP written examination. The SMEs reviewed the items and item statistics and made the following updates to the item pool: 65 new items were moved into pre-test status to be used on future examinations as non-scored items; 106 pre-test items were moved into approved item status to be used as operational items on future examinations.

- **Examination Rollout**
  As a result of the 2000 Job Analysis Survey conducted by NCSBN, the 2000 Written Cut Score Study, and the above-mentioned meetings, CAT*ASI rolled out several new examination forms in the fourth quarter of 2001. This roll out included implementing six new NNAAP written examination forms, three new NNAAP oral examination forms, and three new NNAAP Spanish examination forms, based on a revised content outline and a new passing standard. CAT*ASI also implemented the new passing standard for the individual skills on the NNAAP skills evaluation in the fourth quarter of 2001.

  A new practice examination was placed on the CAT*ASI web site to reflect the changes in the weighting of each content area in the written examination content outline.

- **Differential Item Functioning Review**
  CAT*ASI has undertaken a project to review Differential Item Functioning (DIF) in the NNAAP item pool. SMEs from a representative sample of CAT*ASIs client states (Colorado, New Jersey, Pennsylvania and Washington state) are participating in a DIF analysis which will be complete by June 2002. The results of the analysis will be reviewed by CAT*ASIs psychometrician specializing in nurse aide market issues.

Potential New Business

CAT*ASI will submit a bid for the Wisconsin Nurse Aide Testing and Registry contract. The Department of Health and Family Services, Bureau of Quality Assurance will make the vendor decision by the end of May 2002. This is a five-

year contract with four optional years. Wisconsin tests approximately 11,000 nurse aides annually and has approximately 148,000 nurse aides on their Registry.

- **Paper/Pencil Initiative**
  An initiative is underway at CAT*ASI to reduce the turnaround time for candidate score reports and client reports in the paper/pencil testing market. Same day results reporting for paper/pencil exams is the goal for this re-engineering project. CAT*ASIs nurse aide clients will continue to administer their tests in a paper/pencil mode, and they will have the added benefit of rapid results return. A pilot study is planned for 2002.

Summary of NNAAP™ Examination Results for Testing Year 2001 Pass Rates by State

State	Skills		Written	
	% Pass	Number	% Pass	Number
AK	84.40%	571	88.60%	552
AL	58.70%	2256	77.40%	2088
CA	91.50%	8544	86.30%	9030
CO	60.90%	3869	85.80%	3442
CT	84.30%	2538	77.80%	2727
DC	44.70%	485	69.00%	487
DE	71.40%	824	84.60%	765
FL	76.00%	15814	78.30%	15738
ID	N/A	N/A	92.50%	1820
LA	73.20%	888	67.10%	978
MD	42.90%	4424	77.40%	3897
MN	85.30%	6922	88.20%	6678
MS	68.70%	3358	76.20%	3269
ND	89.80%	1225	90.40%	1225
NH	93.20%	468	97.70%	436
NJ	87.70%	5064	64.40%	5323
NM	N/A	N/A	79.40%	2155
NV	67.10%	1100	79.90%	956
OH	62.70%	8942	86.30%	7461
PA	77.30%	12158	87.40%	11154
RI	N/A	N/A	81.50%	1564
SC	72.70%	4537	74.50%	4531
TX	N/A	N/A	78.40%	18309
VA	63.10%	5160	78.60%	4728
VI	67.40%	46	49.30%	67
WA	84.30%	5503	85.00%	5547
WY	82.00%	1220	95.00%	1102
Totals	**74.70%**	**95916**	**81.20%**	**116029**

National Nurse Aide Assessment Program (NNAAP™) Written/Oral Examination Content Outline

The NNAAP Written Examination is comprised of seventy (70) multiple-choice questions. Ten of these questions are pre-test (non-scored) questions on which statistical information will be collected. The NNAAP Oral Examination is comprised of 60 multiple-choice questions and 10 word recognition (or reading comprehension) questions. This content outline became effective on November 1, 2001.

I. Physical Care Skills

A. Activities of Daily Living .....7% of exam (4 questions)
1. Hygiene
2. Dressing and Grooming
3. Nutrition and Hydration
4. Elimination
5. Rest/Sleep/Comfort

B. Basic Nursing Skills .....37% of exam (22 questions)
1. Infection Control
2. Safety/Emergency
3. Therapeutic/Technical Procedures
4. Data Collection and Reporting

C. Restorative Skills .....5% of exam (3 questions)
1. Prevention
2. Self Care/Independence

II. Psychosocial Care Skills

A. Emotional and Mental Health Needs .....10% of exam (6 questions)
B. Spiritual and Cultural Needs..... 3% of exam (2 questions)

III. Role of the Nurse Aide

A. Communication .....10% of exam (6 questions)
B. Client Rights .....15% of exam (9 questions)
C. Legal and Ethical Behavior.....5% of exam (3 questions)
D. Member of the Health Care Team.....8% of exam (5 questions)

Panel Members

Elizabeth Lund, Executive Officer, TN, Area III, *Chair*

Jay Douglas, Board Staff, VA, Area III

Rachel Gomez, Board Member, TX-VN, Area III

Cynthia Gray, Executive Officer, NH, Area IV

Barbara Holtry, Board Staff, OR, Area I

Janice McRorie, Board Member, NC, Area III

Cheryl Payseno, Board Member, WA, Area I

Board Liaison
Deborah Burton, Board Member, OR, Area I, Director-at-Large

Staff
Kristin Hellquist, Associate Director of Policy and External Relations

Rosemary Gahl, Policy and External Relations Assistant

Relationship to Strategic Plan

Strategic Initiative 5 – Governance & Leadership Development and Organizational Capacity:
NCSBN will support the education and development of Member Board staff, Board Members and the Board of Directors to lead in nursing regulation.

Outcome 5: NCSBN recognizes significant contributions and historical milestones.

Meeting Dates

- October 28, 2002
- Conference calls as needed
- August 7-8, 2003 (hosting events as planned)

Attachments

None.

Report of the 25th Anniversary Panel

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of NCSBN 25th Anniversary Planning Advisory Panel

The purpose of the NCSBN 25th Anniversary Planning Advisory Panel is to plan activities to commemorate and celebrate NCSBN's 25th Anniversary in 2003. In addition, the panel will also develop events to celebrate the 100-year history of nursing regulation in the United States and its territories.

Highlights of FY02 Activities

- Publicity will occur during 2003 and the celebration will commence at the 2003 Delegate Assembly meeting in Alexandria, Virginia. NCSBN will highlight the first four nursing boards that are celebrating 100-year anniversaries in *Council Connector*. A special booklet will be prepared for the membership to commemorate these milestones.
- The key activity will be an off-site gala celebration dinner to commemorate the 25th anniversary of NCSBN at the Women in Military Memorial on the grounds of Arlington National Cemetery.
- In addition, the panel will be a co-host of a 'Birthday Party' at the annual awards luncheon at Delegate Assembly to celebrate NCSBN and the member boards' birthdays.
- The panel has chosen a special anniversary logo for the yearlong celebration for NCSBN. It will be unveiled, along with other surprises, at the 2002 Delegate Assembly.

Future Activities

The panel looks forward to finalizing plans for the members of NCSBN to celebrate its 25-year milestone and to publicizing the important work of NCSBN (along with nursing regulation during the past 100 years). Each Member Board will have its own unique section in the anniversary booklet that is already under way.

Report of Disaster Preparedness Task Force

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of the Disaster Preparedness Task Force

The Disaster Preparedness Task Force was created in November 2001 to establish a resource and mechanism for Member Boards to communicate and identify critical information, possible responses and potential plans of action in developing and maintaining emergency preparedness and disaster planning strategies.

Specifically, the task force developed a framework for a template to address the internal and external functions of Member Boards, related to disaster preparedness. The template was designed to serve as a tool and an additional resource for Member Boards, related to their individual needs and efforts. The information included in the template was not intended to represent all issues, concerns and possible strategies. Rather, the design and content of the template was intended to be thought provoking and provide a framework to assist Member Boards in plan development, implementation strategies and re-assessment.

Highlights of FY02 Activities

- Surveyed the needs of Member Boards regarding disaster preparedness and planning.
- Developed and distributed an "alert" pertaining to the Model State Emergency Health Powers Act, to Member Board executive officers.
- Developed and distributed a draft Member Board Disaster Preparedness Plan Template to all Member Board executive officers that could serve as a framework and resource for the internal and external functions and operations of Member Boards.
- Solicited and incorporated comments and feedback on the draft template and reissued an updated version of the template with enhancements, for reference and resource purposes.
- Distributed periodic communications to Member Board Executive Officers on relevant disaster preparedness and bioterrorism concerns.

Future Activities

- Conduct periodic reviews of the Disaster Preparedness Plan Template.
- Monitor relevant issues and concerns.
- Communicate information to Member Boards related to disaster preparedness, public protection and bioterrorism.
- Conduct ad hoc meetings, as information is available.

Task Force Members

Donna Dorsey, Executive Officer, MD, Area IV, Chairperson

Polly Johnson, Executive Officer, NC, Area IV

Barbara Zittel, Executive Officer, NY, Area IV

Staff
Joseph Dudzik, Director of Human Resources

Relationship to Strategic Plan

Strategic Initiative 2 – Regulatory Effectiveness: The National Council will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome 1: Advanced regulatory strategies promote public protection and effective nursing practice.

Meeting Dates

- December 4, 2001 (Conference Call)
- January 11, 2002 (Conference Call)
- February 13, 2002 (Conference Call)
- February 27, 2002 (Conference Call)

Attachments

A. NCSBN Member Board Disaster Preparedness Plan Template

Introduction

In November 2001, the Board of Directors of the National Council of State Boards of Nursing (NCSBN) approved the creation of a Task Force to develop a framework and template to address the internal and external functions of Member Boards related to disaster preparedness. This template is intended to serve as a tool and an additional resource for Member Boards related to their individual needs and efforts. The information included is not intended to represent all issues, concerns, and possible strategies. Rather, the content should be thought-provoking and provide a framework to assist the Member Boards in plan development, implementation and re-assessment strategies in Disaster Preparedness efforts.

For clarification purposes, internal functions of Member Boards are defined as organizational and operational processes and procedures of State Boards of Nursing. External functions are defined as formal and informal relationships Member Boards support on an ongoing basis that may affect the work of Boards of Nursing. Examples of external relationships include state agencies and departments, other state boards of nursing, other professional boards, regulatory agencies, and health care providers.

Disaster Preparedness Task Force – Attachment A

NCSBN Member Board Disaster Preparedness Plan Proposed Template

List of Contents

Disaster Preparedness Outline

This outline summarizes the key components of a comprehensive disaster preparedness plan. Critical elements of the plan focus on disaster prevention and damage reduction, immediate response activities, recovery or salvage procedures, and rehabilitation of damaged materials. It may be useful to have a plan in which all elements are fully developed. As an option, a "phased" approach can also be applied to disaster preparedness. As a first phase, the planner(s) can begin with a few sections (in outline form). This option would allow an institution to focus first on those issues that are of greatest concern. In a subsequent phase, the planners can gradually add more detail and other sections as they become better educated, have time to pursue the plan, and are able to develop consensus on how the institution should organize its preparedness activities.

I. Pre-Planning Activities

A. Secure the support of leadership and the appointment of Key personnel.
B. Review Disaster History and Trends and Categorize Disasters by Type.
C. Draft a Project Mission Statement.
D. Conduct fact-finding and process definition tasks as key components in the planning and assessment process.
E.Assess Your Organization's Level of Readiness.

II. Vulnerability Assessment

A. Identify potential Risks. Potential risks are defined as events that can cause an unexpected interruption of an organization' Business functions. An abbreviated listing of possible events include:
1. Fire
2. Violent Weather (i.e. Tornado, Hurricanes, Blizzards Heat, etc.)
3. Earthquakes
4. Gas Explosions
5. Floods (inside and outside building)

6. Power Outages
7. Sabotaged Computer System
8. Destroyed Equipment
9. Compromised Structural Integrity of Building
10. Workplace Violence
11. Chemical / Nuclear Leak
12. Terrorist acts
13. Health Emergency
14. Mass Immunizations

B. Identify resources and functions that may be affected by unexpected business interruptions, such as:
1. Staff
2. Facility
3. Inventory
4. Essential Information
5. Business Operations
6. Internal and External Communication
7. Customers, Vendors
8. Decreased Revenue
9. Increased Expenses

III. Business Impact Analysis.

A. Coordinate organizations' efforts to ensure the continued availability of **"Internal"** essential services, programs and operations, including all the resources involved.

B. Coordinate organizations' efforts to ensure the continued availability of **"External"** essential services, programs and operations, including all the resources involved.

C. Prepare appropriate responses to unexpected interruptions of **Internal and External** "essential business functions" and provide guidelines to fully recover operations, services programs within acceptable time-lines.

D. Plan Design and Content. Identify all "essential business functions".
1. A service or activity that is considered "essential" by management for continued operation.
2. Non-performance of this function would significantly impair the successful functioning of the business or organization.

E. Identify Critical Organizational Functions.
1. Business Operations
2. Office / Administrative Operations
3. Communication
4. Regulatory Activities
5. Information Technology
6. Financial Management
7. Human Resources

IV. Preparing for External Disasters within your State and Surrounding Areas.

A. Coordinate organizations' efforts in addressing statewide and surrounding area disasters, including response and recovery strategies.

V. Plan Development.

A. Identify Roles and Responsibilities of Disaster Plan Team.

B. Develop and confirm framework of functions, activities and time frames.

C. Ensure the availability of necessary resources including personnel, crisis communication plan, information, equipment, financial arrangements, services and accommodations.

VI. Project Evaluation

A. Testing & Plan Maintenance. Plan, assess, test, and reassess processes.

Please note: this template is a living document. Any ongoing comments, suggestions and recommendations, from Member Boards for enhancements and inclusion are appreciated. For your convenience, a Comments Form is provided at the end of the document. Please forward any feedback to the attention of Joseph Dudzik, Director of Human Resources, at NCSBN.

With the ongoing assistance and input provided by Member Boards, we are confident that this template will provide a sound framework for Member Boards to utilize in the development, implementation and reassessment strategies of Disaster Preparedness efforts.

Sincerely,
NCSBN Disaster Preparedness Task Force

Disaster Plan Content Checklist

This checklist provides a general overview of proposed content information of a disaster plan. Respective appendices and Resources are referenced in the description.

Date	Subject Title and Description
	Recovery Team – Emergency Information Sheet List of recovery team members (including work and home phone numbers), with description of responsibilities, scope of authority, and reporting lines.
	Elements of Disaster Plan – One-page summary of immediate tasks/ steps to be taken. (See Appendix 1.)
	Disaster Preparedness Plan – Outline (Internal) Overview of Plan including strategies, phases, purpose, author, organization, scheduled updates. (See Resource 1.)
	Building / Facility Inspection Checklist – Detailed, step-by-step instructions on all phases of salvage operation, including discussion of recovery from the range of incidents that are possible (e.g., roof/plumbing leaks, flooding, fire, etc.) and information covering each of the following: storage areas, aisles, entrances and exits, windows; fire extinguishers, fire alarms, sprinklers, smoke/fire detectors, enunciators; shut-offs and master switches for power, water, gas, HVAC (heating, ventilation, and air-conditioning) system, elevator controls, etc.; priority collections by department.(See Appendix 2.)
	Board Preparation Information and Checklist – An overview and detailed checklist for Board to insure operational and financial security of organization. (See Resource 2.)
	Staff Emergency Information & Communication Plan "Telephone Tree" – Detailed staff listing with emergency contact information including office, home and cell phone number, next of kin, and insurance and beneficiary information, and strategy for contacting them, and communication vehicles that can be used.
	Crisis Communication Plan – Internal plan of action for contacting key stakeholders, BODs, attorney, members, customers, and staff. Included in this plan are Press Release Strategies and External Communications Strategies.
	Emergency Action Plan – Outline of internal procedures to be followed in advance of emergency for which there is advance warning (e.g., hurricane, flooding), including assignment of responsibilities for actions. Building evacuation should be included in plan and distribution / education of information must be ensured.
	Record Keeping / Record Retention and Archives – Lists and locations of important records and archived materials. Detailed by department, subject, and/or location. Media included in records collection, such as book journals, manuscripts/records, coated vs. uncoated stock, sound recordings, photo, computer/electronic media. Multiple copies of all forms should exist off-site, including inventory forms, packing lists, requisitions and purchase orders, etc.
	Business Recovery Checklist – Summary of tasks / steps to be taken by operational function. (See Appendix 3.)

