Meeting Presentations

Tuesday, August 3, 2004

1:30 – 2:30 pm Examination Committee Forum – Century Ballroom C
Anita Ristau, RN, MS  
*Chair, NCSBN Examination Committee*

Casey Marks, PhD  
*NCSBN Director of Testing Services*

4:00 – 5:00 pm NCSBN Research Services Update – Pershing South
Lynda Crawford, PhD, RN, CAE  
*NCSBN Director of Research Services*

June Smith, PhD, RN  
*NCSBN Associate Director of Research Services*

Wednesday, August 4, 2004

10:35 am – 12:00 pm Nursys® Update – Pershing North
Angela Diaz-Kay, MBA  
*NCSBN Director of Information Technology*

10:35 am – 12:00 pm Practice Breakdown – Roanoke
Kathy Malloch, PhD, MBA, RN  
*Chair, NCSBN Practice Breakdown Advisory Panel*

Karla Bitz, PhD, RN  
*Member, NCSBN Practice Breakdown Advisory Panel*

2:30 – 4:00 pm PR&E Committee Forum – Century Ballroom C
Cookie Bible, APN  
*Chair, NCSBN PR&E Committee*

Barbara Newman, RN, MS  
*Chair, NCSBN PR&E Model Revisions Subcommittee*
Shared Visions, New Pathways

2004 Examination Committee Report

Anita Ristau, RN, MS
Chair, NCSBN Examination Committee

Casey Marks, PhD
NCSBN Director of Testing Services
### Strategic Initiatives

#### Relationship to Strategic Plan

**Strategic Initiative 1**

*Nursing Competence.* NCSBN will assist Member Boards in their role in the evaluation of nurse and nurse aide competence.

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### Strategic Initiative Outcomes

- Entry-level nurse competence is assessed by the NCLEX® examinations.
- NCLEX is administered at international sites for purposes of domestic licensure.
- Stakeholders are educated about the NCLEX examination program and related products/services.
Examination Committee Charge

The committee will provide general oversight of the NCLEX examination process, including item development, examination security, psychometrics, examination administration and quality assurance to ensure consistency with the Member Boards’ need for examinations.

Examination Committee Members

- Anita Ristau, MS, RN
  - Vermont, Area IV
- Teresa Bell-Jones, MS, JD, RN
  - California-RN, Area I
- Josse Daniell, MA, RN
  - Minnesota, Area II
- Shaila Ekstrom, PhD, RN
  - Nebraska, Area II
- Faith Fields, MSN, RN
  - Arkansas, Area III
- Claire Giamanco, MSN, RN
  - Louisiana-PN, Area III
- Mary Kay Habgood, PhD, RN
  - Florida, Area III
- Ruia Hart, MSN, RN
  - Massachusetts, Area IV
- Lorraine Heman, MSN, RN
  - Iowa, Area II
- Pamela Randolph, MS, RN, CPNI
  - Arizona, Area I

Board Liaison: Maria Hobbs, DSN, RN
Kentucky, Area III

Examination Committee IRSC Charge

The subcommittee will:

- Evaluate all RN and PN pretest questions as well as all operational items
- Evaluate actual candidate examinations in relation to a variety of criteria
- Provide written reports to the Examination Committee at each business meeting
- The subcommittee may assist the Examination Committee by providing committee representation at item development meetings
- Individual Examination Committee members act as chair of the Item Review Subcommittee on a rotating basis
IRSC Members

Cheryl Anderson, MSN, BSN, RN
- CA, Area I
Luisa Ballesta, MSN, RN
- CA-RN, Area I
Kathleen M. Breguet, MS, CS, RN,
- CA, Area IV
Beverly Foster, BSN, MSN, MPH, PhD, RN
- NC, Area III
Karen Green, MSN, CNA, RN
- HS, Area II
Susan Jones, PhD(c), MSN, RN
- KY, Area II
Mary Ann Lambert, MSN, RN
- NV, Area I
Carmen Lopez Rodriguez, MSN, RN, CNP
- PR, Area IV
Marc Law, MS, RN
- NJ, Area IV

IRSC Members

Ted Murphy, PhD, RN
- MO, Area II
Perrie Cron, LPN
- ND, Area II
Janetta Pucci, MSN, RN
- ND, Area II
Donya Robey, MSN, RN
- TN, Area III
Linda Santos, MSN, RN
- ND, Area II
Nancy J. Smith, PhD, RN, BC, FAANP
- CO, Area I
Elaine Tate, MS, EDD, RN
- LA-RN, Area III
Caela Thomas, PhD, RN
- AR, Area III

Recommendation to the Delegate Assembly

Adopt the proposed changes to the NCLEX-PN® Test Plan
## Rationale for Recommendations for the 2005 NCLEX-PN® Test Plan

### 2003 PN Practice Analysis Study
- Empirical data collected from newly licensed nurses
- Report of Findings from the 2003 LPN/VN Practice Analysis Linking the NCLEX-PN® Examination to Practice (Smith & Crawford)

### Expert Judgment
- Examination Committee
- Practice Analysis Panel of Experts
- Member Boards
- NCLEX Testing Services Staff
- Pearson-VUE Test Development Staff

## Proposed 2005 NCLEX-PN® Test Plan

### What is retained?
- Overall Format - Test Plan Section Headings
- Client Needs Structure
- Classification of Cognitive Levels

## Proposed 2005 NCLEX-PN® Test Plan

### What is changed?
- "Integrated Concepts & Processes" to "Integrated Processes"
- Re-distribution of Content and Percentage of Test Items
- Cognitive Complexities to Cognitive Abilities
### Distribution of Content: Part 1

<table>
<thead>
<tr>
<th>Client Needs Categories/Subcategories</th>
<th>Proposed 2005 PN Test Plan Percentage of Exam Items</th>
<th>2002 PN Test Plan Percentage of Exam Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe and Effective Care Environment</td>
<td></td>
<td>A. Safe, Effective Care Environment</td>
</tr>
<tr>
<td>• Coordinated Care</td>
<td>11-11%</td>
<td>1. Coordinated Care</td>
</tr>
<tr>
<td>• Safety and Infection Control</td>
<td>8-14%</td>
<td>2. Safety and Infection Control</td>
</tr>
<tr>
<td>Health Promotion and Maintenance</td>
<td>7-12%</td>
<td>B. Health Promotion And Maintenance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Growth and Development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Through the Life Span</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Prevention and Early Detection of Disease</td>
</tr>
</tbody>
</table>