Date	Subject Title and Description
	Reference Checklist – A listing of available external resources that provide a frame of reference in Disaster Preparedness efforts (See RESOURCE 3).
	Preparing For External Disaster – Detailed plan outline that addresses concerns and plans of action for disasters occurring external to your organization but within your State or Surrounding Area (See Appendix 4).
	Emergency Services Checklist – Names of emergency service contacts, consultants and other specialists, sources of auxiliary/volunteer personnel, etc. For lists of resources outside the institution, it will be useful to provide day and night/weekend contacts and phone numbers, along with some details about the resource such as the type and quantities of materials available, cost and payment terms, and/or special arrangements/contracts that exist (See Resource 4).
	Accounting Information – Description of institutional funds available in a recovery effort and procedures/authorization for access to them.
	Insurance Information – Explanations of coverage, claim procedures, record-keeping requirements, restrictions on staff/volunteers entering a disaster area, information on state/federal disaster relief procedures.
	In House Supply Listing – Locations and inventory of in-house supplies, sources of commercial supplies/equipment that may be purchased.
	Location of Keys – Information about the location of, and means of access to keys or combinations for achieved information, elevators, offices, etc. Note: For security reasons, it may not be prudent to provide exact information about all these. In such cases, the plan should specify a procedure for contacting the individuals who have the proprietary information.

This listing is intended to serve as an overview of recommended essential planning elements that should be included in preparing and administering an effective Disaster Plan. These tasks can be modified to better serve the organization and Disaster Planning strategy.

Appendix 1: Elements of a Disaster Plan

Task #	Element	Date Completed
1	Assign responsibility	
2	Educate the committee and others as appropriate	
3	Work with local emergency agencies	
4	Define the scope of the planning project	
5	Establish goals and timetable	
6	Develop reporting schedule and lines	
7	Assess the collections and set salvage priorities	
8	Determine and rank potential hazards	
9	Assess prevention and protection needs	
10	Consider financial implications	
11	Write the plan	
12	Distribute the plan and train staff	
13	Test the plan and revise as needed	
14	Document and assess the process	

Appendix 2: Building/Facility Inspection Checklist

Title and Description	Date Last Inspected
Outdoor Hazards 1. Railings, benches, planters, light/flag poles well anchored; 2. Overhanging trees/branches trimmed	
Building 1. No sign of cracks/seepage visible in exterior or interior walls 2. Compliance with seismic, fire, electrical, and other codes	
Roof 1. "Sloped" or "pitched" (i.e., not flat) 2. Roof covering sound 3. No buckling/bubbles, leaks, cracks, standing water 4. Flashing/caulking intact 5. Equipment on roof prohibited or (if present) properly anchored	
Drainage (eaves, gutters, downspouts, scuppers, drains, interior columns) 1. Connected into sewer system 2. Water directed away from building footings 3. Draining freely 4. Good drainage around doors	
Windows and skylights 1. Caulking/sealants sound 2. Trees/limbs trimmed away	
Fire safety 1. Emergency Evacuation Plan is posted, distributed, updated 2. Fire-resistant structure 3. Concrete flooring, with no air passages between floors 4. Concealed spaces (e.g., false ceilings) identified 5. Fire detection in all concealed spaces 6. Stairways and pipe shafts enclosed 7. Electrical wiring in good condition 8. Appliance cords in good condition 9. Appliances unplugged nightly 10. Do staff have keys to mechanical rooms and janitorial closets	

The inspection checklist is designed to serve as an integral part of an institutional disaster preparedness program. Through periodic inspections and information-gathering activities outlined, staff can reduce the institution's vulnerability to a disaster. Some of this information will be gathered in regular tours of the building, while other elements will be ascertained in conversations with others in the organization.

The information gathered can be used in two ways.

1. Some conditions identified will require repair, replacement, or other maintenance activity. For example, if drains are not flowing freely from the roof, a simple cleaning will remedy that condition. If fire extinguishers are missing from a critical area, they may be purchased and installed.
2. Staff will identify some conditions that are not easily resolved. The existence of such conditions will alert the institution to vulnerabilities that must be considered in the institution's disaster plan. For example, if there is no automatic fire suppression capability, it may not be immediately installed. But this vulnerability should signal the disaster preparedness team to plan carefully for other strategies that will reduce the risk of fire.

In actual use, the institution will create its own checklists based on the frequency with which each item needs to be checked. Some will need attention only once or every few years (e.g., identifying the type of roof on the structure).

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Others will require just annual or semi-annual inspections, as is the case with furnace and boiler inspections. Still others will merit monthly or quarterly attention, such as fire extinguisher inspections and examination of toe plumbing.

Many of the inspections outlined here are likely to be the duty of personnel responsible for facilities maintenance. In those cases, the assigned staff needs to:

1. Develop mechanisms for learning of remedial actions that are needed and,
2. Verify that the inspections are done as scheduled.

Those areas not included in inspections by facilities staff should be assigned to staff that are most capable of ensuring follow-up. As a consideration, staff assigned to the administrative services area or the library/archives are possible selections. One individual should keep copies of the completed checklists and track progress in completing repairs and other actions noted on the forms. This may be done by the administrator responsibility for the building or by the chair of the disaster preparedness committee. The suggested checklist for tracking Building and Facility Management Inspections begins on the previous page.

Title and Description	Date Last Inspected
11. Regular Fire Marshall visits 12. Fire Marshall visits used productively (e.g., floor plans given to Fire Dept., high-priority collection areas noted; appropriate follow-up on observed Code violations) 13. Detection systems; appropriate type(s) present, wired to 24-hour monitoring station, tested regularly 14. Appropriate extinguishers present; Inspected appropriately and on schedule 15. Automatic suppression system (i.e., sprinklers, Halon) present and operating 16. Staff trained in: sounding alarms, interpreting enunciator panels (if present), notifying Fire Dept. and others as needed	
Heating, ventilation, and air conditioning (HVAC) system 1. Automatic shut-off capacity in event of fire 2. Furnace/boiler inspected each fall 3. Air conditioning; no leaks, no mold present, effective drainage from condensation-collecting pans, dehumidification capacity 4. Capable of operating on exhaust to reduce smoke	
Stack areas 1. Shelves well braced 2. No water sources located above collections 3. Books shelved snugly 4. Shelving 4-6" off floor 5. "Canopies" atop shelving units 6. No valuable materials in basement 7. Exits unobstructed 8. Important collections away from windows	
Protection from water damage 1. Pipes and plumbing well supported 2. No pipe/plumbing leaks 3. Water detectors present 4. Sump pumps and back-ups present 5. Appropriate dehumidifiers available 6. No leakage/seepage through walls	

Title and Description	Date Last Inspected
7. Valuable material stored above ground level 8. Valuable and fragile media stored in protective enclosures 9. Staff have access to keys; mechanical rooms and janitorial closets 10. Staff have knowledge of location of water main and have appropriate tools (if needed) for shut-off	
Security 1. Book drops (if any) located away from building or in fire-resistant enclosure 2. Building exterior well lighted 3. Locks/alarms on all windows and doors 4. Intrusion detectors/alarms present and monitored 24-hours 5. An effective closing procedure to ensure building is vacant	
Housekeeping 1. Cleaning supplies and other flammables stored safely 2. Trash removed nightly 3. Staff room cleaned daily and well 4. Smoking prohibited 5. Food and drink prohibited, and prohibition enforced 6. Pest management strategies in place and effective	
Insurance 1. Policy up to date 2. Acts of God" covered 3. Replacement costs specified as needed 4. Staff are aware of records required for claims, and those records maintained safely 5. Duplicate shelf list, catalog, inventory, and/or back-up computer tapes for entire collections	
Construction projects 1. Responsibility for fire safety precautions clearly specified in contract 2. Fireguards used in all cutting/welding operations 3. Debris removed nightly 4. Fire-resistant partitions used 5. Extra fire extinguishers on hand	

This checklist provides a recommended task schedule for operational units/functions during business recovery.

Appendix 3: Business Recovery Checklist

Senior Management
- ❑ Remain visible to employees / stakeholders
- ❑ Delegate recovery roles
- ❑ Establish a Recovery Steering Committee
- ❑ Direct, manage and monitor the recovery
- ❑ Avoid temptation to participate hands-on
- ❑ Publicly praise successes
- ❑ Clearly communicate new roles, responsibilities
- ❑ Rationally amend business plans, projections
- ❑ Closely control media, analyst communications

Human Resources

Continuously:
- ❑ Re-assess / prioritize allocation of resources
- ❑ Monitor productivity of personnel
- ❑ Provide appropriate retraining
- ❑ Monitor employee morale
- ❑ Guard against employee burnout
- ❑ Monitor for delayed stress / trauma
- ❑ Provide counseling and support
- ❑ Pay employees / beneficiaries timely

Technology / Management
- ❑ Identify, prioritize mission critical applications
- ❑ Prepare business impact analyses by unit
- ❑ Re-assess original recovery plans
- ❑ Continuously assess recovery site stability
- ❑ Recover / reconstruct all critical data

Within the recovery environment:
- ❑ Assess the adequacy of information security
- ❑ Assess the adequacy of system security
- ❑ Re-assess recovery tolerance / timeframes
- ❑ Evaluate recovery contingencies
- ❑ Develop and test recovery plans
- ❑ Develop emergency plans for recovery staff

Customers, Clients and Suppliers
- ❑ Re-establish customer, vendor contracts
- ❑ Reconsider revenue, profit projections
- ❑ Recover, reconstruct contracts, customer data

In the post-disaster environment, access:
- ❑ Changed customer requirements
- ❑ Ability to respond to customer requests, inquiries
- ❑ Changed customer, supplier market behavior
- ❑ Appropriate products / product mix
- ❑ Customer / counter party stability
- ❑ Supplier / vendor reliability
- ❑ Status of existing orders / contracts

Business Operations
- ❑ Assess ability to deliver customer orders
- ❑ Identify outsourcing opportunities
- ❑ Refresh supply chain management
- ❑ Analyze lease requirements / options
- ❑ Establish new risk-mitigating controls
- ❑ Amend policies and procedures

Continuously re-assess the adequacy of:
- ❑ Recovery site
- ❑ Existing plant and equipment
- ❑ Production capacity
- ❑ Communications / sales capacity
- ❑ Transaction settlement processes

Financial Management
- ❑ Separately track losses, recovery costs
- ❑ Formally notify insurers of claims
- ❑ Protect facilities from further damage
- ❑ Seek interim relief from insurers
- ❑ Investigate regulatory relief
- ❑ Contact analysts / rating agencies
- ❑ Pay current insurance premiums

Re-establish:
- ❑ Payroll & benefits processes
- ❑ Accounts payable / receivable processes
- ❑ Billing / credit / market risk monitoring
- ❑ External / internal reporting
- ❑ Key reconciliation's
- ❑ Other financial controls
- ❑ Meaningful key performance indicators
- ❑ Transaction controls / limits
- ❑ Authorities / approval limits

Re-assess:
- ❑ Cash flow projections
- ❑ Budgeting & closing process / timing

Developing a Plan for Obtaining Nurses to Meet a Disaster Need and for Issuing Licenses and Verification of Licenses

When a disaster occurs in a the state or surrounding area the board may be asked to issue licenses for nurses coming into the state or verifying licenses for out of state. Most of the states have provisions in the law to deal with licensure in the times of a disaster, but there remains a need to validate licenses. The board may also be asked to participate in developing the nursing resources in the state for disaster preparedness or serve as a clearing house for volunteers. Whenever there is a disaster, it stresses the system and it is important that board's be prepared to respond quickly and effectively. Good planning can also prevent the modification of standards in order to provide nursing care, i.e. expanded activities for unlicensed people. The checklist provides some ideas for developing a plan in case of disaster.

Appendix 4: Preparing for an External Disaster Within Your State or Surrounding Area

Checklist

- ❑ Create list of contact information for all staff.
- ❑ Identify staff for management, licensure and verification activities in an emergency.
  -Prepare plan for 24 hour coverage
  -Train staff
  -Include backup staff for each role. In this activity, it is a good idea to train more staff than those who normally do the work.
- ❑ Identify volunteers who could assist the Board. Volunteers can be especially helpful handling phones and walk-ins.
- ❑ How will you communicate with staff, volunteers and others? Are cell phones available? Does the State have a method for communication in a disaster?
- ❑ Identify critical operations needed to license or verify individuals. Determine what operations are needed to do only those activities necessary during an emergency situation.
- ❑ Identify alternatives to usual manner of licensing or verification. Plan an alternative to on-line and telephone verification. How will you license or verify if the database is down or telephone access is gone? For example, if your information is also on Nursys, it could be an alternative site.
- ❑ If out of state nurses need licenses to practice in the state, develop a plan for immediate licensure.
- ❑ Does all staff understand their roles in an emergency situation?
- ❑ Develop contingency plan if office cannot be accessed.
- ❑ Consider sending staff to a staging area to do onsite licensing and verification.
- ❑ Work with agencies and nursing groups to assure that they understand the plan for licensure and verification.
- ❑ Identify groups in the State who are working on preparedness and become part of those groups as a member or observer.
- ❑ Establish relationships with agencies (health department, hospitals, emergency management) to preplan how the need for nurse will be met. There is a tendency to modify standards for the emergency if nurses are not available. What can be done to assure that there are adequate nurses?
- ❑ Consider ways to use inactive nurses or non-renewed nurses as unlicensed assistive personnel. Could they work on immunizations with an update and supervision or help in a shelter?
- ❑ Develop a method for accessing volunteer nurses. For example, can a roster of volunteers be created or can the newsletter be used to make people aware of the need with information about what to do if one wants to help in an emergency?

- ❑ Publish written or Web site articles advising nurses to have a current hard copy of their nurse license and photo ID readily available.
- ❑ Develop a list of "what ifs" and solutions to avoid delay in a real situations; for example, How do you allow / credential a nurse to work, who comes into the state and loses all identification?
- ❑ Are there rules that can be suspended in a disaster?
- ❑ Any legislation required in order to implement plan?
- ❑ Many states are passing legislation that allows the governor to suspend certain laws and rules in a disaster. Develop a list of any rules or laws that would need to be suspended and those that cannot be suspended.
- ❑ Test the plan and revise as needed.

Disclaimer

The following project outline is provided solely as a guide. It is only intended to be one example of requirements for a disaster recovery project plan. It is not, by any stretch of the imagination, the only way to set up a project plan.

Resource 1: Disaster Recovery Planning

Project Plan Outline

If you are new to recovery planning, make sure that you research the subject thoroughly before embarking on a disaster recovery project. Consider engaging a consultant (internal or external to your organization) to help you in your project planning effort. Disaster recovery planning ***is not*** a two-month project, and neither is it a project that once completed, you can forget about. An effective recovery plan is a ***live*** recovery plan. The plan must be maintained current and tested/exercised regularly.

1. Program Description
   A. Pre-Planning Activities (Project Initiation)
   B. Vulnerability Assessment and General Definition of Requirements
   C. Business Impact Analysis
   D. Detailed Definition of Requirements
   E. Plan Development
   F. Testing Program
   G. Maintenance Program
   H. Initial Plan Testing and Plan Implementation
2. Planning Scope and Plan Objectives
3. Project Organization and Staffing
4. Project Control
5. Schedule of Deliverables
6. Resource Requirements

The primary objective of a Business Resumption Plan is to enable an organization to survive a disaster and to reestablish normal business operations. In order to survive, the organization must assure that critical operations can resume normal processing within a reasonable time frame. Therefore, the **goals** of the Business Resumption Plan should be to:

A. Identify weaknesses and implement a disaster prevention program;
B. Minimize the duration of a serious disruption to business operations;
C. Facilitate effective co-ordination of recovery tasks; and
D. Reduce the complexity of the recovery effort.

Historically, the information technology / data processing function alone has been assigned the responsibility for providing contingency planning. Frequently, this has led to the development of recovery plans to restore computer resources in a manner that is not fully responsive to the needs of the business supported by those resources. Contingency planning is a business issue rather than a data processing issue. In today's environment, the effects of long-term operations outage may have a catastrophic impact. The development of a viable recovery strategy must, therefore, be a product not only of the provider's of the organization's data processing, communications and operations center services, but also the users of those services and management personnel who have responsibility for the protection of the organization's assets.

The methodology used to develop the plans, emphasize the following key points:

A. Providing management with a comprehensive understanding of the total effort required to develop and maintain an effective recovery plan;
B. Obtaining commitment from appropriate management to support and participate in the effort;
C. Defining recovery requirements from the perspective of business functions;
D. Documenting the impact of an extended loss to operations and key business functions;
E. Focusing appropriately on disaster prevention and impact minimization, as well as orderly recovery;
F. Selecting project teams that ensure the proper balance required for plan development;
G. Developing a contingency plan that is understandable, easy to use and easy to maintain; and
H. Defining how contingency-planning considerations must be integrated into ongoing business planning and system development processes in order for the plan to remain viable over time.

The successful and cost effective completion of such a project requires the close cooperation of management from all areas of Information Systems as well as business areas supported by Information Systems. Senior personnel from Information Systems and user areas must be significantly involved throughout the project for the planning process to be successful.

In closing, it is important to keep in mind that the aim of the planning process is to:

A. Assess existing vulnerabilities;
B. Implement disaster avoidance and prevention procedures; and

C. Develop a comprehensive plan that will enable the organization to react appropriately and in a timely manner if disaster strikes.

1. Program Description

Since recovery planning is a very complex and labor intensive process, it therefore requires redirection of valuable technical staff and information processing resources as well as appropriate funding. In order to minimize the impact such an undertaking would have on scarce resources, the project for the development and implementation of disaster recovery and business resumption plans should be part of the organization's normal planning activities.
The proposed project methodology consists of eight separate phases, as described below.

A. Phase 1 – Pre-Planning Activities (Project Initiation)
Phase 1 is used to obtain an understanding of the existing and projected computing environment of the organization. This enables the project team to: refine the scope of the project and the associated work program; develop project schedules; and identify and address any issues that could have an impact on the delivery and the success of the project.

During this phase a Steering Committee should be established. The committee should have the overall responsibility for providing direction and guidance to the Project Team. The committee should also make all decisions related to the recovery planning effort. The Project Manager should work with the Steering Committee in finalizing the detailed work plan and

developing interview schedules for conducting the Security Assessment and the Business Impact Analysis.

Two other key deliverables of this phase are:
1. The development of a policy to support the recovery programs; and
2. An awareness program to educate management and senior individuals who will be required to participate in the project.

B. Phase 2 - Vulnerability Assessment and General Definition of Requirements

Security and control within an organization is a continuing concern. It is preferable, from an economic and business strategy perspective, to concentrate on activities that have the effect of reducing the possibility of disaster occurrence, rather than concentrating primarily on minimizing impact of an actual disaster. This phase addresses measures to reduce the probability of occurrence.

This phase will include the following key tasks:
1. A thorough Security Assessment of the computing and communications environment including personnel practices; physical security; operating procedures; backup and contingency planning; systems development and maintenance; database security; data and voice communications security; systems and access control software security; insurance; security planning and administration; application controls; and personal computers.
2. The Security Assessment will enable the project team to improve any existing emergency plans and disaster prevention measures and to implement required emergency plans and disaster prevention measures where none exist.
3. Present findings and recommendations resulting from the activities of the Security Assessment to the Steering Committee so that corrective actions can be initiated in a timely manner.
4. Define the scope of the planning effort.
5. Analyze, recommend and purchase recovery planning and maintenance software required to support the development of the plans and to maintain the plans current following implementation.
6. Develop a Plan Framework.
7. Assemble Project Team and conduct awareness sessions.

C. Phase 3 - Business Impact Assessment (BIA)

A Business Impact Assessment (BIA) of all business units that are part of the business environment enables the project team to: identify critical systems, processes and functions; assess the economic impact of incidents and disasters that result in a denial of access to systems services and other services and facilities; and assess the "pain threshold," that is, the length of time business units can survive without access to systems, services and facilities.

The BIA Report should be presented to the Steering Committee. This report identifies critical service functions and the timeframes in which they must be recovered after interruption. The BIA Report should then be used as a basis for identifying systems and resources required to support the critical services provided by information processing, other services and facilities.

D. Phase 4 - Detailed Definition of Requirements

During this phase, a profile of recovery requirements is developed. This

profile is to be used as a basis for analyzing alternative recovery strategies. The profile is developed by identifying resources required to support critical functions identified in Phase 3. This profile should include hardware (mainframe, data and voice communications and personal computers), software (vendor supplied, in-house developed, etc.), documentation (DP, user, procedures), outside support (public networks, DP services, etc.), facilities (office space, office equipment, etc.) and personnel for each business unit. Recovery Strategies will be based on short term, intermediate term and long-term outages.

Another key deliverable of this phase is the definition of the plan scope, objectives and assumptions.

E. Phase 5 - Plan Development
During this phase, recovery plans components are defined and plans are documented. This phase also includes the implementation of changes to user procedures, upgrading of existing data processing operating procedures required to support selected recovery strategies and alternatives, vendor contract negotiations (with suppliers of recovery services) and the definition of Recovery Teams, their roles and responsibilities. Recovery standards are also being developed during this phase.

F. Phase 6 - Testing/Exercising Program
The plan Testing/Exercising Program is developed during this phase. Testing/exercising goals are established and alternative testing strategies are evaluated. Testing strategies tailored to the environment should be selected and an on-going testing program should be established.

G. Phase 7 - Maintenance Program
Maintenance of the plans is critical to the success of an actual recovery. The plans must reflect changes to the environments that are supported by the plans. It is critical that existing change management processes are revised to take recovery plan maintenance into account. In areas where change management does not exist, change management procedures will be recommended and implemented. Many recovery software products take this requirement into account.

H. Phase 8 - Initial Plan Testing and Implementation
Once plans are developed, initial tests of the plans are conducted and any necessary modifications to the plans are made based on an analysis of the test results.

Specific activities of this phase include the following:
1. Defining the test purpose/approach;
2. Identifying test teams;
3. Structuring the test;
4. Conducting the test;
5. Analyzing test results; and
6. Modifying the plans as appropriate.

The approach taken to test the plans depends, in large part, on the recovery strategies selected to meet the recovery requirements of the organization. As the recovery strategies are defined, specific testing procedures should be developed to ensure that the written plans are comprehensive and accurate.

2. Planning Scope and Plan Objectives

The primary objective of recovery planning is to enable an organization to survive a disaster and to continue normal business operations. In order to survive, the organization must assure that critical operations can resume/continue normal processing. Throughout the recovery effort, the plan establishes clear lines of authority and prioritizes work efforts. The key objectives of the contingency plan should be to:

A. Provide for the safety and well-being of people on the premises at the time of a disaster.
B. Continue critical business operations.
C. Minimize the duration of a serious disruption to operations and resources (both IT and other).
D. Minimize immediate damage and losses.
E. Establish management succession and emergency powers.
F. Facilitate effective co-ordination of recovery tasks.
G. Reduce the complexity of the recovery effort.
H. Identify critical lines of business and supporting functions.

Although statistically the probability of a major disaster is remote, the consequences of an occurrence could be catastrophic, both in terms of operational impact and public image. Management appreciates the implications of an occurrence; therefore, it should assign on-going responsibility for recovery planning to an employee dedicated to this essential service.

Management must make a decision to undertake a project that satisfy the following objectives:

A. Determine vulnerability to significant service interruptions in the Data Center and business facilities and define preventive measures that may be taken to minimize the probability and impact of interruptions;
B. Identify and analyze the economic, service, public image and other implications of extended service interruptions in the Data Center and other business facilities;
C. Determine immediate, intermediate and extended term recovery needs and resource requirements;
D. Identify the alternatives and select the most cost effective approaches for providing backup operations capability and timely service restoration; and
E. Develop and implement contingency plans that address both immediate and longer-term needs for the Data Center and other business facilities.

3. Project Organization and Staffing

The project team organization is designed to maximize the flexibility needed to deal with the implementation of a plan in the most efficient manner possible. As explained earlier in this document, disaster recovery and business resumption planning is a complex and labor-intensive program. A key factor in the successful development and implementation of recovery and resumption programs in other organizations is the dedication of a full-time resource to recovery/business continuity planning.

Recovery plans should be treated as living documents. Both the information processing and the business environments are constantly changing and becoming more integrated and complex. Recovery plans must keep pace with these changes. Continuous testing/exercising of plans is essential if the organization wants to ensure that recovery capability is maintained in such an environment. The organization also must ensure that staff with recovery responsibilities are prepared to execute the plans.

This cannot be achieved without a full-time resource with responsibility for: maintaining plans; coordinating components and full plan tests; training staff with recovery responsibilities; and updating plans to reflect changes to the information processing and business environments.

A. Steering Committee
The Steering Committee should include representatives from key areas of the organization:
1. Information Systems
2. Technology Support
3. Systems Development
4. Network and Operations Services
5. Voice Communications
6. Key Business Units

B. Project Team
The composition of the Project Team may vary depending on the environments and business units for which plans are developed. It is important to note that the managers of environments and business units for which plans are developed will be responsible for the maintenance and testing of their respective plans. However, the Person/unit responsible for recovery/continuity planning should retain the role of co-coordinator of testing activities, major plan revisions and maintainer of the Master Plan.

The Core Project Team is automatically part of other project teams. Internal Audit should be invited to be part of all teams. The managers represented on the various teams may choose to recommend other senior individuals in their area to represent them or to join specific teams where their expertise will be required for the development of the plans.

C. Suggested Core Project Team Composition
1. Project Manager
2. Computer and Network Operations
3. Systems Support
4. Voice, Network and Communications

D. Suggested Information Systems/Technology Support Team Composition
1. Network & Communications
2. Facilities Management
3. Network Development and Support
4. Database Administration
5. Information Systems Security
6. Operations
7. Network Support
8. Network Implementation

E. Business Units Team
The members of the various Business Unit teams will be different for each Business Unit.

4. Project Control

The management and control for this project should be supported by project management software. The software should be used for scheduling of personnel resources to specific tasks and identification of end deliverables and their target completion dates. Recovery Planning software implemented during Phase 2 of the project will be used to document the plans.

During Phase 1 activities, detail work plans for Data Processing and user personnel identifying tasks and responsibilities along with their associated start and completion dates will be developed.

5. Schedule of Deliverables

The following is a schedule of deliverables by phase that will be developed and delivered as part of this project.

Phase/Deliverable
Phase 1 - Pre-Planning Activities (Project Initiation)
A. Revised Detail Work Plan
B. Interview Schedules
C. Policy Statement
D. Recovery Planning Awareness Program

Phase 2 - Vulnerability Assessment
A. Security Assessment Report
B. Scope of Planning Effort
C. Plan Framework
D. Recommendation on Recovery Planning Software
E. Implementation of Recovery Planning Software

Phase 3 - Business Impact Analysis
A. Business Impact Assessment Report

Phase 4 - Detailed Definition of Requirements
A. Recovery Needs Profile
B. Plan Scope, Objectives and Assumptions

Phase 5 - Plan Development
A. Data Center Recovery Plan
B. Prototype Business Units Resumption Plan
C. Recovery Standards

Phase 6 - Testing Program
A. Testing Goals
B. Testing Strategies
C. Testing Procedures

Phase 7 - Maintenance Program
A. Maintenance Procedures
B. Change Management Recommendations

Phase 8 - Initial Plan Testing and Implementation
A. Initial Test Report
B. Implementation

6. Resource Requirements

Organizations who have tried to develop disaster and business resumption plans without dedicating the required resources to the effort have been largely unsuccessful in implementing effective recovery plans. Some organizations, after spending time and money developing recovery plans, have failed in maintaining their recovery capability. This is mostly due to a lack of commitment to keep their plans current or to do regular testing of recovery capabilities.

It is therefore essential, that management is committed to the development, implementation and maintenance of this program, that required resources are

freed up during the development cycle and that a resource be dedicated to the on-going maintenance of the program.

Resource requirements can be divided into three categories, namely:
- Personnel
- Capital Costs
- Ongoing costs

Capital Costs

A large volume of data will be gathered during various stages of the plan development. This data will be essential to the plan and has to be maintained on an on-going basis. There are several products on the market that have been designed to support the development, testing and maintenance of recovery plans. These products are evaluated during Phase 2 of the project. The final cost depends on the product chosen.

Other one-time costs may include the purchase of equipment related to establishing redundancy in the area of voice and data communications, data processing equipment (including personal computers), data processing emergency support and backup equipment (such as UPS, diesel generators, etc.) and business equipment (photocopiers, FAX machines, etc.).

Ongoing Costs

Ongoing costs include rentals, services contracts and maintenance contracts. Some of these costs are hard to estimate ahead of time but could include the following:

A. Shell/Hot Site Contract.
B. Recovery Planning Software Maintenance Contract.
C. Service and maintenance fees relating to recovery and backup equipment and services.

Computing & Networking Services (CNS & University of Toronto 2000)

This resource is referenced from Board Source (formerly the National Center for Nonprofit Boards (NCNB)). The checklist is intended to provide Boards with an operational perspective while still maintaining a governance focus. Suggestions and input related to this document can be forwarded directly to Board at the email provided below.

This information was obtained from the Web site www.boardsource.com.

Resource 2: Preparing Your Board and Organization for Disaster Recovery & Checklist

The events of September 11 and its aftermath inevitably turned the attention of nonprofit board members, executives, and staff to matters of disaster preparedness. More than ever, nonprofit and nongovernmental organizations, along with every other segment of society, are feeling the effects of disasters – natural or manmade. To combat this uncertainty, the National Center for Nonprofit Boards (NCNB) is taking a leading role in closely examining ways in which boards can respond to situations such as the events of September 11 and other disasters.

NCNB believes that the role of boards is to ensure that the organizations they serve will not only survive in the event of a disaster but also be able to continue their critical roles as support structures in their communities. By mandating the establishment and implementation of policies that provide for emergency preparedness, boards can ensure that their organizations are better able to weather the storm brought about by unanticipated disasters.

NCNB needs your help in adding to our checklist of emergency preparedness measures that nonprofit organizations across the nation can consider for implementation. What follows is a preliminary checklist we compiled with the help of a panel of experts. However, it is in no way exhaustive or complete. Instead, we designed the checklist to serve as a basis for ongoing dialogue among nonprofit leaders on emergency preparedness.

NCNB has incorporated insights gained from a variety of contributors and included the feedback into the checklist provided. It is anticipated that this document will continue to evolve as the subject of disaster preparedness and recovery evolves. NCNB plans to publish a booklet in 2002 on the broader topic of the board's role in crisis situations.

NCNB invites you to be a part of this continuing dialogue by sending your thoughts and your organization's experiences to rtraister@NCNB.org.

Board Checklist

Board Preparation

Your board must decide on several important issues to ensure it is prepared for disaster.

- ❑ If applicable, amend the bylaws to allow the board to make decisions without face-to-face meetings. In the event of a disaster, it may not be possible — or safe — to meet in person.
- ❑ Make a plan for the board to make decisions in the event members cannot be reached or are lost. If the bylaws require a certain number of board members to reach a decision, consider a provision for emergencies — with defined criteria for what constitutes an emergency.

Develop an Employee and Volunteer Emergency Plan

- ❑ People (employees, board members, volunteers) are the most valuable asset of your organization.
- ❑ Make sure your chief executive creates and implements a plan or reviews the existing one, and keeps it up to date with current events. Emergency plans should include all safety considerations, as well as instructions on where to meet or get information during a chaotic situation. The plan should be part of the organizational culture and all employees, volunteers and board members should be familiar with it.

- ❑ Define the criteria that constitute a disaster for your organization and would cause the emergency plan to go into effect.
- ❑ Schedule phases of implementation for the plan (first hours, first days, first weeks, etc).
- ❑ Decide who makes immediate decisions in emergency situations; establish a chain of command for backup.
- ❑ Develop site-specific emergency plans for protection and evacuation of people, and check federal and state laws for compliance.
- ❑ Investigate professional counseling services available in your area and, if possible, establish relationships with groups that can provide services after a disaster.
- ❑ Allow discretionary time off and time at work for employees and volunteers to catch up on news, check in on loved ones, and nurture fellowship with their colleagues.
- ❑ Use practice drills incorporating mock scenarios to test the effectiveness of the plan.