### Distribution of Content: Part 2

<table>
<thead>
<tr>
<th>Client Needs Categories/Subcategories</th>
<th>Proposed 2005 PN Test Plan Percentage of Exam Items</th>
<th>2002 PN Test Plan Percentage of Exam Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial Integrity</td>
<td>5-14%</td>
<td>Psychosocial Integrity</td>
</tr>
<tr>
<td>Physiological Integrity</td>
<td></td>
<td>9. Coping and Adaptation</td>
</tr>
<tr>
<td>• Basic Care and Comfort</td>
<td>11-17%</td>
<td>10. Psychosocial Adaptation</td>
</tr>
<tr>
<td>• Pharmacological Therapeutics</td>
<td>5-10%</td>
<td>Physiological Integrity</td>
</tr>
<tr>
<td>• Reduction of Risk Potential</td>
<td>10-16%</td>
<td>7. Basic Care and Comfort</td>
</tr>
<tr>
<td>• Physiological Adaptation</td>
<td>12-15%</td>
<td>8. Pharmacological Therapeutics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Reduction of Risk Potential</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. Physiological Adaptation</td>
</tr>
</tbody>
</table>

### Proposed Implementation Timeline for 2005 NCLEX-PN® Test Plan

- **November 2003**: Examination Committee receives results of 2003 PN practice analysis and recommends revisions to the 2007 NCLEX-PN® Test Plan
- **November 2003**: Circulate proposed 2005 NCLEX-PN® Test Plan to the NCBN Board of Directors and the Member Boards requesting feedback by March 31, 2003
- **April 2004**: Examination Committee review of feedback and approval of proposed 2005 NCLEX-PN® Test Plan
- **August 2004**: Delegate Assembly action
- **September 2004**: Standard setting recommendation by the Panel of Judges
- **Oct Nov. 2004**: Board of Directors evaluates passing standard
- **April 2005**: Implementation of 2005 NCLEX-PN® Test Plan
Outcome A

Entry-level nurse competence is assessed by the NCLEX examinations.

Continuously Improve Development of the NCLEX Examinations

Evaluated and monitored NCLEX examination policies and procedures

Monitored all aspects of examination development

Monitored all aspects of examination administration

Time Length for the NCLEX-RN Examination

The Board of Directors approved the Examination Committee recommendation for additional time for the NCLEX-RN examination

The extra hour will be added to all NCLEX-RN examinations beginning October 1, 2004
Investigate the Feasibility of Increasing Frequency Of NCLEX Administrations

As of January 1, 2004 NCSBN policy was amended to permit candidates to test as often as once every 45 days or eight times per year. Member Boards can make re-testing time periods longer but not more frequently than NCSBN policy.

Set Performance Benchmarks for Existing English Proficiency Examinations

A recommended passing standard should reflect the level of English language proficiency, as measured by TOEFL, believed necessary for entry-level nurses to possess in order to be able to perform important nursing responsibilities safely and effectively. The Examination Committee recommended that a score of 220 on the computerized TOEFL (550 on the written TOEFL) be required to demonstrate the minimum degree of English proficiency necessary to be a safe and effective, entry-level nurse. The committee expects this tactic to continue in FY05, with the International English Language Testing System (IELTS) English proficiency examination.

Compare Equivalency of NCLEX-RN with Spanish Language Puerto Rican Nurse Licensure Examination

Despite the lack of complete information, the following identified issues signify non-trivial differences between the NCLEX-RN and the Puerto Rican RN examinations:
- Different Languages
- Scope of Practice Represented
- Examination Validity/Legal Defensibility
- Psychometric Soundness
- Number of Examinations
- Examination Security and Integrity
- Examination Difficulty

Information available fails to support a position of equivalency between the two examinations.
Investigate Reasons For Non-Licensure Of Nursing School Graduates

US-educated RNs (n=28) listed the following reasons for delaying/not taking NCLEX:
- Not confident in my ability to pass exam – 26% (n=7)
- General test-taking anxiety – 15% (n=4)
- Registration/ATT expired – 15% (n=4)
- Increased family responsibilities – 10% (n=3)

The internationally-educated RNs (n=343) listed the following reasons, and 17 respondents note the unasked category of 'Financial Reasons':
- Not enough time to prepare – 18% (n=63)
- Not confident in my ability to pass exam – 11% (n=50)
- Registration/ATT expired – 11% (n=38)

Investigate Reasons For Non-Licensure Of Nursing School Graduates

The PN respondents, US-educated (n=45), to the delaying/not taking question, listed the following reasons including 6 respondents in the 'Financial reasons' category:
- Not confident in my ability to pass exam – 27% (n=15)
- General test-taking anxiety – 15% (n=14)
- Registration/ATT expired – 14% (n=10)

Finally, the PN internationally educated respondents (n=37) noted the following reasons:
- Not enough time to prepare – 15% (n=11)
- CGNRS – 14% (+10)
- Registration/ATT expired – 14% (n=10)
- Non-US transcript/program evaluation incomplete – 10% (n=7)

Outcome B

NCLEX is administered at international sites for purposes of domestic licensure.
NCLEX is Administered at International Sites for Purposes of Domestic Licensure

Utilizing the security and location selection criteria that were accepted and approved by the NCSBN’s Delegate Assembly in 2002, the Examination Committee has selected:

- United Kingdom (England)
- Hong Kong
- South Korea

as the initial three countries for international testing locations.

It is important to note that these countries were selected because they rated highly across all criteria under consideration.

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NCLEX is Administered at International Sites for Purposes of Domestic Licensure

The Examination Committee used the following approved criteria to evaluate initial locations for international administration of the NCLEX examinations:

- National Security
- Examination Security
- Similarity with U.S. Intellectual Property and Copyright Laws
- Pearson Locations with High Stakes Testing
- Numbers and Locations of Internationally Educated Nurses
- Regional Accessibility
- Number of U.S. Military Personnel and Dependents
- Similarity to U.S. Nursing Educational Systems

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Criteria For The Evaluation Of International Administration Locations

<table>
<thead>
<tr>
<th>Country</th>
<th>Security</th>
<th>Urbanization</th>
<th>Pearson Locations with High Stakes Testing</th>
<th>Number of Viability</th>
<th>Number of Shortages</th>
<th>Number of Additional Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>4</td>
<td>78</td>
<td>17,719</td>
<td>0,841</td>
<td>210</td>
<td>21</td>
</tr>
<tr>
<td>Belgium</td>
<td>3</td>
<td>66</td>
<td>22,977</td>
<td>14</td>
<td>29</td>
<td>2,817</td>
</tr>
<tr>
<td>China</td>
<td>2</td>
<td>121</td>
<td>27,125</td>
<td>24</td>
<td>96</td>
<td>2,716</td>
</tr>
<tr>
<td>France</td>
<td>3</td>
<td>86</td>
<td>20,930</td>
<td>0</td>
<td>29</td>
<td>2,646</td>
</tr>
<tr>
<td>Germany</td>
<td>2</td>
<td>46</td>
<td>20,974</td>
<td>2</td>
<td>29</td>
<td>2,623</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>3</td>
<td>60</td>
<td>20,974</td>
<td>0</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>Japan</td>
<td>3</td>
<td>62</td>
<td>20,974</td>
<td>0</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>Mexico</td>
<td>3</td>
<td>62</td>
<td>20,974</td>
<td>0</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>Nigeria</td>
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<td>62</td>
<td>20,974</td>
<td>0</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>Russia</td>
<td>3</td>
<td>62</td>
<td>20,974</td>
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<td>0</td>
<td>90</td>
</tr>
<tr>
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<td>21</td>
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<td>17,719</td>
<td>0,841</td>
<td>210</td>
<td>21</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
NCLEX is Administered at International Sites for Purposes of Domestic Licensure

Based on all current NCLEX examination program policies and procedures, including all current security protocols, the Examination Committee will oversee administration of the NCLEX-RN and PN examinations in international locations with the following conditions:

- International NCLEX administration will begin in January 2005,
- International NCLEX Examination fees will be established by the NCLEX Board of Directors for examination administration outside Member Board jurisdictions,
- Three or fewer locations will be utilized as the initial set of international administration locations to pilot the initiative,
- Utilizing standards and criteria for NCLEX administration performance, international testing locations may be added or removed during FY05, and,
- In all circumstances, international testing in a location will not be implemented if all security policies and procedures currently in place are not employed.

NCLEX is Administered at International Sites for Purposes of Domestic Licensure

Next Steps:
- Establish Global International Testing Fee
  • International testing fee is expected to be different than the domestic fee
  • Premium service, Premium fee
- Publish international testing registration and scheduling procedures in 2005 Candidate Bulletins
  • No changes for Member Boards
- Begin administration in January 2005

Outcome D

Stakeholders are educated about the NCLEX examination program and related products/services
Stakeholders are educated about the NCLEX examination program and related products/services

NCLEX Outreach
- Presentations
- Video
- Publications
- NCLEX Invitational
- NCLEX Program Reports
- NCLEX Quick Results

Future Activities
- Continue to monitor all administrative, test development, and psychometric aspects of the NCLEX examination program
- Evaluate enhancements to NCLEX examination process
- Evaluate NCLEX Outreach initiatives
- Administer NCLEX examination in international locations
- Research and recommend English as a second language competency examinations and valid passing standards
- Evaluate the NCLEX-PN® Passing Standard

Questions and Answers

Thank you
Shared Visions, New Pathways

Research Findings

Lynda Crawford, PhD, RN, CAE
NCSBN Director of Research Services

June Smith, PhD, RN
NCSBN Associate Director of Research Services
LPN/VN Studies

Spring 2001 Practice and Professional Issues Survey (PPPI), Research Brief Volume 2
- Demographics
- Work settings
- Languages useful in practice settings
- Supervision of UAPs
- Alternative/complementary therapies
- Adequacy of educational preparation
- Adequacy of work orientations
- Knowledge of Nurse Practice Act
- Involvement in errors
- LPN/VN work with special patient populations

LPN/VN Studies

2001 Employers Survey, Research Brief Volume 3
- Adequacy of educational preparation
- Preparation to provide safe, effective care
- Desired staff percentage of LPN/VNs

Winter 2002 PPPI, Research Brief Volume 5
- Demographics
- Work settings
- LPN/VN care of pediatric clients
- Mathematical calculations performed
- Use of nursing diagnoses
- Characteristics of typical work day
LPN/VN Studies

Exploring the Value of CE Mandates, Research Brief Volume 6
- Growth in 10 areas of ability
- Hours of CE accumulated
- Factors contributing to growth in abilities

Spring 2002 PPI, Research Brief Volume 7
- Demographics
- Work settings
- Experiences with distance education
- Transition to practice
- Practice outcomes: Errors & difficulties with assignments
- Preparation for practice
- Communication issues

LPN/VN Studies

Winter 2003 PPI, Research Brief Volume 12
- Demographics
- Work settings
- Preparation for practice
- Practice errors
- Nurses educated outside the U.S.

2002 Employers Survey, Research Brief Volume 14
- Adequacy of new LPN/VN preparation
- Factors used to evaluate newly licensed LPN/VNs for potential employment
- Transition activities
- Policies and practices related to nurse/assistive personnel relationships

LPN/VN Studies

2003 Spring PPI, Research Brief Volume 15
- Demographics
- Work settings
- Transition activities
- Policies and practices related to nurse/assistive personnel relationships
- Findings may be compared with those from 2003 Employers Survey
LPN/VN Studies

2003 LPN/VN Practice Analysis, Research Brief Volume 17
- Demographics
- Work settings
- Certifications
- Orientations
- Shifts
- Administrative responsibilities
- Alternative/complementary therapies used
- Activities performed
- Importance and usage of categories of knowledge

Profile of LPN/VNs: Demographics

Average age 32.7 years (SD 9.4 years)
7.9% male
Ethnic/racial background
- 67% white, Caucasian
- 16.2% black, African American
- 6.5% Hispanic/Latino
- 6.1% Asian
- 1% American Indian/Alaskan native
- 0.5% native Hawaiian/other Pacific Islander
- 2.7% multiethnic

60% were previously nurse aides for an average of 4.9 years
- 26% worked as a nurse aide in their current employing facility
37% certified in IV therapy
### Profile of LPN/VNs: Education

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>85%</td>
</tr>
<tr>
<td>Associate degree</td>
<td>9%</td>
</tr>
<tr>
<td>RN programs</td>
<td>3%</td>
</tr>
<tr>
<td>Educated outside the U.S.</td>
<td>3%</td>
</tr>
</tbody>
</table>

21% Enrolled in RN program
- 84% ADN
- 10% BSN
- 6% Diploma

19% had applied to RN program but weren’t enrolled
- 47% completing pre-requisites
- 20% on waiting lists
- 26% couldn’t afford tuition
- 3% turned away because classes were too full
- 1% failed to meet program requirements
18% had non-nursing college degrees