Finances

- ❑ Prepare for financial recovery after an emergency or disaster. Reserve funds should be available so your organization can continue to provide important services despite problems facing your organization.
- ❑ Establish a financial reserve for use in the event of a disaster. Make sure the reserve is unrestricted and easily liquidated in the event of an emergency.
- ❑ Make sure the board chair and other key people have access to funds.
- ❑ Store multiple copies of information about accounts, investments and assets in off-site locations.
- ❑ Identify areas of budget that are not crucial to mission, from which funds can be redirected, if necessary, in a crisis.
- ❑ Contact key funders to solicit their input about the redirection of funds in times of crisis, and about putting funds into emergency reserves.
- ❑ Ask funders and board members if they can and will provide emergency funds in an emergency situation.
- ❑ Make sure your organization has adequate insurance for all assets: people, information, business continuation/interruption, and property.
- ❑ Consider whether to include the executive officer and others under "key person" insurance and investigate intellectual property coverage.
- ❑ Review your insurance coverage for restrictions for damages from acts of war and natural disasters. Investigate the timeliness of payments for claims.
- ❑ Consider the possibility that the banking industry could be directly impacted by the crisis.
- ❑ As a last resort, revisit the budget and reforecast revenues and expenditures.
- ❑ Use mock scenarios to test the effectiveness of the plan.

Administrative

- ❑ Administrative planning is imperative for an organization to survive after an emergency or disaster.
- ❑ The board chair should know how to access all critical information pertaining to the organization in the event of an emergency. The chief executive should provide the board chair with a binder containing this information and instructions (See attachment with a sample table of contents). This information should be backed up in electronic format and a hard copy should be kept off site.
- ❑ Have a plan in place for an acting or interim chief executive, and develop a succession plan.

- ❑ Establish relationships with multiple vendors for goods and services – including temporary help – in the event that your regular suppliers are unavailable.
- ❑ Create a contingency plan for continuing work if your facilities are not usable. If possible, create a strategic partnership with another organization with a similar mission to share office space and equipment if one of the organizations' office space is rendered unusable by a disaster.

Information Technology (IT)

- ❑ Information is another valuable asset of any organization.
- ❑ Back up all data on a daily basis, and store the backups off site in multiple locations.
- ❑ Document IT procedures and inventory, and maintain this information in an off-site location.
- ❑ Develop an overall IT disaster recovery plan.
- ❑ Contract with an off-site IT firm to get new systems set up quickly in the event of irreparable damage to the systems or offices.

Communications

- ❑ After a disaster has occurred, you will need to alert the community to your status and future plans as soon as possible.
- ❑ Designate a spokesperson and backup spokesperson for the organization.
- ❑ Advise employees, board members, and volunteers not to speak on behalf of the organization unless authorized to do so.
- ❑ Have crisis communication statements for as many conceivable situations as possible.
- ❑ Develop a message to donors to help raise finds quickly after a disaster.
- ❑ Prioritize communications in order of importance (constituency, board, media, etc.)
- ❑ Communicate with *all* of your constituents. Stay in touch with service recipients, customers, clients, volunteers, donors, members, staff and the board about services that are curtailed or other issues that arise as a result of the disaster.
- ❑ Set media expectations by contacting media representatives *before* a disaster strikes and making them aware that they will be contacted by a designated spokesperson for the organization and when they will be contacted in the scope of a major event.
- ❑ If your regular communication channels are down, have several backup channels in place. In the event cell phones and computers are not working, consider low-tech options like portable short wave, amateur (HAM), or citizens' band (CB) radios powered by batteries as alternatives when other methods of communication are not available.
- ❑ Leverage the public focus on the disaster, to the extent that you can, to appropriately draw attention to your mission.

Return to Work

- ❑ The need for the services your organization provides does not go away during a crisis; in fact, the need may increase – especially if your organization provides a direct community service. If you have planned for the eventuality of an emergency or disaster – barring extreme circumstances, such as extensive loss of life within the ranks – your organization should be able to continue fulfilling its mission.
- ❑ Assess how your mission is related to or can contribute to your constituents' recovery and, where appropriate, reallocate resources for greater impact.
- ❑ Rethink your approach to donors in light of the circumstances.
- ❑ Reassess what in your preparedness planning did not work well in recovery, and realign plans for better preparedness next time.

Resource 3

Reference Checklist

This checklist can serve as a guide to creating your organization's strategy for dealing with an emergency or disaster. Below are some additional resources. Also check with your state and local government and other sector and trade associations.

- ❑ Nonprofit Risk Management Center (http://www.nonprofitrisk.org)
- ❑ Internal Revenue Service (http://www.IRS.gov)
- ❑ Occupational Safety and Health Administration (http://www.osha.gov)
- ❑ Society for Human Resources Management (http://www.shrm.org)
- ❑ American Red Cross (http://www.redcross.org)
- ❑ Council on Foundations (http://www.cof.org)
- ❑ Solinet Corp. (http://www.solinet.net)
- ❑ Disaster Recovery Journal (http://www.drp.com)
- ❑ Federal Emergency Management Agency (FEMA) (http://www.fema.gov/)
- ❑ The National Mental Health Association (http://www.nmha.org/)
- ❑ BoardSource (Formerly, the National Center for Non-Profit Boards (http://www.boardsource.org)
- ❑ Your local government, volunteer center, fire and police, and neighborhood emergency response teams

Resource 4

Emergency Services Checklist

This checklist is intended serve as a convenient reference for emergency service contacts. The contacts listed in this document should include internal and external resources that would provide the organization with immediate or essential services, at a time of emergency or crisis. It is recommended that this listing be updated quarterly.

Emergency Contacts	Firm Contact	Phone (Day & Night)
Ambulance		
Fire Department		
Hospital		
Police Department		
Security Office		
Sheriff		
Telephone Company		
Utility Company		
Other		

Specialized Services & Consultants	Firm Contact	Phone (Day & Night)
Architect		
Carpenter		
Chemist		
Computer Engineer		
Conservator		
Consultant (s)		
Data Recovery Service		
Dehumidification Service		
Dehumidifiers		
Electrician		
Exterminator		
Fire Restoration		
Fumigation Service		
Insurance Agent		
Janitorial Service		
Lawyer		
Locksmith		
Mycologist		
Pallets (wooden)		
Plumber		
Preservationist		
Space, storage		
Trucking Service		
Truck, refrigerated		
Other:		

NCSBN Member Board Disaster Preparedness Template Comments Form

1. Based on the information provided and your Disaster Preparedness needs, what content have you found to be considered **HELPFUL?**

2. Based on the information provided and your Disaster Preparedness needs, what content have you found to be considered **NOT HELPFUL?**

3. What **additional information** might be useful to you in your Disaster Preparedness efforts?

4. How would you describe the **organization of information?**

5. Additional Comments.

Please forward comments to:
Joseph Dudzik
Director of Human Resources
National Council of State Boards of Nursing
676 N. St. Clair, Suite 550
Chicago, Illinois 60611
Phone: 312-787-6555, ext. 144
Fax: 312-787-6898
E-mail: jdudzik@ncsbn.org

Thank you!

Panel Members

Faith Fields, Executive Director, AR, Area III, Chair

Carey Duffy, Board Staff, ND, Area II

Dawn Kammerer, Board Staff, CA-RN, Area I

Ruth Takeda, Board Staff, CO, Area I

Board Liaison
Mark Majek, TX, Area IV Director

Staff
Angela Diaz-Kay, Director of Information Technology

Wade Strawbridge, Project Manager

Relationship to Strategic Plan

Strategic Initiative 4 – Information Technology: The National Council will develop information technology solutions valued and utilized by Member Boards to enhance regulatory sufficiency.

Outcome 3: Nur*sys™* is the preferred national database among Member Boards, employers and nurses for licensure information.

Report of the Nur*sys*™ Advisory Panel

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background

The purpose of the Nursys™ Advisory Panel is to represent the Member Board community of end users and to provide the Nursys end users a communication channel and a collective voice to articulate important Nursys-related issues. This group reviews requests from members and staff to change or enhance the Nursys application and procedures, and provides advice and feedback to the Nursys team on these requests and proposed solutions. The group develops policy options for the Board and is dealing with the issues surrounding non-participation in Nursys and discipline reporting.

Highlights of Activities

- Provided Nursys access privileges to Professional Credential Services, Inc. (PCS) as requested by Massachusetts.
- Completed the analysis on whether to continue utilizing Donnelly Marketing as the Nursys data collection vendor or bring the function in-house.
- Planned and developed an agenda for an IT Summit to provide an opportunity for technical professionals, administrators and supervisors to discuss technology issues and concerns common to boards of nursing as well as to make valuable technical contacts and learn new skills. The IT Summit was scheduled for Tempe, AZ, July 14-15, 2002.
- Completed and implemented the following Nursys enhancements:
- Online editing for discipline information.
- Integrated Crystal Reports as a mechanism for members to view and print discipline report.
- Implemented Jurisdiction Alert feature.
- Redesigned discipline entry.
- Added logout feature.
- Extended Nursys Verification Expiration to 90 days.
- Enhanced the Verification Availability Report.
- Migrated database from MS SQL to Oracle.
- Designed and developed online submission of Nursys verification form and fee.
- Designed and developed public access for NLCA.
- Updated Nursys' compact functions.
- Reviewed and prioritized all Nursys change requests and determined the top projects for the Nursys team and the Nursys Advisory Panel to focus on:
- Implemented online submission of Nursys verification form and fee.
- Implemented public access for NLCA.
- Worked with members to encourage participation for Nursys as well as reporting of discipline.
- Reviewed the mandatory data elements required for participation in Nursys.
- Analyzed the inconsistency of data in Nursys.
- Analyzed the use of the Exam/Education data.
- Improve communication with Member Boards.
- Continue to enhance the discipline function within Nursys.
- Revised and developed Nursys policies as required and appropriate.

- Included Indiana and Montana into the Nursys regular data collection cycle.
- Provided Nursys technical resources and support to assist Member Boards in developing computer applications for data download into Nursys.
- Provided additional, technical enhancements to improve productivity, performance and communication for all Member Boards utilizing Nursys.
- Initiated conversations with Donnelly Marketing regarding cost reductions for data collection.
- Documented generic workflow processes that Member Boards could incorporate into their daily licensing and discipline operations.
- Negotiated an additional two-year contract with Donnelly Marketing for Nursys data collection including an increase in the update frequency to daily.

Future Activities

- Complete and implement the top Nursys projects.
- Continue to review and prioritize requests as they are received.
- Provide resources and support to Member Boards for Nursys related issues.
- Evaluate the IT Summit.

Meeting Dates

- November 16, 2001 (telephone conference call)
- January 28-29, 2002
- February 28-March 1, 2002
- April 19, 2002 (telephone conference call)
- June 18-19, 2002
- July 19, 2001 (telephone conference call)

Attachments

None.

Task Force Members

Patricia Uris, Executive Officer, CO-Area I, Chair

Dwayne Jamison, Board Staff, MS-Area III

Kathy Malloch, Board Member, AZ-Area I

Kathryn Schwed, Board Staff, NJ-Area IV

Karla Bitz, Board Staff, ND-Area II (from January 1, 2002)

Neysa Gaskins, OH-Area II (until January 1, 2002)

Consultant
Patricia Benner

Board Liaison
Joey Ridenour, Executive Officer, AZ, Area I, President

Staff
Vickie Sheets, Director of Practice and Regulation

Relationship to Strategic Plan

Strategic Initiative 2 – Regulatory Effectiveness: The National Council will assist Member Boards to implement strategies to promote regulatory effectiveness to fulfill their public protection role.

Outcome 2: Models for system and individual accountability address practice issues.

Outcome 6: New knowledge and research supports regulatory approaches to discipline, remediation and alternative processes.

Report of the Practice Breakdown Research Task Force

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of the Practice Breakdown Research Task Force

The National Council of State Boards of Nursing Board of Directors appointed the Practice Breakdown Research Advisory Panel to develop new knowledge about the causes of nursing practice breakdown using in-depth criteria and extensive redacted materials. The goal of the project is to learn from the experience of nurses who have had episodes of practice breakdown and provide resources to support Member Boards in addressing practice breakdown through the discipline process. An additional goal is to develop an approach for Boards to support the prevention of common areas of practice breakdown.

Twenty pilot cases were analyzed (during 2000 and 2001), delving deep into the factual content of cases by using information obtained from a variety of redacted materials, ranging from the initial complaint to nurse narrative, other witness statements, investigation reports, hearing transcripts and staff interviews, and determined that it was possible to utilize a phenomenological methodology. The pilot cases were used to develop an audit instrument, called TERCAP - *A Taxonomy of Error, Root Cause Analysis and Practice Responsibility*, which was used to track case elements and recurring themes. A description of the pilot study for this project has been accepted for publication by the *Journal of Nursing Administrators* and publication is expected later this year.

Revised Methodology

Originally, the methodology for obtaining and tracking the data for the implementation of the study was to have centralized collection of discipline, summarization of cases and TERCAP completion. While the centralized collection and development of case summaries would assure consistency in coding of TERCAP, development of case summaries for each case was very work-intensive. In addition, some states reported difficulty in releasing the complete investigation file due to varying data privacy concerns; for confidentiality concerns and to enable Board representatives closer to the case to complete the TERCAP instruments more efficiently, the data collection methodology has been revised. The participating board staff will now be expected to complete the TERCAP instrument based on its review of the case record. A software package called eListen will be used to make the TERCAP available on-line for participating boards.

Development of Taxonomy for Error Reporting, Root Cause Analysis and Analysis of Practice Responsibility (TERCAP) Coding Protocol

The primarily focus of the committee through March 2002 was the development of the TERCAP Coding Protocol. The coding protocol provides definitions and examples of every instrument element. This was an extremely critical project activity. The protocol is the basis of training materials for the representatives of boards of nursing participating in the research project and will guide the collection of data using TERCAP instrument.

TERCAP Training Workshop and Member Evaluation

On April 11-12, 2002, 15 representatives from 14 of the 15 project states attended a workshop in Chicago to learn about the project, review the TERCAP instrument and be familiarized with their role in the research.

The workshop participants were enthusiastic about the instrument and the study. They indicated that the basic framework, taxonomy of error and the elements proposed for collection are useful and workable. During the discussion of the different processes used in their different boards, they identified new considerations that impact the methodology of the project. The advisory panel had intended to include sample cases in the discipline process prior to final resolution. After a careful consideration of the impact of privacy and information laws in the various states, we determined that project participants should identify and report cases only after final resolution.

After using the TERCAP template and protocol to code a pilot case, the workshop participants provided valuable input regarding the wording of elements, protocol definitions and protocol examples. On the second day of the workshop, participants were provided a demonstration of the software to be used.

Case collection began in July 2002 after suggested changes from the participants were made.

An education session for members will be integrated during the "Dialogue on Current Research Programs" at the NCSBN Annual Meeting on August 13, 2002.

Highlights of FY02 Activities

- Submission and acceptance for publication by the *Journal of Nursing Administration*. Publication is expected later in 2002.
- Refinement of the TERCAP (*A Taxonomy of Error, Root Cause Analysis and Practice Responsibility)* research instrument.
- Development of TERCAP Coding Protocol.
- Recruitment of participant boards for Phase I of the Study.
- Completed the TERCAP Training Workshop.
- Incorporated suggestions from the workshop participants to finalize the TERCAP template and protocol.
- Case collection began in July 2002.
- Created and tested an electronic instrument.

Future Activities

- Complete and publish monograph on pilot cases, *Lessons from Boards*.
- Revise and resubmit federal grant proposal.
- Develop discipline resources based on TERCAP, protocol and research findings.
- Review relevant findings from the Commitment to Excellence discipline template data collection for continuity.

Meeting Dates

- September 24-25, 2001
- January 12-13, 2002
- April 11-12, 2002 (TERCAP Training Workshop)

Attachments

A. TERCAP Template
B. Participating Boards of Nursing

❑ 7-10 years
❑ 11-15 years
❑ More than 15 years

12. How much total nursing practice experience did the nurse have? ***Choose one answer.***
❑ Less than one year
❑ 1-2 years? 3-4 years
❑ 5-6 years
❑ 7-10 years
❑ 11-15 years
❑ More than 15 years

Nursing Role

13. Check the box that best describes the primary nursing role for the subject nurse at the time of the reported incident(s).