New LPN/VNs felt most prepared to:
- Administer medications
- Understand the rationale for nursing actions
- Provide care to 2+ clients
- Work effectively within a healthcare team
- Perform psycho-motor skills
Profile of LPN/VNs: Education

New LPN/VNs felt least prepared to:
- Provide care to 6+ clients
- Meet clients’ spiritual needs
- Guide care provided by assistive personnel
- Administer medications to 10+ clients
- Know when and how to call a client’s physician

33% of employers rated LPN/VNs as adequately prepared to provide safe, effective care

Profile of LPN/VNs: Work Settings

Facilities
- 42% hospital
- 45% long-term care, nursing homes
- 10% community-based settings
- 3% other

Top 5 practice settings
- 44% nursing home, skilled or intermediate care
- 30% medical/surgical units
- 8% rehabilitation
- 7% other long-term care
- 7% critical care

Profile of LPN/VNs: Transition to Practice

<table>
<thead>
<tr>
<th>Method</th>
<th>%</th>
<th>Ave Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Formal Orientation</td>
<td>8.9</td>
<td></td>
</tr>
<tr>
<td>Classroom instruction/skills lab only</td>
<td>1.2</td>
<td>3.1</td>
</tr>
<tr>
<td>Classroom and/or skills lab plus supervised work with patients</td>
<td>15.9</td>
<td>4.7</td>
</tr>
<tr>
<td>Work with an assigned preceptor w or w/o additional classroom or skills lab work</td>
<td>68.4</td>
<td>4.5</td>
</tr>
<tr>
<td>Formal internship w or w/o additional classroom or skills lab work</td>
<td>1.8</td>
<td>5.5</td>
</tr>
<tr>
<td>Other</td>
<td>2.9</td>
<td>3.3</td>
</tr>
</tbody>
</table>
Profile of LPNs/VNs: Shifts

<table>
<thead>
<tr>
<th>Scheduled Length of Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 hours</td>
</tr>
<tr>
<td>8 hours</td>
</tr>
<tr>
<td>&lt; 6 hours</td>
</tr>
<tr>
<td>10 hours</td>
</tr>
</tbody>
</table>

Profile of LPNs/VNs: Shifts

<table>
<thead>
<tr>
<th>Shift Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day</td>
</tr>
<tr>
<td>Evening/night rotate</td>
</tr>
<tr>
<td>Day/evening rotate</td>
</tr>
<tr>
<td>Night</td>
</tr>
</tbody>
</table>

Profile of LPNs/VNs: Overtime

Work an average of **4.6 hours of overtime** per week

**12-18%** report approximately **6.5 hours** of weekly mandatory overtime
Profile of LPN/VNs: Numbers of Clients

Hospital
- Average 4 clients in first assignment
- Average 7 clients in current assignment

Nursing Home/LTC
- Average 26 clients in first assignment
- Average 32 clients in current assignment

Profile of LPN/VNs: Administrative Responsibilities

43% reported one or more administrative roles
- 75% in LTC
- 11% in hospitals
- 29% in community settings

Charge nurse
- 60% in LTC
- 8% in hospitals
- 13% in community settings

Team leader
- 14% in LTC
- 3% in hospitals
- 7% in community settings

Profile of LPN/VNs: How Spend Time

- Physiological Adaptation 12%
- Management of Care 16%
- Safety and Infection Control 13%
- Physical Function and Maintenance 14%
- Psychological / Emotional Health 10%
- Basic Care and Comfort 13%
- Medication Administration 11%
- Reduce Risk of Complications 11%
- Pain Management 10%
Profile of LPN/VNs: Activities

Most frequently performed activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Ave. Freq</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain client confidentiality</td>
<td>4.41</td>
</tr>
<tr>
<td>Use standard precautions</td>
<td>4.39</td>
</tr>
<tr>
<td>Document client care</td>
<td>4.37</td>
</tr>
<tr>
<td>Maintain current, accurate MAR</td>
<td>4.26</td>
</tr>
<tr>
<td>Verify identity of client</td>
<td>4.24</td>
</tr>
<tr>
<td>Provide for privacy needs</td>
<td>4.22</td>
</tr>
<tr>
<td>Follow the rights of medication administration</td>
<td>4.21</td>
</tr>
<tr>
<td>Provide medication by oral route</td>
<td>4.12</td>
</tr>
<tr>
<td>Take client’s VS</td>
<td>4.01</td>
</tr>
</tbody>
</table>

Profile of LPN/VNs: Activities

Activities performed with the least frequency

<table>
<thead>
<tr>
<th>Activity</th>
<th>Ave. Freq</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use a laser to remove client's unwanted hair</td>
<td>0.15</td>
</tr>
<tr>
<td>Provide care for client with non-substance related dependency</td>
<td>0.17</td>
</tr>
<tr>
<td>Perform hemodialysis treatment</td>
<td>0.19</td>
</tr>
<tr>
<td>Administer phototherapy to newborn</td>
<td>0.21</td>
</tr>
<tr>
<td>Perform fetal heart monitoring before labor</td>
<td>0.21</td>
</tr>
<tr>
<td>Monitor a client in labor</td>
<td>0.22</td>
</tr>
<tr>
<td>Start or restart an IV on a pediatric client</td>
<td>0.25</td>
</tr>
<tr>
<td>Lead client group session</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Profile of LPN/VNs: Scope of Practice Issues

Care Planning:
- 48% reported independently developing clients’ plans of care an average of 1.95 times per day
- 83% reported contributing to the development of clients’ plans of care an average of 2.9 times per day
- 57% reported independently changing clients’ plans of care an average of 1.78 times per day
- 81% reported contributing to change made in clients’ plans of care an average of 2.57 times per day
### Profile of LPN/VNs: Scope of Practice Issues

**Assessment:**
- 84% reported collecting
  data for initial or admission
  health history an average of 2.68
  times per day
- 72% reported completing
  data collected for health history
  to expected norms for decision-making
  or care planning an average of 2.29
  times per day
- 64% reported collecting baseline
  physical data on admission of client
  an average of 2.62 times per day
- 77% reported completing baseline
  physical data to norms for
decision-making or care planning
  an average of 2.52 times per day
- 96% reported re-assessing selected
  system or systems an
average of 3.8 times per day

**Teaching:**
- 78% reported independently
  planning and providing
  education to client/family about
  safety precautions an
average of 2.24 times per day
- 91% reported assisting in or
  re-entering education about
  safety precautions an
average of 2.58 times per day
- 61% reported independently
  planning and providing
  education about managing
  behavioral disorders an
average of 1.86 times per day
- 60% reported assisting in or
  re-entering education about
managing behavioral disorders an
average of 1.83 times per day
- 64% reported providing client/family information about
  condition, expected progress and outcomes an
average of 2.43 times per day

### Profile of LPN/VNs: Scope of Practice Issues

**Intravenous Therapies:**
- 58% reported hanging IV fluids or giving
  IV/TP through peripheral line an
average of 3.01 times per day
- 32% reported giving medications by
  IV/P through a peripheral line an
average of 2.27 times per day
- 38% reported giving IV fluids, IV/TP or IV/P through
  central venous catheter an
average of 2.08 times per day
- 53% reported hanging TPN an
average of 1.82 times per day
### Profile of LPN/VNs: Scope of Practice Issues

#### Intravenous Therapies:
- 55% reported starting initial peripheral IV on an adult client an average of 2.17 times per day
- 47% reported restarting an IV line on an adult client an average of 2.17 times per day
- 19% reported starting or restarting an IV line on a pediatric client an average of 1.31 times per day

#### Other Issues:
- 28% reported administering blood products an average of 1.58 times per day
- 40% reported monitoring transfusion of blood product an average of 1.53 times per day

#### Other Issues:
- 23% reported performing peritoneal dialysis exchanges an average of 1.34 times per day
- 17% reported performing hemodialysis treatments an average of 1.11 times per day
- 52% reported monitoring a client recovering from conscious sedation an average of 1.58 times per day
Profile of LPN/VNs: Relationship with RNs

2003 Employers Survey Comments:

- 61% reported RNs supervised LPN/VNs
- 39% reported RNs and LPN/VNs performed same or similar roles

****

Profile of LPN/VNs: Relationship with RNs

2003 Employers Survey Comments:

"RN that LPN/LVN function in a similar capacity, except where scope of practice clearly states RN must assess and sign."

****

Profile of LPN/VNs: Relationship with RNs

2003 Employers Survey Comments:

"RNs supervise LPNs and make their assignments."

****

"RNs take charge and assist LPNs as needed. RNs assess and educate, LPNs re-assess and re-educate clients. RNs lead the team."

****

"RNs supervise LPNs. RN does case management. LPN does home visits, some education and some wound care. No initial assessments."

****

Profile of LPN/VNs: Relationship with RNs

2003 Employers Survey Comments:

"RNs & LPNs are both utilized as charge nurses. Charge nurses supervise individual units, but they do work as a team."

****

"They work at basically the same jobs and at the same levels. The RNs are respected for their clinical & assessment skills, but we have no attitude that they are superior to the LPNs."

****
Profile of LPN/VNs: Relationship with RNs

2003 PPI, RN comments:

- 38% reported that RNs supervised LPN/VNs
- 62% reported RNs and LPN/VNs had the same role or roles that differed only in specific tasks the RNs were required to perform for the LPN/VN’s clients.

Profile of LPN/VNs: Relationship with RNs

2003 PPI, RN comments:

“The RN is responsible for all tasks and cares of the LPN.”

*****

“RNs are directly responsible for LPNs.”

*****

“RNs supervise LPN duties—which are the same as an RN with the exception of IV push medications.”

Profile of LPN/VNs: Relationship with RNs

2003 PPI, RN comments:

“RNs and LPNs do the same job. RNs just have to sign off initial assessments.”

*****

“Their day-to-day responsibilities are very similar. LPN/VNs are not allowed to do admissions, note orders or be lead nurses. Other than these things, the work load is the same.”

*****

“The two are indistinguishable until an LPN is required to get an RN to complete a task only RNs can do. All LPNs & RNs work well together.”
Profile of LPN/VNs: Relationship with RNs

2003 PPI, LPN/VN comments:

- 48% reported RNs supervised LPN/VNs
- 52% reported they had the same roles or that the roles were the same except for specific tasks the RNs were required to perform for the LPN/VNs clients.

Profile of LPN/VNs: Relationship with RNs

2003 PPI, LPN/VN comments:

“LPNs are working under the supervision of RNs. RNs are in charge. LPNs have to report to RNs and inform of any changes in pts. conditions, incidents, etc.”

*****

“The LPN rarely sees the RN supervising the case. The RN visits the pt. in daylight hours and LPNs work 7pm - 8 am.”

*****

“RN is ultimately responsible for LPN, LPN is responsible for CNA.”

Profile of LPN/VNs: Relationship with RNs

2003 PPI, LPN/VN comments:

“They are both charge nurse because there is only one nurse that works on the floor during the shift. LPNs do the same thing as the RNs except RNs have two forms that they fill out when admitting a pt. that the LPNs don’t use. Otherwise all duties, etc. are the same.”

*****

“RNs and LPNs have their own separate assignment of pts. But teamwork is utilized if anyone needs assistance or has questions.”

*****

“RNs & LPNs basically do the same duties, however, RNs are considered a resource for additional information and are accountable for the information given.”
### Summary

LPNs/VNs start practice at about 32-33 years of age.

About 1 in 5 LPNs/VNs have applied to a RN program but are not currently enrolled.

Accessible location and timing of prerequisite courses and tuition assistance are 2 methods of facilitating further nursing education for LPNs/VNs.

The number of LPNs/VNs employed in hospitals is growing.

---

### Summary

LPNs/VNs are not well prepared to care for the numbers of clients they are assigned early in their entry-level practice.

The majority of LPNs/VNs in long term care work as charge nurses or team leaders.

About half of the new LPNs/VNs report independently developing and changing clients’ plans of care.

About three-fourths of the new LPNs/VNs report assessment activities that go beyond data collection.

---

### Summary

About three-fourths of the LPNs/VNs report independently planning and providing client/family education.

More than half of the new LPNs/VNs report providing fluids, TPN or medications through IV lines.