Staff
❑ Staff Nurse/Clinician
❑ Hospice Nurse
❑ School Nurse
❑ Public Health/Community Nurse
❑ Home Nurse
❑ Telephone Triage

Advanced Practice
❑ Nurse Practitioner
❑ Nurse Anesthetist
❑ Nurse Midwife
❑ Clinical Nurse Specialist

Executive/Administrative
❑ Nurse Manager
❑ Assistant Nurse Manager/Charge Nurse
❑ Supervisor/Assistant Supervisor
❑ Chief Nursing Officer/Executive Patient Care Leader

Case Management/Review
❑ Nurse Case Manager
❑ Utilization Review/Health Plan Review
❑ Risk Management/Error Reduction and Prevention

Educators
❑ Nurse Educator - Faculty
❑ Nurse Educator - Inservice

Other
❑ Please specify: _____

Other Health Provider Roles

14. Did the nurse ever work in any other types of health provider role? ***Choose one answer.***
❑ Yes ❑ No ❑ Unknown
If yes, please specify type: _____

Other Background Information

15. Had the nurse ever been asked to resign or terminated from employment as a nurse? ***Check all that apply.***
❑ Never
❑ Yes, from a position related to the complaint
❑ Yes, from a previous nursing position
❑ Unknown

Section Two – Environmental Elements

A. Setting

16. Indicate the year of incident: _____

17. Indicate the weekday of the incident in the complaint. ***Choose one.***
❑ Weekend (21.1.1)
❑ Holiday (21.1.2)
❑ Weekday (21.1.3)
❑ Incidents occurred over multiple shifts (21.1.4)

18. Indicate the time of the incident: _____
OR
❑ Incident occurred over multiple shifts (21.17)

19. For work day when incident occurred:
a. Indicate work start time: _____
b. Indicate work end time: _____
c. Describe type of shift:
❑ 8 hour
❑ 10 hour
❑ 12 hour
❑ Other – please specify: _____

OR
❑ Incident occurred over multiple shifts (21.17)

20. Was the nurse working overtime when the incident occurred?
❑ Yes ❑ No ❑ Unknown

Community Setting

21. Indicate the type of community where the incidents occurred. ***Choose one.***
❑ Rural (lowly populated, farm, ranch land, communities 10,000 or less)
❑ Suburban (towns, communities of 10,000 to 50,000)
❑ Urban (any city over 50,000)
❑ Unknown

22. What was the setting where the incident started? ***Choose one.***
❑ Adult Day Care (23.1)
❑ Assisted Living/Board and Care (23.2)
❑ Correctional Facility (23.3)
❑ Emergency Rescue Unit (23.4)
❑ Hospice (23.6)
❑ Hospital (23.7)
❑ Cardiac Step Down (23.7.1)
❑ Central Supply (24.7.2)
❑ Emergency Room (23.7.3)
❑ Intensive Care Unit (23.7.4)
❑ Labor/Delivery (23.7.5)
❑ Long-Term Acute Care (23.7.6)
❑ Nursery (includes neonatal) (23.7.7)

continued

- ❑ Nursing Unit (Medical-Surgical) (23.7.8)
- ❑ Oncology (23.7.9)
- ❑ Operating Room (23.7.10)
- ❑ Outpatient (23.7.11)
- ❑ Pediatrics (23.7.12)
- ❑ Pharmacy (24.7.13)
- ❑ Psychiatric (23.7.14)
- ❑ Recovery Room (23.7.17)
- ❑ Sub-Acute Care (23.7.18)
- ❑ Other (please specify) _____ (23.7. 19)

❑ Home Health Care (23.8)
❑ Mental Health Facility (23.9)
❑ Nursing Facility (Free standing) (23.10)
- ❑ Skilled (23.10.1)
- ❑ Intermediate (23.10.2)

❑ Outpatient Facility (23.11)
- ❑ Ambulatory Surgery (23.11. 1)
- ❑ Rehabilitation (23.11.2)
- ❑ Urgent Care Clinic (23.11.3)
- ❑ Free-Standing Birth Center (23.11.4)

❑ Patient's Home/Work (includes occupational Health) (23.12)
❑ Prescriber's Office (includes physician, nurse advanced practitioner, other prescribers) (23.14)
❑ School (23.15)
❑ Other (please specify) _____ (23.16)
❑ Unknown (23. 17)
❑ Call Center/Telenursing (telephone triage) (23.18)
❑ Public Health/Other Community (23.19)

23. Where did the practice breakdown continue? If incident occurred in only one place, go to Section Three. ***Check all that apply.***
- ❑ Adult Day Care (24.1)
- ❑ Assisted Living/Board and Care (24.2)
- ❑ Correctional Facility (24.3)
- ❑ Emergency Rescue Unit (24.4)
- ❑ Hospice (24.6)
- ❑ Hospital (24.7)
  - ❑ Cardiac Step-Down (24.7.1)
  - ❑ Central Supply (24.7.2)
  - ❑ Emergency Room (24.7.3)
  - ❑ Intensive Care Unit (24.7.4)
  - ❑ Labor/Delivery (24.7.5)
  - ❑ Long-Term Acute Care (24.7.6)
  - ❑ Nursery (includes Neonatal) (24.7.7)
  - ❑ Nursing Unit (Medical-Surgical) (24.7.8)
  - ❑ Oncology (24.7.9)
  - ❑ Operating Room (24.7.10)
  - ❑ Outpatient (27.7.11)
  - ❑ Pediatrics (24.7.12)
  - ❑ Pharmacy (24.7.13)
  - ❑ Psychiatric (24.7.14)

continued

- ❑ Radiology (27.4.15)
- ❑ Respiratory Care (24.7.16)
- ❑ Recovery Room (PACU) (24.7.17)
- ❑ Sub-Acute Care (24.7.18)
- ❑ Other (please specify) _____ (24.7.19)

❑ Home Health Care (24.8)
❑ Mental Health Facility (24.9)
❑ Nursing Facility (Free-Standing) (24.10)
- ❑ Skilled (24.10.1)
- ❑ Intermediate (24.10.2)
- ❑ Pharmacy (24.10.3)

❑ Outpatient Facility (24.11)
- ❑ Ambulatory Surgery (24.11.1)
- ❑ Rehabilitation (24.11.2)
- ❑ Urgent Care Clinic (24.11.3)
- ❑ Free-Standing Birth Center (24.11.4)

❑ Patient's Home/Work (includes Occupational Health) (24.12)
❑ Pharmacy (24.13)
❑ Prescriber's Officer(includes physician, advanced practice nurse, other prescribers) (24.14)
❑ School (24.15)
❑ Other (please specify) _____ (24.16)
❑ Unknown (24.17)
❑ Call Center/telenursing (telephone triage) (24.18)
❑ Public Health/other Community (24.19)

Section Three – Nurse's Description of Events

In Section Three, the nurse's narrative describing the event[s], including relevant patient information, the nurse's perception of what occurred, how the problem practice was discovered, the nurse's response and actions, and the nurse's recommendation for preventing recurrence is provided. Ideally, the nurse presents his/her understanding of the event in the nurse's words. In some situations, the investigator's narrative (with quotes) will be used to capture the nurse's story.

In addition to a description of what occurred during the reported situations, any observations by the nurse regarding system issues or other contributing factors should be included.

Section Four – Taxonomy of Error

The taxonomy focuses on the subject nurse's error.
Please check all that apply in each box.

❑ **24. Lack of Attentiveness of Surveillance**
If box 24 is not checked, go to box 25.

a. The practice breakdown involved lack of attentiveness and surveillance related to patient's:
- ❑ Reaction to medications or treatment
- ❑ Need for ventilatory assistance
- ❑ Dangerous cardiac arrhythmias
- ❑ Compromised patient airway
- ❑ Post-operative complications
- ❑ Patency of IV
- ❑ Need for suicide precautions
- ❑ Undetected significant signs and symptoms
- ❑ Need for care tailored to history and anticipated needs

b. The practice breakdown was related to nurse:
- ❑ Failure to monitor patient for an unsafe period of time
- ❑ Not detecting substandard care
- ❑ Not recognizing error

c. Indicate relevant patient characteristics:
- ❑ Infant or child
- ❑ Elderly
- ❑ Cultural misunderstandings/conflict
- ❑ Language difficulties
- ❑ Mental status
- ❑ Cognitive ability
- ❑ Developmental disability
- ❑ Diminished functional ability or specific disability due to illness or therapies
- ❑ Post-Anesthesia
- ❑ Post-Surgical
- ❑ Other (please specify) _____

❑ **25. Lack of Agency/Fiduciary Concern**
If box 25 is not checked, go to box 26.
- ❑ Did not notify MD or other health care provider of patient condition
- ❑ Lack of insight regarding patient needs so that nurse focuses on other task demands while not recognizing needs of patient
- ❑ Specific patient requests or concern unattended
- ❑ Inappropriate withholding of treatment without patient or family consent
- ❑ Missed or diminished sense of patient safety
- ❑ Lack of respect for patient/family concerns and dignity
- ❑ Patient abandonment
- ❑ Deliberately covering up error
- ❑ Boundary violations

continued

- ❑ Breach of confidentiality
  - ❑ Unintentional
  - ❑ Intentional
- ❑ Nurse attributes responsibility to others
  - ❑ Failure to act on behalf of patient due to lack of reimbursement
- ❑ Other (please specify)_____

❑ **26. Lack of or Faulty Intervention**
If box 26 is not checked, go to box 27.
- ❑ Endangerment of patient due to lack of intervention by nurse
- ❑ Error in performance of procedure/intervention
- ❑ Delay in procedure or treatment
- ❑ Directing substandard care
- ❑ Other (please specify) _____

❑ **27. Inappropriate Judgment**
If box 27 is not checked, go to box 28.
- ❑ Lack of adequate assessment/information
- ❑ Not detecting faulty or missing patient information
- ❑ Clinical implications of signs, symptoms and/or interventions not recognized
  - ❑ Problem in knowledge application
  - ❑ Clinical significance of patient's condition not recognized
  - ❑ Lack of skillful/timely implementation of interventions
- ❑ Lack of appropriate priorities
- ❑ Tunnel vision (quick focus on presumed cause)
- ❑ Inappropriate intervention, not what is needed
- ❑ Faulty logic/use of rote or convention
- ❑ Lack of evaluation of patient response to therapy
- ❑ Poor judgment related to medication administration
- ❑ Operating new equipment without orientation/ training
- ❑ Poor judgment in the supervision of others
  - ❑ Inappropriate patient care assignment
  - ❑ Inappropriate delegation/assignment
  - ❑ Expectations not clearly communicated
  - ❑ Staff is inadequately monitored
  - ❑ Failure to evaluate effectiveness of delegation or assignment
  - ❑ Lack of follow-up on problems
- ❑ Inappropriate acceptance of delegation or assignment of medical treatment or procedure
- ❑ Acceptance of inappropriate patient care assignment
- ❑ Inappropriate (not indicated) care
- ❑ Other (please specify) _____

❑ **28. Missed or Mistaken Physician or Other Health Care Provider Order**

If box 28 is not checked, go to box 29.

- ❑ Missed physician's or other provider's order
- ❑ Misinterpreted telephone or other verbal order
- ❑ Misinterpreted physician's or other provider's handwritten order
- ❑ MD or other health care provider error undetected resulting in execution inappropriate order
  - ❑ Fails to identify inappropriate medication or treatment, gives inappropriate medication or treatment
  - ❑ Fails to confront physician or other health care provider, gives inappropriate medication or treatment
  - ❑ Confronts immediate healthcare provider who orders inappropriate medication or treatment but does not go further up chain of command, gives inappropriate medication or treatment
- ❑ Other (please specify) _____

❑ **29. Lack of Prevention**

If box 29 is not checked, go to box 30.

- ❑ Failure to take preventive measures
- ❑ Breach of infection precaution
  - ❑ Breach of universal precaution
  - ❑ Breach of specific precautions
  - ❑ Administers un-sterile IV
- ❑ Used contaminated equipment
- ❑ Not recognizing equipment failure
- ❑ Other (please specify) _____

❑ **30. Documentation Errors**

If box 30 is not checked, go to box 31.

- ❑ Deliberate changing/falsification of documentation to cover up error
- ❑ Failure to document care that has been provided
- ❑ Pre-charting
- ❑ Failure to accurately document
- ❑ Erroneous charting
- ❑ Falsification of records, other
- ❑ Lack of documentation of observations or actions
- ❑ Other (please specify) _____

Please follow directions throughout this section.

❑ **31. Medication Errors**

This category of error addresses a variety of elements related to medication errors. Portions of this section are adapted from the NCCMERC medication error taxonomy and are used with their permission. ***If the reported incident(s) did not involve a medication error, go to Section Five.***

A. Medication Administered

Medication that was actually administered (or potentially if near-miss).

Name of Drug (or other products, if applicable) (51.1): _____

If medication, check the classification.

- ❑ Proprietary (Trade) Name (51.1.1)
- ❑ Established (Generic) Name (51.1.2)
- ❑ Compounded Ingredients (51.1.3)

Indicate if the error was related to any of the following medication characteristics. ***Check as many as apply.***

- ❑ Strength (51.2)
- ❑ Dose, Frequency and Route (51.3)
- ❑ Status (51.4)
  - ❑ Prescription (51.4.1)
  - ❑ Over-the-Counter (51.4.2)
  - ❑ Investigational (51.4.3)
- ❑ Name of Manufacturer (51.5)
- ❑ Name of Labeler or Distributor (51.6)
- ❑ Tablet (52.1)
  - ❑ Extended-Release (52.1.1)
- ❑ Capsule (52.2)
  - ❑ Extended-Release (52.2.1)
- ❑ Oral liquid (52.3)
  - ❑ Concentrate (52.3.1)
- ❑ Injectable (52.4)
- ❑ Cream-Ointment-Gel-Paste (52.5)
  - ❑ Dermal Patch (52.6.1)
- ❑ Aerosol (spray and metered) (52.6)
- ❑ Other (52.7) _____
- ❑ Unit Dose (53.1)
- ❑ Multiple Dose Vials (Injectable) (53.2)
- ❑ Single Dose Vials (Injectable) (53.3)
- ❑ Intravenous Solutions (53.4)
  - ❑ Manufacturer Prepared (53.4.1)
  - ❑ Institution Prepared (53.4.2)
  - ❑ Nurse Prepared (53.4.3)
- ❑ Syringes (53.5)
- ❑ Manufacturer Samples (53.6)
- ❑ Others (please specify) (53.7)

  _____

B. Medication Ordered

Medication that was ordered and intended to be administered.

Name of Drug (or other products, if applicable) (56.1): _____

If medication, check the classification.

- ❑ Proprietary (Trade) Name (56.1.1)
- ❑ Established (Generic) Name (56.1.2)
- ❑ Compounded Ingredients (56.1.3)

Indicate if the error was related to any of the following medication characteristics. ***Check as many as apply.***

- ❑ Strength (56.2)
- ❑ Dose, Frequency and Route (56.3)
- ❑ Status (56.4)
  - ❑ Prescription (56.4.1)
  - ❑ Over-the-Counter (56.4.2)
  - ❑ Investigational (56.4.3)
- ❑ Name of Manufacturer (56.5)
- ❑ Name of Labeler or Distributor (56.6)
- ❑ Tablet (57.1)
  - ❑ Extended-Release (57.1.1)
- ❑ Capsule (57.2)
  - ❑ Extended-Release (52.2.1)
- ❑ Oral liquid (57.3)
  - ❑ Concentrate (57.3.1)
- ❑ Injectable (57.4)
- ❑ Cream-Ointment-Gel-Paste (57.5)
  - ❑ Dermal Patch (57.6.1)
- ❑ Aerosol (spray and metered) (57.6)
- ❑ Other (57.7) _____
- ❑ Unit Dose (58.1)
- ❑ Multiple Dose Vials (Injectable) (58.2)
- ❑ Single Dose Vials (Injectable) (58.3)
- ❑ Intravenous Solutions ((58.4)
  - ❑ Manufacturer Prepared (58.4.1)
  - ❑ Institution Prepared (58.4.2)
  - ❑ Nurse Prepared (58.4.3)
- ❑ Syringes (58.5)
- ❑ Manufacturer Samples (58.6)
- ❑ Others (please specify) (58.7)

  _____

C. Personnel Involved Initial Error

Select one.

- ❑ Physician (61.1)
- ❑ Pharmacist (61.2)
- ❑ Nurse (61.3)
  - ❑ Nurse Practitioner (61.3.1)
  - ❑ Nurse Anesthetist (61.3.2)
  - ❑ Nurse Midwife (61.3.3)
  - ❑ Clinical Nurse Specialist (61.3.4)
  - ❑ Registered Nurse (61.3.2)
  - ❑ Licensed Practical Nurse (61.3.3)
- ❑ Physician Assistant (61.4)
- ❑ Dentist (61.5)
- ❑ Support Staff (61.8)
  - ❑ Pharmacy Technician (61.8.1)
  - ❑ Nurses Aide (61.8.2)
  - ❑ Medication Aide (61.8.3)
  - ❑ Clerical (61.8.4)

continued

- ❑ Other (please specify) (61.8.5)_____
- ❑ Health Professional Student (61.9)
  - ❑ Medicine (61.9.1)
  - ❑ Pharmacy (61.9.2)
  - ❑ Nursing (61.9.3)
  - ❑ Other (please specify)(61.9.5)_____
- ❑ Patient/Caregiver (61.10)_____
- ❑ Other (please specify)(61.11)_____
- ❑ Unknown (61.12)

E. Error Discovered By

Select one.

- ❑ Physician (63.1)
- ❑ Pharmacist (63.2)
- ❑ Nurse (63.3)
  - ❑ Nurse Practitioner (63.3.1)
  - ❑ Nurse Anesthetist (63.3.2)
  - ❑ Nurse Midwife (63.3.3)
  - ❑ Clinical Nurse Specialist (63.3.4)
  - ❑ Registered Nurse (63.3.2)
  - ❑ Licensed Practical Nurse (63.3.3)
- ❑ Physician Assistant (63.4)
- ❑ Dentist (63.5)
- ❑ Support Staff (63.8)
  - ❑ Pharmacy Technician (63.8.1)
  - ❑ Nurses Aide (63.8.2)
  - ❑ Medication Aide (63.8.3)
  - ❑ Clerical (63.8.4)
- ❑ Other (please specify)(63.8.5)_____
- ❑ Health Professional Student (63.9)
  - ❑ Medicine (63.9.1)
  - ❑ Pharmacy (63.9.2)
  - ❑ Nursing (63.9.3)
  - ❑ Other (please specify)(63.9.5)_____
- ❑ Patient/Caregiver (63.10) _____
- ❑ Other (please specify) (63.11)_____
- ❑ Unknown (63.12)

D. Personnel Perpetuating Error

Select one.

- ❑ Physician (62.1)
- ❑ Pharmacist (62.2)
- ❑ Nurse (62.3)
  - ❑ Nurse Practitioner (62.3.1)
  - ❑ Nurse Anesthetist (62.3.2)
  - ❑ Nurse Midwife (62.3.3)
  - ❑ Clinical Nurse Specialist (62.3.4)
  - ❑ Registered Nurse (62.3.2)
  - ❑ Licensed Practical Nurse (62.3.3)
- ❑ Physician Assistant (62.4)
- ❑ Dentist (62.5)

continued

- ❑ Support Staff (62.8)
  - ❑ Pharmacy Technician (62.8.1)
  - ❑ Nurses Aide (62.8.2)
  - ❑ Medication Aide (62.8.3)
  - ❑ Clerical (62.8.4)
  - ❑ Other (please specify) (62.8.5)_____
- ❑ Health Professional Student (61.9)
  - ❑ Medicine (62.9.1)
  - ❑ Pharmacy (62.9.2)
  - ❑ Nursing (62.9.3)
  - ❑ Other (please specify)(62.9.5)_____
- ❑ Patient/Caregiver (62.10)_____
- ❑ Other (please specify) (62.11)_____
- ❑ Unknown (62.12)

F. Error Type

Check all that apply.

- ❑ Dose Omission (70.1)
- ❑ Improper Dose (70.2)
- ❑ Resulting in Over-dosage (70.2.1)
- ❑ Resulting in Under-dosage (70.2.2)
- ❑ Extra Dose (70.2.3)
- ❑ Wrong Strength/Concentration (70.3)
- ❑ Wrong Drug (70.4)
- ❑ Wrong Dosage Form (70.5)
- ❑ Wrong Technique (70.6)
- ❑ Wrong Route of Administration(70.7)

Route Given	*Route Intended*
❑ IV	Gastric (70.7.1)
❑ Intrathecal	IV (70.7.2)
❑ IV	Oral (70.7.3)
❑ IV	IM (70.7.4)
❑ IM	IV (70.7.5

- ❑ Other (please specify) (70.7.6)_____
- ❑ Wrong Duration (70.8)
  - ❑ Too fast (70.8.1)
  - ❑ Too slow (70.8.2)
- ❑ Wrong Time (70.9)
- ❑ Wrong Patient (70.10)
- ❑ Monitoring Error (70.11)
  - ❑ Drug-Drug Interaction (70.11.1)
  - ❑ Drug-Food/Nutrient Interaction (70.11.2)
  - ❑ Documented Allergy (70.11.3)
  - ❑ Drug-Disease Interaction (70.11.4)
  - ❑ Clinical (e.g., blood glucose, PT/PTT, heart rate, BP, etc.) (70.11.5)
- ❑ Deteriorated Drug Error (expired drug) (70.12)
- ❑ Other (please specify) (70.13) _____

G. Causes

Indicate the reported causes of the medication error, as stated in the perspective of the reviewer of the incident.

1. Communication. ***Check all that apply.***

- ❑ Verbal Communication (81.1)
  - ❑ Lack of Collaboration and communication among care providers (81.1.1)
  - ❑ Lack of review/management of patient's whole therapeutic regimen (81.1.2)
  - ❑ Failure to provide adequate patient/caregiver instruction (81.1.3)
  - ❑ Failure to Listen (81.1.4)
- ❑ Written Communication (81.2)
  - ❑ Illegible handwriting (81.2.1)
  - ❑ Abbreviations (81.2.2)
  - ❑ Non-metric measurements (81.2.3)
  - ❑ Trailing zero (81.2.4)
  - ❑ Leading zero (81.2.5)
  - ❑ Decimal point (81.2.6)
  - ❑ Misread or didn't read (81.2.7)
  - ❑ Missing documentation (81.2.8)
- ❑ Misinterpretation of the order (81.3)

2. Name Confusion. ***Check all that apply.***

- ❑ Proprietary (Trade) Name Confusion (83.1)
  - ❑ Suffix Confusion (83.1.1)
  - ❑ Prefix Confusion (83.1.2)
  - ❑ Sound-alike to another trade name (83.1.3)
  - ❑ Sound-alike to generic name (83.1.4)
  - ❑ Look-alike to another Trade name (83.1.5)
  - ❑ Look-alike to generic name (83.1.6)
  - ❑ Appears to be misleading (83.1.7)
  - ❑ Confusion with Over-the-Counter "Family Trade Names" (83.1.8)
- ❑ Established (Generic) Name Confusion (83.2)
  - ❑ Sound-alike to another generic (83.2.1)
  - ❑ Sound-alike to a trade name (83.2.2)
  - ❑ Look-alike to another generic (83.2.3)
  - ❑ Look-alike to a trade name (83.2.4)

3. Labeling

- ❑ Manufacturer Packaging (85.1)
- ❑ Label of dispense product (85.2)
- ❑ Package insert (85.4)
- ❑ Electronic Reference material (85.5)
- ❑ Printed Reference material (85.6)? Advertising (85.7)

If any of the above are selected, please specify nature of problem: _____

4. **Human Factors.** ***Check all that apply.***
   - ❑ Knowledge deficit (87.1)
     - ❑ Desired action misunderstood (87.1.1)
     - ❑ Not knowing risks (87.1.2)
     - ❑ Incorrect use (87.1.3)
   - ❑ Performance deficit (87.2)
     - ❑ Infiltration IV (87.2.1)
     - ❑ IV Technical skills (87.2.2)
     - ❑ Venipuncture (87.2.3)
     - ❑ Administering medication poured or drawn by another nurse (87.2.4)
   - ❑ Miscalculation dosage or infusion rate (87.3)
   - ❑ Computer error (87.4)
     - ❑ Incorrect selection from a list by computer operator (87.4.1)
     - ❑ Incorrect programming into the database (87.4.2)
     - ❑ Inadequate screening for allergies, interactions, etc. (87.4.3)
   - ❑ Error in stocking/restocking/cart filling (87.5)
   - ❑ Drug Preparation Error (87.6)
     - ❑ Failure to activate delivery system (87.6.1)
     - ❑ Wrong diluent (87.6.2)
     - ❑ Wrong amount of diluent (87.6.3)
     - ❑ Wrong amount of active ingredient added to final product (87.6.4)
     - ❑ Wrong drug added (87.6.5)
   - ❑ Transcription error (87.7)
     - ❑ Original to paper/carbon paper (87.7.1)
     - ❑ Original to computer (87.7.2)
     - ❑ Original to facsimile (FAX) (87.7.3)
     - ❑ Recopying MAR (87.7.4)
   - ❑ Stress (High volume workload, etc) (87.8)
   - ❑ Fatigue/Lack of Sleep (87.9)
   - ❑ Confrontational or intimidating behavior (87.10)
   - ❑ Failure to check patient ID (87.11)
   - ❑ Failure to follow the Six Rights of Medication Administration: (87.12)
     - ❑ Right patient (87.12.1)
     - ❑ Right medication (87.12.2)
     - ❑ Right dose ((87.12.3)
     - ❑ Right route (87.12.4)
     - ❑ Right time (87.12.5)
     - ❑ Right reason (87.12.6)

5. Packaging/Design. Check all that apply.
   - ❑ Inappropriate Packaging or Design (89.1)
   - ❑ Dosage Form (Tablet/Capsule) confusion (89.2)
     - ❑ Confusion due to similarity in color, shape, and/or size to another product (89.2.1)
     - ❑ Confusion due to similarity in color, shape, and/or size of the same product but different strength (89.2.2)

continued

   - ❑ Devices (89.3)
     - ❑ Malfunction (89.3.1)
     - ❑ Wrong Device Selected (89.3.2)
     - ❑ Adapters (89.3.3
     - ❑ Automated distribution/vending systems (89.3.4)
     - ❑ Automated Counting Machines (89.3.5)
     - ❑ Automated Compounders (89.3.6)
     - ❑ Oral Measuring Devices (89.3.7)
     - ❑ Infusion Devices (89.3.8)
     - ❑ Infusion Pumps (89.3.8.1)
     - ❑ PCA pumps (89.3.8.2)
     - ❑ Other (please specify)(89.3.8.3)

       _____

Section Five – Primary Category of Error

The reviewer should select only one category of error, the category that this case is most about in relation to patient harm.

- ❑ 24. Lack of Attentiveness/Surveillance
- ❑ 25. Lack of Agency/Fiduciary Concern
- ❑ 26. Lack of/ or Faulty Intervention/Action
- ❑ 27. Inappropriate Judgment
- ❑ 28. Missed or Mistaken Order, Physician or Other Authorized Provider
- ❑ 29. Lack of Prevention
- ❑ 30. Documentation Errors
- ❑ 31. Medication Errors

Section Six – Practitioner Contributions

32. Check all factors that contributed to the nurse's practice breakdown.
    - ❑ Nurse's inexperience with situation
    - ❑ Unfamiliar setting
    - ❑ Multiple/repeat occurrences
    - ❑ Conflict and/or communication breakdown
    - ❑ Understandable (though wrong and competing) rationale for action taken
    - ❑ Other (please specify) _____
    - ❑ History of prior corrective actions/discipline ***by employer***
      ❑ Clinical ❑ Interpersonal ❑ Behavioral
    - ❑ History of prior complaints /discipline ***by board of nursing***
      ❑ Clinical ❑ Interpersonal ❑ Behavioral
    - ❑ Lack of correction of identified impairment
      - ❑ Drug/alcohol
      - ❑ Functional ability
      - ❑ Mental Health

Section Seven – Health Care Team Contributions

33. Check all elements that are a factor in the nurse's practice breakdown.

Other Health Team Members Involved

- ❑ Supervisory personnel
- ❑ Nurse
  - ❑ Nurse practitioner/ other APRN
  - ❑ Registered Nurse
  - ❑ Licensed Practical Nurse
  - ❑ New graduate nurse
  - ❑ Temporary or float nurse
  - ❑ Other (please specify) _____
- ❑ Physician
- ❑ Physician Assistant
- ❑ Pharmacist
- ❑ Respiratory Therapist
- ❑ Other health professional (please specify) _____
- ❑ Health professional student
  - ❑ Medicine
  - ❑ Pharmacy
  - ❑ Nursing
- ❑ Support staff
  - ❑ Nurses aide
  - ❑ Medication aide
  - ❑ Clerical
  - ❑ Dietary
  - ❑ Housekeeping
- ❑ Other
- ❑ Family/friend caregiver
- ❑ Patient

Contributing Factors Related to Staffing

- ❑ Lack of supervisory/management support
- ❑ Lack of experienced nurses
- ❑ Lack of nursing support staff
- ❑ Lack of clerical support
- ❑ Lack of other health team support

Health Care Team and Work Environment

- ❑ Unit level conflict/non-supportive environment
- ❑ Failure of Health Team Communication
- ❑ Failure to work together as team
- ❑ Other (please specify)

  _____

Other

- ❑ Illegible handwriting (physician orders)

Section Eight – System Issues

34. Check all factors that contributed to the nurse's practice breakdown.

Environmental Factors

- ❑ Environment contributions
  - ❑ Lighting (90.1)
  - ❑ Noise level (90.2)
  - ❑ Frequent interruptions/distractions (90.3)
- ❑ Floor stock (90.12)
- ❑ Lack of adequate supplies/equipment
- ❑ Equipment failure
- ❑ Power failure
- ❑ Physical environmental hazards
- ❑ Similar/misleading labeling (other than meds)
- ❑ Other (please list) _____

Communication Factors

- ❑ Communication systems
- ❑ Communication breakdown
  - ❑ Interpersonal
  - ❑ Unit level
  - ❑ Interdepartmental
- ❑ No adequate channels resolving disagreements
- ❑ Record inaccessibility
- ❑ Computer down
- ❑ Verbal orders
- ❑ Preprinted orders
- ❑ Patient counseling
- ❑ Failure to provide patient identification
  - ❑ Right patient
  - ❑ Right procedure
  - ❑ Right site
  - ❑ Right time

Employee Safety/Support Factors

- ❑ Lack of detection/intervention for impaired nurse
  - ❑ Drug/alcohol
  - ❑ Functional ability
  - ❑ Mental health
  - ❑ Other (please specify) _____

Leadership/Management Factors

- ❑ Unclear lines authority/responsibility
- ❑ Poor supervision/support by others?
- ❑ Inadequate/non-current policies/procedures
- ❑ Assignment or placement of inexperienced personnel
- ❑ Unreliable nurse extenders
- ❑ Nurse shortage, sustained, at institution level
- ❑ Overwhelming assignments
- ❑ Forced choice in critical circumstances

Backup and Support Factors

- ❑ System for covering patient care (90.8)
  - ❑ Medical (90.8.1)
  - ❑ Allied Health (90.8.2)
  - ❑ Pharmacy (90.8.3)
  - ❑ Nursing (90.8.4)
  - ❑ Other (90.8.5) (please specify) _____

continued

- ❑ Lack of availability health care professional (90.6)
  - ❑ Medical (90.6.1)
  - ❑ Allied Health (90.6.2)
  - ❑ Pharmacy (90.6.3)
  - ❑ Nursing (90.6.4)
  - ❑ Other (90.6.5) (please specify)_____
- ❑ Lack adequate response lab/x-ray/pharmacy
- ❑ Lack adequate response other departments

Other Factors

- ❑ Lack of staff orientation
- ❑ Lack of ongoing education/training
- ❑ Other (please specify) _____

Section Nine – Patient Outcome

35. Patient Harm Index
In selecting the patient outcome category, select the highest-level severity that applies during the course of the practice breakdown.

No Harm

- ❑ Category A – Circumstances or events that have the capacity to cause harm (31.1)

Error, No Harm

- ❑ Category B – An error occurred but did not reach the patient (32.1)
- ❑ Category C – An error occurred that reached the patient, but did not cause harm (32.1)
- ❑ Category D – An error occurred that resulted in the need for increased patient monitoring but no patient harm (32.3)

Error, Harm

- ❑ Category E – An error occurred that resulted in need for treatment or intervention and caused temporary harm (33.1)
- ❑ Category F – An error occurred that resulted in initial or prolonged hospitalization and caused temporary patient harm (33.2)
- ❑ Category G – An error occurred that resulted in permanent patient harm (33.3)
- ❑ Category H – An error occurred that resulted in a near-death event (e.g., anaphylaxis, cardiac arrest) (33.4)

Error, Death

- ❑ Category I - An error occurred that resulted in patient death (34.1)

Section 10 – Nurse Outcome

36. Select process for resolution of complaint.
  - ❑ Resulted in dismissal of complaint – ***if checked, go to box 40 (no Board action).***
  - ❑ Resulted in enrollment in Alternative program – ***if checked, go to box 37.***
  - ❑ Resulted in continuing the Board disciplinary process leading to Board action – ***if checked, go to box 38.***

❑ 37. Alternative to Discipline Process
If the nurse's practice breakdown was evaluated using an alternative process as a non-discipline approach to case resolution check the appropriate outcome listed below. ***If box 34 is not checked, skip to box 37.***

Requirements of Alternative Program Participation
Check all actions included in the nurse's agreement with the alternative program.