Employers and nurses report that RNs and LPNs/VNs have similar work roles.
## NCSBN Contacts

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Phone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Research</td>
<td>Lynda Crawford</td>
<td>312-525-3634</td>
<td><a href="mailto:l.crawford@ncsbn.org">l.crawford@ncsbn.org</a></td>
</tr>
<tr>
<td>Associate Director of Research</td>
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<td>312-525-3651</td>
<td><a href="mailto:j.smith@ncsbn.org">j.smith@ncsbn.org</a></td>
</tr>
</tbody>
</table>

To order Research Briefs:
- Sue Shephard – 312-525-3677; sshephard@ncsbn.org
Shared Visions, New Pathways

Nursys Update

Angela Diaz-Kay, MBA
NCSBN Director of Information Technology
Nursys® Update for FY2004

Angela Diaz Kay
NGSBN
Director of Information Technology

Ad-hoc Nursys Advisory Panel FY2004

- Faith Fields – EO AR
- Lanette Anderson – EO WVPA
- Jodi Schmitt – EO MO

Nursys Advisory Panel FY04-05

- Sheryl Meyer, Chairperson, MN
- Lanette Anderson, EO WVPA
- Lisa Ferguson-Ramos, OH
- Adrian Overrow, KS
- Amber Hendrickson, AZ
- Mark Majeks, TX, Beard Leeson
## Nursys® Update Overview

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Current Priorities</th>
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<tr>
<td>- Nursys Registration</td>
<td>- Increase Participation to 100%</td>
</tr>
<tr>
<td>- ORG &amp; COM Enhancements</td>
<td>- Increase Discipline Data to 100%</td>
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<tr>
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<td>- Exam &amp; Education Simplification</td>
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<td>- Daily Upload</td>
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<td>- Discipline Upload</td>
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<td>- HIROS Reprinting</td>
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<td>- Database Improvements</td>
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<td>- Web-based Training</td>
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<tr>
<td></td>
<td>- Reduced Duplicates</td>
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<td></td>
<td>- Completed Various Requirements</td>
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<td></td>
<td>- RFP</td>
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## Nursys® FY 2004 Achievements

**Trademark Registration**

“We know that our members use this product every day in their role to protect the public. Trademarks are not issued without due consideration for the importance of the product. We should all be proud that this vital product has helped us fulfill the mission for our membership!”

Kathy Apple, Executive Director, NCBSN

**Licensure QuickConfirm Focus Group**

## Nursys® Achievements – cont.

**ORG Enhancements**
- Exam & Education Data Simplification
- <Info Tab> Discipline Input Dates are executed Dynamically
- <Reports Tab> New Multiple Compact Licenses Report
- Investigation Alert Flag associated to Individual
- Overall Stability and Reliability Improved
### Nursys Achievements – cont.

**COM Enhancements**
- Credit Card processing improvements
- Restrict the user from accidentally submitting multiple requests and subsequent changes
- Improved Error Handling and Reporting
- Improved Up-Time & Stability
- Enhanced the User Interface
  - Improved Navigation and Communication
  - Frequently Asked Questions

### Nursys Achievements – cont.

**Licensure Data Daily Upload**
- Donnelley integrated to Client/Server architecture
- NCSBN System Redesign
  - Introduction of BizTalk Infrastructure
  - Automated Data Validation, Insertion, and exception handling
  - Performance Enhancements
- Daily Upload Expanded Functionality
  - Improved secondary match logic by Donnelley
  - Improved data validation by Donnelley
  - BizTalk Interchange Integration
  - Cookbook for Member Boards joining Daily Implementation
- Web-based Training

### Nursys Achievements – cont.

**Technology Enhancements**
- Performance and Stability
- Data Cleanup
Nursys® Achievements – cont.

- HIPDB Reporting
  - Re-architecture of Application to be Client/Server
  - Data Alignment and Synchronization with HIPDB
  - Integrated within BizTalk Architecture
  - Improved handling of Revisions & Corrections
  - Improved execution Cycle-time
- Issues with HIPDB
  - Slow Turn-around for Data Uploads
  - Slow Response to Inquiries and Issues
  - Moving Target On Technical Specifications

Nursys® Achievements – cont.

- Discipline Upload
  - Acceptance of Discipline Data directly from Boards of Nursing
    - Support multiple input formats
  - System Architecture Overview
    - Secure Communications
    - BizTalk Integration
    - Client/Server Application Architecture
    - Real-time processing

Nursys® Priorities FY04-05

- ORG Efforts
  - Two major release of enhancement requests
  - Nurse Fraud/Imposter Detection
  - APRN Tracking
  - TEP CPR
  - Work-Force Data
- COM Efforts
  - One major release of enhancements
  - QuickConfirm Focus Group enhancements
Nursys® Priorities – cont.

Export (Back to Donnelley)
- Integrated with new Nursys® Admin Utility
  - Data Corrections
  - Invoice Collapse requests
  - License moves
  - Inserts
- Daily automated feed to Donnelley
- Increase participation towards 100%
- Increase discipline data to 100%
- Area feedback

Participants

Daily
- Arkansas
- Minnesota
- North Carolina
- South Dakota

Weekly
- Arizona
- Idaho
- Iowa
- Maryland
- New Mexico
- Texas

Monthly
- Colorado
- Delaware
- Florida
- Indiana
- Maine
- Massachusetts
- Mississippi
- Missouri
- Montana
- Nebraska
- North Dakota
- Ohio
- Oregon
- Tennessee
- Utah
- Vermont
- Wisconsin

Participation Queue

- W. Virginia PN – Late summer 2004
- New Jersey – Anytime Now
- Virginia – September 2004
- Alaska (expressed interest)
- Connecticut (expressed interest)
- Kentucky (expressed interest)
Shared Visions, New Pathways

**Study of Practice Breakdown**

Kathy Malloch, PhD, MBA, RN  
*Chair, NCSBN Practice Breakdown Advisory Panel*

Karla Bitz, PhD, RN  
*Member, NCSBN Practice Breakdown Advisory Panel*
### Study of Practice Breakdown

Kathy Malloch, PhD, MBA, RN, AZ
Chair, Practice Breakdown Advisory Panel

Karla Bitz, PhD, RN, ND
Member, Practice Breakdown Advisory Panel

### Patient Safety Initiatives

- Learning about when incidents occur
- Anticipating new areas of concern
- Finding deeper, more generic patterns in failures
- Developing, prototyping and evaluating new approaches to patient safety

### Challenges for Patient Safety Research

- How are errors identified?
- Can errors be "recovered from" by counteractions?
- How to trigger those counteractions?
- How will changes in systems effect error tolerance?
- How could unintended side effects create new paths to failure?
Wealth of Discipline Data

- Boards of Nursing have thousands of discipline cases to draw upon.
- Boards of Nursing have an opportunity to learn from these episodes of nursing practice breakdown.
- Boards of Nursing can promote prevention by identifying nurses and nursing situations "at risk."