- ❑ **Alternative Program for Practice Concerns**
  - ❑ Program Agreement
  - ❑ Practice only under supervision
  - ❑ Complete specific education requirements
  - ❑ Nursing practice consultation /comply with recommendations
  - ❑ Practice audit
  - ❑ Other consultation
  - ❑ Nurse available for interviews/board rep
  - ❑ Reports from employer
  - ❑ Reports from self
  - ❑ Reports from other
  - ❑ Release of information
  - ❑ Other _____
- ❑ **Alternative Program for Chemical Dependency/ Other Health Issues**
  - ❑ Program Agreement
  - ❑ Professional evaluation/comply with treatment recommendations
  - ❑ Drug screening
  - ❑ Return to work agreement
  - ❑ Limited Practice hours
  - ❑ Limitations on setting
  - ❑ Practice only under supervision
  - ❑ Continued competence activities
  - ❑ Nurse available for interviews/board rep
  - ❑ Reports from employer
  - ❑ Reports from self
  - ❑ Reports from other
  - ❑ Release of information
  - ❑ Other (please specify) _____

❑ 38. Disciplinary Process
If the nurse's practice breakdown was evaluated through investigation and the board's disciplinary process, check the appropriate result below:
- ❑ Resulted in dismissal of complaint – go to box 40 (no action).
- ❑ Resulted in continuing the Board disciplinary process leading to Board action – go to box 40.

❑ 39. Board disciplinary order
If the board takes disciplinary action against the nurse's license, select the type of action(s) and the requirements in the order in the boxes below. ***Check all actions included in the Board's discipline order.***

Action taken by board
Stayed – action is taken by a board, but is not implemented if criteria specified in order are met
❑ Yes ❑ No

- ❑ Deny – to refuse to issue, renew or reinstate a license
- ❑ Fine – to impose a monetary penalty for a violation
- ❑ Limit/restrict – to reduce a licensee's legally authorized scope of practice
- ❑ Probation/condition – to impose conditions and terms upon a license
- ❑ Reprimand/censure – to issue an official statement of reproof re: the nurse's behavior
- ❑ Reinstatement – to restore a license, with or without limitations and/or conditions
- ❑ Revocation – to involuntarily terminate an individual's license
- ❑ Summary suspension (also emergency, temporary) – to immediately prohibit, on an emergency basis and prior to a hearing, a licensee from practicing (followed by hearing as specified in laws and rules
- ❑ Automatic suspension – to immediately prohibit practice on the basis of court actions regarding the mental incompetence or other causes specified in state law. No further court action or board hearing is necessary
- ❑ Suspension – to prohibit a licensee from practicing for a period of time (definite or indefinite time period
- ❑ Voluntary surrender – to accept (either by board or authorized staff, an individual's offer to return license
- ❑ Otherwise discipline – other disciplinary actions used by jurisdictions, either specifically stated in laws and rules or interpretation of statutes and/or rule/regulation

Board Requirements
Check all requirements included in the Board's discipline order.
- ❑ Diminished (or limited)scope of practice
- ❑ Practice only under supervision
- ❑ Complete specific education requirements
- ❑ Undergo ordered professional evaluation and comply with treatment recommendations
  - ❑ Mental health
  - ❑ Chemical dependency
  - ❑ Functional ability
- ❑ Practice audit
- ❑ Other consultation
- ❑ Restricted setting
- ❑ Restricted activities
- ❑ Nurse available for interviews/board rep
- ❑ Reports from employer
- ❑ Reports from self
- ❑ Reports from other
- ❑ Release of information (PERSONAL)
- ❑ Participation in Alternative Program as stipulated by Board
- ❑ Other

continued

❑ 40. No Action
Dismissal of complaint – check the box that best describes the nature of the complaint dismissal (***check all that apply***):
- ❑ Dismissal, no violation
- ❑ Dismissal, non-jurisdictional
- ❑ Dismissal, not rising to level of board action
- ❑ Dismissal, referred to another board/agency
- ❑ Dismissal, non-public letter of concern
- ❑ Dismissal, non-public advisory letter
- ❑ Dismissal, public letter no violation
- ❑ Dismissal, public advisory letter

END OF TERCAP

Practice Breakdown Research – Attachment B

An Epidemiology of Nursing Error (Practice Breakdown Study) Phase I Participants

The following boards have submitted Participation Agreements for the study:
Arizona
Colorado
Idaho
Iowa
Maryland
Minnesota
Mississippi
Missouri
Montana
North Carolina
North Dakota
Ohio
South Carolina
Washington State
West Virginia PN
Wyoming

Updated May 23, 2002

Task Force Members

Debra Brady, Executive Officer, NM, Area I, Chairperson

Charlene Kelly, Executive Officer, NE, Area II

Barbara Zittel, Executive Officer, NY, Area IV

Joey Ridenour, Executive Officer, AZ, Area I

Consultant
Patricia Benner

Board Liaison
Marcia Hobbs, Board President, KY, Area III, Vice President

Staff
Nancy Chornick, Director of Credentialing and Professional Development

Carin L. Zuger, Administrative Assistant

Relationship to Strategic Plan

Strategic Initiative 5 – Governance & Leadership Development and Organizational Capacity: The National Council will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation.
Outcome 1: Member Board staff and members access multiple levels of educational programs to develop core competencies in regulation.

Meeting Dates

- January 18 & 19, 2002
- March 15, 2002 (conference call)
- April 12 & 13, 2002

Attachments

A. Action Plan

Report of Regulatory Credentialing Program Development Task Force

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background

NCSBN has long recognized the need for educational opportunities for its members. Although the NCSBN has offered continuing education sessions for many years, there has not been an overall comprehensive plan for these offerings that would ensure that our members would have access to the breath and depth of the regulatory knowledge needed.

The Regulatory Credentialing Program Development Task Force was formed in FY02 and charged with exploring the feasibility of developing a doctoral-level regulatory program as a credentialing vehicle for members. At the direction of the Board of Directors, the Regulatory Credentialing Program Development Task Force met with the Member Board Leadership Task Force to determine if there was overlap between the charges of the two groups. Based on that meeting, the Regulatory Credentialing Program Development Task Force was given the additional charge of developing continuing education and/or certification programs for regulators.

The task force conducted a survey to determine the interest of Member Boards in a doctoral-level regulatory program. The survey indicated a lack of sufficient interest and the task force decided that a doctoral program is not feasible at this time. However, there was interest expressed in educational opportunities including offerings developed at the graduate level which could be used by students desiring credit in the area of nursing regulation.

The task force proposed to the Board of Directors a comprehensive multilevel educational program on nursing regulation that would meet the educational needs of Member Boards. It is anticipated that the proposed program will meet Member Board educational needs and also develop a substantive knowledge base in nursing regulation.

At its May 2002 meeting, the Board of Directors approved the action plan submitted by the Regulatory Credentialing Program Development Task Force.

Highlights of FY02 Activities

- Reviewed doctoral program materials.
- Surveyed Member Boards regarding interest in a doctoral program.
- Met with co-chairs of the Member Boards Leadership Development Task Force.
- Developed an action plan for educational program for Member Boards.

Future Activities

- A continuing education seminar on regulation is planned for summer, 2003. A planning group, as described in the action plan, will develop the program. The feasibility of implementing a regulatory certification program will be explored in FY03.

Regulatory Credentialing Program Development Task Force – Attachment A

Proposed Action Plan

The program will meet the varied needs of Member Boards by offering a multi-level program of continuing education, potential certification and graduate level credit for graduate students (Fig. 1.). The program will consist of a series of non-overlapping educational seminars that will provide continuing education to participants. Completion of the package of continuing education offerings could entitle the participant to certification. Additionally, the educational seminars could be used for credit by graduate students with the addition of supplemental activities such as research projects, articles, projects done in association with boards of nursing, etc. Oversight and the granting of credit would be done by the student's graduate institution.

Fig. 1. Proposed Educational Program for Member Boards

Advanced Regulatory Core Curriculum Units	Level of Offerings		
	Level 1	Level 2	Level 3
1. Public Protection/Role Development of Nursing Regulators	Continuing education offering	Package of CE offerings for national certification	Applicable to masters/doctoral study (individual university approval/ independent studies
2. Discipline			
3. Competency Evaluation/ Remediation Strategies			
4. Organizational Structure/ Behavior			

Level of Offerings

First Level: Continuing Education – NCSBN has been providing continuing education offerings to Member Boards for many years. The proposed program differs from that previously done by NCSBN in terms of preplanning, depth of the seminars and the method of development. The topic of each seminar would be one of the units of the Advanced Regulatory Core Curriculum.

The Advanced Regulatory Core Curriculum consists of four units: (1) Public Protection/ Role Development of Nursing Regulators, (2) Discipline, (3) Competency Evaluation/Remediation Strategies and (4) Organizational Structure/Behavior. Each educational seminar would be based on one of these four regulatory units. The schedule of the program would be planned and shared with Member Boards. Each educational seminar would be an indepth offering 3 days long. To insure quality of the offerings, a planning group of experts in the field would be used to develop the content.

Second Level: Certification Program – The certification program could use the educational seminars as the basis for certification. Completion of the four units could be for certification. More information is needed before the task force can fully recommend the certification program. (See discussion under "Implementation.")

Third Level: Graduate Academic Credit – The proposed program would provide those members interested in graduate education with the opportunity to use the program to gain graduate credit in nursing regulation. In addition to the educational seminar, additional experiences could be provided, such as research projects, presentations, articles, contracting with a board to do a project, an internship with a board of nursing, to augment the continuing education experience. Graduate level credit will be granted by the student's academic institution.

Planning Group

A planning group would be convened to develop each continuing education seminar. Selection of the members of the group would be based on the expertise needed for the topic of the educational seminar. A new planning group would be convened for each seminar.

The task force identified continuity as a very important element contributing to the success of the program. Members suggested that an NCSBN staff person be assigned to the program. It is also suggested that one or two nurse regulators be included on each planning group to maintain a regulatory perspective. Preferably the same nurse regulators would be a part of each planning group.

Seminars

The offering will consist of a three-day educational seminar on one of the four identified regulatory units. For each educational seminar, preparation readings would be required. In this way, the attendees will come with a baseline of knowledge. After the education seminars, materials based on the presentation can be developed for other media such as online delivery or published works. In this way, a substantive knowledge base can be developed. It is anticipated that the seminars will not be static in nature. Rather, as new knowledge is developed, the seminars will be updated and new topics added.

The Regulatory Credentialing Development Task Force developed the following as the Advanced Regulatory Core Curriculum for the seminars. Ethics and technology are considered threads of the curriculum. For each unit, the unique ethical and technologic issues would be identified:

Advanced Regulatory Core Curriculum

1. Public Protection/ Role Development of Nursing Regulators
   a. Concepts – legislation
   b. Relationship to decision-making (public protection vs. professional interests)
   c. Historical perspective
   d. Role development
   e. Identity relationships
   f. Nature of administrative law
   g. Delineation of public safety mandates and violations in regulatory practice
   h. Knowledge and role development in protecting the safety of the public
   i. Effectiveness of regulation/measuring outcomes
   j. Ethical implications
   k. Technology implications

2. Discipline
   a. Criminal background checks
   b. What is effective discipline; alternative dispute resolution
   c. Known discipline models
   d. Other bodies of knowledge and research that would be helpful
   e. Culture of nursing and its affect on type and characteristics of discipline cases in comparison to other disciplines
   f. Reporting discipline, reliance on others to report discipline cases (systems issue)
   g. Non-English speaking and discipline – correlational studies
   h. Discipline from a cultural perspective
   i. New systems to decrease errors (e.g. alter system for identifying incompatibil ities or toxicity, timing alerts, allergy alerts)
   j. Development of a systematic data base for disciplinary cases regarding errors (e.g. use of TERCAP instrument)
   k. Human factor research – on factors that affect safety and optimal performance (environmental factors such as noise, lighting, shift work, shift length)
   l. Ethical implications
   m. Technology implications

3. Competency Evaluation/Remediation Strategies
   a. Continued competency— individual and institutional issues
   b. Natural decision making process
   c. Clinical reasoning
   d. Professional competency
   e. Naturalistic studies of excellence and breakdowns in practice performance
   f. Impact of global work force
   g. Endorsement immigration/impact of global immigration
   h. Developing links between means and outcomes
   i. USMLE exam-correlation studies
   j. Quality assurance
   k. Development of ongoing published analyses
   l. Complaint process feedback loops between regulation and education
   m. Ethical implications
   n. Technology implications

4. Organizational Structure/Behavior
   a. Professional organizations/legislators/public interactions
   b. Board/staff relationship in board of nursing
   c. Board development
   d. Budget analysis
   e. Finance/economics
   f. Case studies of legislative actions, impact of laws in different states
   g. Negotiation and communication skills involved in working with legislators
   h. History of regulation
   i. Policy development

Implementation

The task force suggests that the program be implemented in two stages:

Stage One

Continuing Education – the first seminar can be piloted and evaluated to determine if the program is feasible. The task force is suggesting the first seminar be offered June 2003.

Graduate Credit – this can be accomplished in conjunction with the continuing education program. The educational offering can be marketed to relevant graduate programs such as those with health policy programs.

Stage Two

Certification Program – The task force suggests that more information is needed before a decision to implement a certification program can be made. This includes:

1. Interest in certification – A survey should be conducted to establish the interest level of Member Boards for a certification program in nursing regulation.
2. Other aspects of certification programs such as legal issues, possible obstacles, needed resources, criteria for recertification, etc., need to be explored to determine if a certification program is an appropriate investment for NCSBN.

Report of the Resolutions Committee

Recommendations to the Delegate Assembly

The purpose of this report is for information only.

Background of the Resolutions Committee

The Resolutions Committee is a Standing Committee and responsible to review, evaluate, and report to the Delegate Assembly on all resolutions and motions submitted by the delegates of Member Boards. The committee is also charged to review the resolutions process and make recommendations for process improvements. An important objective in the committee's work this year was to assure that outcomes of resolutions and motions proposed do not duplicate ongoing work otherwise contained in the strategic plan.

Highlights of FY02 Activities

- **National Council Resolutions Committee Policy**
  The committee completed a thorough review of existing NCSBN policy and recommended a new policy, 5.5 *Annual Meeting: Submitting Resolutions for Delegate Assembly*, to reflect criteria for resolutions and the role of the committee as established by the 2001 bylaws revisions.
- **Resolutions Committee Operating Policies and Procedures**
  The committee conducted a comprehensive review and revision of the Committee Operating Policies and Procedures to direct its work in preparations for the 2002 Delegate Assembly. The existing policies and procedures had not been reviewed since 1996 and contained language incompatible with bylaws and current practices.
- **Standing Rules of the 2002 Delegate Assembly**
  The committee submitted a recommendation to the Bylaws Committee for substantive revisions to the *2001 Standing Rules* for the 2002 Delegate Assembly. The new language clarifies who is entitled to make motions and resolutions in accordance with the bylaws, appropriately reflects deadlines, and states the expectations for the makers of motions and resolutions.
- **Call for Motions and Resolutions**
  A *Call for Motions and Resolutions* was prepared and distributed to the executive officers and board presidents on March 1, 2002. The committee improved materials to enhance clarity and provide for the needed documentation to properly evaluate and analyze the motions and resolutions by the committee. The letter to members from the committee emphasized and encouraged early participation in the process in order to provide information to the voting delegates in the *Business Book*.

  The *Call for Motions and Resolutions* provided all necessary material needed to prepare complete motions and resolutions, including the Operating Policies and Procedures, Resolutions Submission Form, and an enhanced Fiscal Impact Statement. New this year were several reference documents to assure that motions and resolutions conform to the bylaws, standing rules, mission and strategic plan. Additionally, all information and material regarding the Call for Motions and Resolutions is provided on the Members Only section of the NCSBN Web site.