Practice Breakdown Advisory Panel

Kathy Malloch, PhD, RN, AJ, Chair
Karta Biz, PhD, RN, ND
Dwayne Jamison, B5, MS
Kathy Schved, JD, NJ
Vicky Gottschalk, MBA, ID
Lisa Enrich, MS, RN, OH
Linda Patterson, MS, RN, WA
Patricia Benner RN, PhD, FAAN, Consultant
Kathy Scott, RN, PhD Consultant
Vickie Sheets, JD, RN, CAE, NCSBN Staff
David Herley, NCSBN Staff

Practice Breakdown Study

Precursor - NCSBN 1997 Study of the Effectiveness of Disciplinary Effectiveness

1999 Board of Directors appointed Disciplinary issues Advisory Committee to develop new knowledge related to nursing discipline cases
Qualitative Interpretive Methodology

Dr. Patricia Benner, of the University of California at San Francisco guided development of the study methodology.

Practice Breakdown Study Goals:

- To articulate errors—language to describe what boards are seeing in practice breakdown cases.
- To link data about errors with identified characteristics.
- To link data about errors with identified patient outcomes.
- To test these relationships.

TERCAP Research Questions:

- What patient characteristics are associated with different types of error?
- What nurse characteristics are associated with different types of error?
- What educational characteristics are associated with different types of error?
- What system factors are associated with different types of error?
- What types of health care institutions are associated with different types of error?
TERCAP Research Questions

- What clusters of types of errors are associated with primary types of error?
- What types of errors are associated with different levels of patient harm?
- What licensure types are associated with different types of errors?
- What work context, such as scheduling, staffing levels and timing of incident are associated with different types of error?
- What patient record types are associated with different types of error?

Practice Breakdown Study

**Year One (FY2000)**

- Collected 12 cases, using detailed information available in case files (files redacted of names and identifiers)
- Conducted in-depth analysis of cases
- Tracked case elements and recurring themes
- Began to develop audit instrument: A Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP)

**Year Two (FY2001)**

- Collected and analyzed additional cases
- Refined TERCAP
- Began to develop TERCAP Coding Protocol
- Developed plan for monograph based on pilot cases
- Began to explore outside funding
### Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP)

#### Tracks Contextual Data
- Setting elements
- Nurse’s description of events
- Health care team contributions
- System issues

#### Tracks Patient Profile
- Patient demographics
- Patient characteristics involved in the practice breakdown

#### Tracks Nurse Profile
- Nurse demographics, including education
- Continued competence activities
- Nurse practice history
- Nurse other history

#### Tracks Practitioner Contributions
- Nurse inexperience with situation
- Unfamiliar setting
- Multiple/repeat occurrences
- Conflict and/or communication breakdown
- Understandable (though wrong or competing) rationale for action taken
- Lack of correction of identified impairment
- History of prior corrective actions/discipline — employer
- History of prior complaints/discipline by board of nursing
**Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP)**

**Practice Breakdown Categories**
- Lack of Attentiveness/Surveillance
- Lack of or Faulty Intervention
- Lack of Professional Responsibility/Patient Advocacy
- Inappropriate Judgment
- Missed or Mistaken Order
- Lack of Prevention
- Documentation Errors
- Medication Errors

**Case Study**
- Nurse assigned eight patients, difficult assignment with combination of serious medical problems as well several fresh post-op patients
- Two patients conditions deteriorated simultaneously, one was identified, the other was not

**Case Study**
- Lack of attentiveness
- Lack of effective monitoring
- Undetected signs and symptoms
- Failure to intervene
- Communication failure
- Failure to supervise assistive personnel
1. Lack of Attentiveness

**Situations when:**

- Nurse did not know what needed to be known or observed about patients and/or staff.
- Nurse failed to observe and stay on top of what is happening with patients and/or staff.

---

Lack of Attentiveness

- Related to specific patients and their needs
- Related to nurse’s omissions or errors
- Related to specific patient characteristics

---

Related to specific patient needs

- 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 signs and symptoms
- Need for care tailored to history, anticipated needs
Lack of Attention:
Related to nurse's omissions or errors

- Lack of effective monitoring for an unsafe time period
- Not detecting substandard care
- Not recognizing error
- Lack of attentiveness due to business or short staffing

Lack of Attention:
Related to Patient Characteristics

- Infant or child
- Elderly
- Cultural conflict/misunderstandings
- Language difficulties
- Cognitive abilities
- Developmental disability
- Mental status
- Diminished functional ability or specific disability due to illness or therapies
- Post anesthesia
- Post surgical
- Other

2. Lack of Professional Responsibility/Patient Advocacy

- Nurse misunderstood or violated the nurse-patient relationship
- Nurse did not put patient needs first
- Nurse did not act responsibly in protecting patient and patient family vulnerabilities
3. Lack of or Faulty Intervention

Nurse failed to act or acted incorrectly on behalf of a patient.

Lack of or Faulty Intervention

- Endangerment of patient due to lack of intervention by nurse
- Error in performance of procedure or intervention
- Delay in procedure or treatment
- Directing substandard care

Lack of Professional Responsibility/Patient Advocacy

- Did not notify physician or other health care provider of patient condition
- Lack of insight regarding patient needs
- Specific patient requests or concerns unattended
- Inappropriate withholding of treatment
- Mistreated or diminished sense of patient safety
- Lack of respect for patient or family concerns and dignity
- Patient abandonment
- Deliberate error cover-up
- Boundary violations
- Breach of confidentiality
- Attributed responsibility to others
- Failed to act due to lack of reimbursement
4. Inappropriate Clinical Judgment

Nurse exhibited inappropriate decision-making, a lack of critical thinking, or good clinical judgment.