Committee Members

Cheryl Koski, Executive Director, WY, Area I, Chairperson

Charles Alexandre, Executive Officer, RI, Area IV

Linda Busch, Board Member, MN, Area II

Polly Johnson, Executive Director, NC, Area III

Board Liaison
Barbara Morvant, Executive Director, LA-RN, Area III, Treasurer

Staff
Donna Nowakowski, MS, RN, CAE, associate executive director for Nursing Regulation

Relationship to Strategic Plan

Strategic Initiative 5 – Governance & Leadership Development and Organizational Capacity: The National Council will support the education and development of Member Board staff, Board Members and Board of Directors to lead in nursing regulation

Outcome 3: A sound organizational governance and management infrastructure advances the National Council's mission and vision.

Meeting Dates

- February 19, 2002 (teleconference call)
- April 30, 2002 (teleconference call)
- July 29, 2002 (teleconference call with Member Boards and their delegates)
- August 15, 2002

Attachments

A. Call for Motions and Resolutions
B. Resolutions Committee Operating Policies and Procedures
C. Motions/Resolutions Submission Form
D. Fiscal Impact Statement

Future Activities

- Open conference call July 29, 2002, for all members and their delegates contemplating motions and resolutions to provide guidance and assistance in the formulation of the language and necessary documents.
- Resolutions Committee meeting to review all motions and resolutions submitted and prepare a report to the delegates on Thursday, August 15, 2002, at 4 pm.
- Resolutions/New Business Forum on Friday, August 16, 2002.

Practice Breakdown Research Task Force – Attachment A

TERCAP: Taxonomy of Error, Root Cause Analysis and Practice Responsibility

Coding Instrument Template
May 2002

Section One – Nurse Demographics

A. Personal Data

1. List the nurse's year of birth _____

2. Check the nurse's gender
   ❑ Female ❑ Male

B. Nursing Education

3. Indicate the nurse's year of graduation for all nursing education programs completed at the time of reported incident(s). ***Include all programs.***
   ___ Practical/Vocational
   ___ Associate Degree, LPN
   ___ Associate Degree, RN
   ___ Diploma, RN
   ___ Regents/Excelsior Program
   ___ AD – BSN Completion
   ___ Baccalaureate, Nursing
   ___ Masters/ND (entry)
   ___ Masters, Nursing
   ___ Advanced Practice – please specify APRN category/type:
   - ❑ Nurse Practitioner
   - ❑ Nurse Anesthetist
   - ❑ Nurse Midwife
   - ❑ Clinical Nurse Specialist

   ___ PhD nursing/EdD/DNSc
   ___ BS or BA, non-nursing
   ___ Master, non-nursing
   ___ PhD or other doctorate, non-nursing
   ___ Other (please specify) _____

4. Was the nurse's basic nursing education program outside the US?
   ❑ Yes ❑ No
   If yes, please list country:_____

C. Nurse Licensure Data

5. Indicate year of the nurse's initial licensure for each applicable license:
   ____ LPN/LVN _____ RN _____APRN

6. Check all license types applicable to you at the time of the complaint.
   ❑ LPN/VN ❑ RN ❑ APRN

7. Did you have active licenses in more than one state?
   ❑ Yes ❑ No

8. Did you have an active license in a Compact state?
   ❑ Yes ❑ No

Licensure Examination History

9. Describe the nurse's licensure examination history for all levels of licensure by checking all boxes that apply. ***Check one box for each question.***
   a. How many times did you take the NCLEX-PN®?
      ❑ One ❑ Two ❑ Three or more
      ❑ Not Applicable ❑ Unknown
   b. How many times did you take the NCLEX-RN®?
      ❑ One ❑ Two ❑ Three or more
      ❑ Not Applicable ❑ Unknown
   c. Did you take the State Board Test Pool (SBTP) Examination (pre-NCLEX) for licensure?
      ❑ Yes ❑ No
   d. Did you take some other examination? (please specify)_____.
      ❑ Yes ❑ No

D. Continued Competence Activities

10. Check all types of continued competence activities the nurse has completed in the last five years.
    ❑ Education
    ❑ National Professional Certification
    ❑ Other (please specify type)
    _____
    ❑ Board mandated Continuing Education
    ❑ Board mandated practice hours
    ❑ Board mandated other (please specify type)
    _____
    ❑ None reported

E. Nurse Work History

11. How long had the nurse been in the nursing position at the time of the reported incident(s)? ***Choose one answer.***
    ❑ Less than one year
    ❑ 1-2 years
    ❑ 3-4 years
    ❑ 5-6 years

continued

Resolutions Committee – Attachment A

Call for Motions and Resolutions to the 2002 Delegate Assembly

March 1, 2002

The Resolutions Committee is seeking motions and resolutions for consideration by the Delegate Assembly at the 2002 National Council Annual Meeting, August 13-17. The Resolutions Committee is a standing committee of the National Council and must review, evaluate, and report to the Delegate Assembly on all motions and resolutions submitted by Member Boards. The Committee therefore encourages your early participation in the process.

Enclosed are documents and reference materials to assist you and your Member Board delegates in the timely submission of resolutions for review and analysis by the Committee. Use of the documents will enable makers to develop motions and resolutions that conform to the National Council Bylaws, 2002 Standing Rules (pending delegate approval), and the Resolutions Committee *Operating Policies and Procedures*. These documents include:

- Resolutions Committee Operating Policies and Procedures
- Resolutions Submission Form
- Fiscal Impact Statement
- Click on the links below to review reference documents:
  - Resolutions Committee Charge
  - National Council Bylaws
  - National Council Mission
  - National Council Strategic Initiatives and Outcomes FY2002-2004

Please carefully review the Resolutions Committee *Operating Policies and Procedures* and other documents before preparing motions and resolutions. This will expedite the Committee review of your submission. Further, we ask that motions or resolutions be submitted using the form provided and include the *Fiscal Impact Statement*. These forms will also be available in a printable version on the National Council Web site in the near future.

The Committee will review all motions and resolutions received by April 22, 2002, in time to include them in the printing of the 2002 Annual Meeting Business Book. This deadline is established to comply with the 45-day mailing notification to Member Boards. Submissions to the Committee received after this initial deadline will still be considered if received by noon on Thursday, August 15, prior to the Committee's 4:00 pm meeting. Thereafter, makers will present motions or resolutions directly to the Delegate Assembly during New Business. Late motions and resolutions will not be included in the Committee report to the Delegate Assembly.

The Committee wishes to advise you of the advantages of submitting motions and resolutions early in the process and by established deadlines. By presenting motions and resolutions to the Committee in a timely way, we will be able to assist you by providing a comprehensive review and evaluation in accordance with the necessary criteria. Further, those motions and resolutions having major potential impact will be accompanied by the necessary rationale and supporting information. If additional analysis is needed, the Committee will have ample opportunity to provide for the necessary evaluation. This will make your presentation of the recommendations to the Delegate Assembly and the Committee's report to be given in a manner that facilitates informed discussion and decision-

This letter was printed on NCSBN letterhead.

It was addressed to Executive Officers and Board Presidents from the Resolutions Committee:

Chairperson
Cheryl Koski, MN, RN, CS, Executive Officer, Wyoming State Board of Nursing, Area 1

Board Liaison
Barbara Morvant MN, RN, Executive Director, Louisiana State Board of Nursing, Finance Committee representative

Committee Members
Charles Alexandre MSN, RN, Director, Rhode Island Board of Nurse Registration & Nursing Education, Area 4

Linda Busch LPN, Board Member, Minnesota Board of Nursing, Area 2

Polly Johnson MSN, RN, Executive Director, North Carolina Board of Nursing, Area 3

making. All motions and resolutions received by the deadlines will be reviewed by the Committee and included in its report to the Delegate Assembly.

The Committee would like to invite participation of representatives of Member Boards (those that have submitted motions or resolutions and those still considering) in a conference call on July 29 at 2:00 pm CST. This call is being held to give members a chance to interact with the Committee members and ask questions or raise issues regarding the submission process or their particular motions and resolutions. This will also provide the Committee an opportunity to understand the nature and intent of motions and resolutions being submitted or considered.

Makers will have an additional opportunity to interact with the Committee during a scheduled meeting on August 15 (individual times TBD). The maker should attend the committee meeting at the appointed time and be prepared to speak to the motion or resolution. The meeting provides an opportunity for the Resolutions Committee to work with submitters should editing, rewriting, or combining of motions and resolutions be necessary.

As a reminder, only delegates, the National Council Board of Directors, and the Examination Committee (for approval of test plans) may make motions at the Delegate Assembly. Therefore, those of you who are not delegates will not be able to make the motion on behalf of your board of delegates at the annual meeting.

We encourage you to share this information with your board members and staff to solicit their input. NCSBN is very enthusiastic about the motions and resolutions process and is looking forward to another productive and successful annual meeting.

Please contact Donna Nowakowski if you have any questions at (312) 787-6555, x141 or dnowakowski@ncsbn.org. *The initial deadline for submission is April 22, 2002*. If this deadline creates difficulty for you, you will have an additional opportunity until August 15 at noon. However, submissions received after April 22 will not be included in the printing of the 2002 Business Book. *All submission forms can be completed electronically, then print the form, sign and send via fax to (312) 787-6898 to the attention of Renee Scaletta at the NCSBN office.*

cc: NCSBN Board of Directors
Kathy Apple, Executive Director

Resolutions Committee – Attachment B

NCSBN Resolutions Committee Operating Policies and Procedures

Purpose

The Resolutions Committee is a standing committee of the Delegate Assembly established under Article X (1)(e) of the National Council Bylaws to review, evaluate and report on all motions and resolutions submitted by Member Boards. The operating policies and procedures serve to guide the work of the Committee and the formulation of motions and resolutions by makers.

Policy

1. All resolutions and non-procedural main motions unrelated to the election of officers and directors must first be submitted to the Chair of the Resolutions Committee before being presented to Delegate Assembly.
2. The Resolutions Committee will receive and analyze all motions and resolutions submitted to it by authorized motion makers. The analysis shall consist of:
   a. Determination of consistency with National Council articles of incorporation, bylaws, mission, purpose and functions, strategic initiatives, outcomes and policies;
   b. Determination of relationship to ongoing programs;
   c. Assessment for duplication with other proposed motions;
   d. Legal implications;
   e. Financial impact.
3. The Resolutions Committee Chairperson will present to the Delegate Assembly oral and/or written reports of all motions and resolutions submitted to it. The report for each motion and resolution shall include the following analyses performed by the Resolutions Committee:
   a. Determination of consistency with National Council articles of incorporation, bylaws, mission, purpose and functions, strategic initiatives, outcomes, and policies.
      Consistent
      Not Consistent (with rationale)
   b. Determination of relationship to ongoing programs
      Not in current Strategic Plan
      In current Strategic Plan (site identified)
   c. Assessment for potential duplication with other proposed motion or ongoing programs
      No duplication
      Duplication (area of duplication specified)
   d. Legal implications
      None
      Implications identified
   e. Financial impact
      None
      Impact identified

   In the event a motion or resolution is submitted too late for the Resolutions Committee to perform its analysis, the Committee will report to Delegate Assembly the absence of any review.

Procedures

1. Motions and resolutions must be submitted by a delegate in accordance with the bylaws and the Standing Rules. The person seconding the motion must also sign all motions. A fiscal impact statement must accompany the motion or resolution.
2. It is desirable to have the motion or resolution submitted in time to include in the mailing to Member Boards 45 days before the Annual Meeting. However, motions and resolutions not submitted in time to meet the 45-day mailing prior to the Annual Meeting should be submitted to the Resolutions Committee by the time and date proscribed in the Standing Rules.
3. The Resolutions Committee will schedule a conference call open to all members prior to the Annual Meeting to enable makers an opportunity to receive assistance in the formulation of the motion or resolution.
4. Makers may submit motions to the Resolutions Committee until the Delegate Assembly concludes its business at the Annual Meeting to allow for all matters to be addressed. However, motions and resolutions not submitted in accordance with the established deadlines are not reviewed and analyzed by the Resolutions Committee and must be reported directly to the Delegate Assembly by the maker during new business.
5. The deadline for receipt of motions and resolutions at the Delegate Assembly shall appear in the Standing Rules for the Delegate Assembly.
6. The Resolutions Committee will meet with each maker in accordance with the schedule and guidelines established. This meeting shall occur as close to the session at which new business will be considered as is consistent with the orderly transaction of the Committee's business. Once discussion is concluded, the Committee will meet in executive session to prepare the motion or resolution for submission to the Delegate Assembly.
7. Courtesy resolutions are proposed directly by the Resolutions Committee.

Motions and Resolutions for Publication

1. Motions and resolutions must be submitted by the deadlines published in the National Council newsletter, *Council Connector,* member mailing, NCSBN Web site, or other form of notice in order to be reviewed by the Resolutions Committee and mailed to Member Boards 45 days before the Annual Meeting.
2. Motions and resolutions submitted in advance of the Annual Meeting will be presented at the Resolutions Forum.
3. The person(s) submitting a motion or resolution must be prepared to attend and discuss the motion or resolution with Resolution Committee at its scheduled meeting and speak to the motion or resolution to the Delegate Assembly.

Motions and Resolutions Received after the Resolutions Committee Meeting

1. A motion or resolution received after the Resolutions Committee meeting at the Delegate Assembly may be presented directly to the Delegate Assembly as new business, provided that the maker first submits the resolution to the Chair of the Resolutions Committee. The Resolutions Committee may make a reasonable attempt to meet with the motion maker to discuss any such motions and resolutions, time permitting, but will not be able to complete a thorough analysis and review.
2. The maker is responsible for duplication of the resolution for distribution to members of the Delegate Assembly. Each resolution or motion should be

accompanied by a written analysis of consistency with National Council mission, purpose and functions, strategic initiatives, outcomes, assessment of fiscal impact and potential legal implications.

Definitions

- **Motion**
  A proposal for consideration by the Delegate Assembly stated in the format, "I move that.…" A motion does not contain the rationale in its wording but the rationale may be submitted with the motion and the maker should be prepared to speak to the motion after seconding to present the rationale.

- **Resolution**
  A non-procedural proposal for consideration by the Delegate Assembly requiring the use of National Council resources and/or staff or expenditures of funds or requesting National Council to undertake strategic initiatives or projects or endorse, adopt or implement any policy or policy initiative and stated in the format, "Whereas …" [any number of whereas statements present the rationale for the proposal]; "therefore be it resolved …" [any number of resolved statements defining the action(s) to be taken].

Revisions Dates:
May 1990
January 1996
February 2002

Resolutions Committee – Attachment C

NCSBN Motions/Resolutions Submission Form

PLEASE TYPE OR PRINT CLEARLY.

Name of Motion/Resolution: _____

Maker: _____

Date: _____ **Phone #:** _____ **E-Mail Address:** _____

I move that:

Rationale for Motion:

Signature of Maker:_____

Member Board:_____

Signature of Second:_____

Member Board:_____

I. Describe the relationship of the motion/resolution to National Council's:
A. *Bylaws, mission, strategic initiatives and outcomes (see Web site for current information)*

B. *Ongoing programs and policies*

II. Identify potential legal implications.

III. Attach a completed Fiscal Impact Statement.

Resolutions Committee – Attachment D

NCSBN Fiscal Impact Statement – FY2002

PLEASE TYPE OR PRINT CLEARLY.

Title of Motion/Resolution: _____

Proposed by: _____

I. PROJECTED DATES

A. Beginning:

b. Completion:

II. RESOURCES ANTICIPATED

Check those resources needed to accomplish motion/resolution.

A. Does this proposal require a committee? ❑ Yes ❑ No ❑ Unsure

1. Number of members anticipated including the chair? _____ ❑ Unsure
2. How many meetings anticipated?
3. Time span of resources: ❑ 1 year ❑ 2 years ❑ 3 or more years ❑ Unsure

B. Does this proposal require printings, mailings, or electronic access (e.g., Web)?

❑ Yes ❑ No

1. Please describe any expected surveys.
2. Please describe other expected printings (special reports, mailings).
3. Please describe any expected electronic resources (e.g., Web site).

C. Will this proposal require outside consultation? ❑ Yes ❑ No

If yes, please select all that apply:

❑ Legal Counsel
❑ Nursing
❑ Testing/Psychometric
❑ Policy/Regulation
❑ Technical (including computer)
❑ Other (please describe)

D. Will this proposal require other resources? ❑ Yes ❑ No

If yes, please complete the following:

1. Please describe expected travel (other than committee meetings).
2. Other (please describe).

III. OTHER COMMENTS REGARDING FISCAL IMPACT.