---

Inappropriate Clinical Judgment

- Lack of assessment, information
- Not detecting faulty or missing information
- Not recognizing clinical implications of signs, symptoms, or interventions
- Inappropriate priorities
- Tunnel vision
- Inappropriate intervention
- Poor judgment related to medication administration
- Operating new equipment without orientation/training
- Inappropriate acceptance of delegation/assignment
- Acceptance of inappropriate patient care assignment
- Inappropriate care

---

Inappropriate Clinical Judgment

- Poor judgment in the supervision of others
  - Inappropriate patient care assignment
  - Inappropriate delegation/assignment
  - Expectations not clearly communicated
  - Inadequate monitoring of nursing staff
  - Lack of follow-up on problems
  - Failure to evaluate effectiveness of delegation or assignment
5. Missed or Omitted Orders

Situations when an error involved missing or mistaken orders

Missed or Omitted Orders

- Did not notify provider of patient condition
- Missed order
- Misinterpreted telephone or verbal order
- Misinterpreted handwritten order
- Physician or provider error undetected, resulting in execution of inappropriate order
  - Failed to identify
  - Failed to confront
  - Failed to go up chain of command

6. Lack of Prevention

Situations when usual measures to prevent hazards or complications due to hospitalization or illness were not taken.
Lack of Prevention

- Failure to take preventive measures
- Breach of infection precaution
- Breach of universal precautions
- Breach of specific infection precautions
- Administers unsterile IV
- Used contaminated equipment
- Did not recognize equipment failure

7. Documentation Errors

* Situations involving *

- Deliberate documentation errors
- False documentation or
- Lack of documentation

Documentation Errors

- Deliberate changing/falsification to cover-up error
- Falsification of records/other
- Failure to document care that was provided
- Pre-charting
- Failure to document accurately
- Erroneous charting
- Lack of documentation of observations or actions
8. Medication Errors

Situations involving errors in the administration of medications

This section of TERAQP adapted from NCC MERC medication error taxonomy, used with permission

Medication Errors

<table>
<thead>
<tr>
<th>Information about:</th>
<th>Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Administered medication</td>
<td>- Communication</td>
</tr>
<tr>
<td>- Ordered medication (if different)</td>
<td>- Name confusion</td>
</tr>
<tr>
<td>-</td>
<td>- Wrong route</td>
</tr>
<tr>
<td>-</td>
<td>- Wrong dose</td>
</tr>
<tr>
<td>For both, track:</td>
<td>- Wrong time</td>
</tr>
<tr>
<td>- Name of drug</td>
<td>- Wrong patient</td>
</tr>
<tr>
<td>- Dose</td>
<td>- Wrong reason</td>
</tr>
<tr>
<td>- Frequency</td>
<td>- Labelling</td>
</tr>
<tr>
<td>- Route</td>
<td>- Human factors</td>
</tr>
<tr>
<td>-</td>
<td>- Computer error</td>
</tr>
<tr>
<td>-</td>
<td>- Nursing knowledge deficit</td>
</tr>
<tr>
<td>-</td>
<td>- Other</td>
</tr>
</tbody>
</table>

Primary Category of Error

The category of error that the case is most about in relation to patient harm
**Primary Category of Error**

*Consider for Each of the Eight Categories of Error:*

- Was this the most proximal cause to the patient’s harm (or risk of harm)?
- Would the practice breakdown have occurred if this cause had not been present?
- Will the practice breakdown recur if the cause is not corrected or eliminated?
- Was this case about not doing something or doing something incorrectly or inappropriately?
- If you were to refer to this reported practice breakdown as a type of case, what would you call it?

---

**TERCAP Analysis Includes:**

- Health care team contributions
- System contributions
- Outcomes

---

**Health Care Team Contributions**

- Identify other health team members involved
- Contributing factors related to staffing
- Health care team and work environment
### 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 member support

### Contributing Factors Related to Health Care Team and Work Environment

- Unit level conflict/non-supportive environment
- Failure of Health Team communication
- Failure to work together as team

### System Contributions

- Environmental contributions
- Communication factors
- Employee safety/support factors
- Leadership/management factors
- Backup and support factors
Environmental Contributions

- Lighting
- Noise level
- Frequent interruptions/disruptions
- Equipment failure
- Power failure
- Physical environment hazards
- Similar/misleading labels (other than meds)

Communication Factors

- Communication Systems
- Communication breakdown
- No adequate channels for resolving disagreements
- Record inaccessibility
- Computer down
- Verbal orders
- Preprinted orders
- Telephone orders
- Patient Counseling
- Failure to provide patient identification

Employee Safety and Support Factors

Lack of detection and intervention for impaired nurse
- Drug/alcohol
- Functional ability
- Mental health
- Other
Leadership / Management Factors

- Unclear scope and boundaries of authority
- Poor supervision by others
- Inadequate/non-current policies and procedures
- Assignment/placement of inexperienced personnel
- Unreliable nurse extenders
- Nursing shortage, sustained, at institution level
- Overwhelming assignments
- Frequent change in critical circumstances

Backup and Support Factors

- System for covering patient care
- Lack of availability of healthcare professionals
- Lack of adequate response by lab/rx/pharmacy
- Lack of adequate response, other departments

Other Factors

- Lack of orientation and training
- Lack of ongoing education and training
### Patient Outcome

**NO HARM**
- Circumstances or events have capacity to cause harm (risk of harm)

**ERROR, NO HARM**
- Error occurred, did not reach patient
- Error occurred, reached patient, no harm
- Error occurred, reached patient, required increased patient monitoring but no harm

### Patient Outcome

**ERROR, HARM**
- Error occurred, resulted in need for treatment or intervention, caused temporary patient harm
- Error occurred, resulted in initial or prolonged hospitalization, caused temporary patient harm
- Error occurred, resulted in permanent patient harm
- Error occurred, resulted in a near-death event

**ERROR, DEATH**
- Error occurred that resulted in patient death

### Nurse Outcome

**Resolution of Complaint**
- Dismissal
- Alternative program
- Disciplinary process
  - Type of Board action
  - Type of requirements in Board Order
Implications for Nursing Regulation

- Encourage use of TERCAP by board investigators
  - Provides language to articulate errors
  - Assists in describing what investigator sees
  - Promotes complete and consistent data collection
  - Provides guidelines for questioning regarding each error category
- Identify risk factors for practice breakdown
- Collaborate with educators to identify areas for improving education
- Collaborate with nursing service to identify high risk situations and develop safeguards
- Facilitate proactive regulation before harm occurs rather than waiting for problems to be reported

Next Steps

- Respond to IOM report using TERCAP to design uniform processes for distinguishing human error from wilful negligence and intentional misconduct
- Publish book on pilot cases
- Create NCSBN repository for nursing error data
- Use knowledge to promote error detection, reporting and error prevention
- Use knowledge to develop resources to support boards of nursing
- Use knowledge to promote transformation of nursing work processes and environment

Long Term Goals

- Promote wide use of TERCAP by boards to track and study practice breakdown
- Explore use of TERCAP by health care institutions to track error data
- Explore external funding to support larger research sample
- Learn from the experiences of nurses
- Use that learning to identify opportunities to promote patient safety by preventing future nursing practice breakdown
Thank You!
Practice, Regulation & Education Committee Forum

Cookie Bible, APN
Chair, NCSBN PR&E Committee

Barbara Newman, RN, MS
Chair, NCSBN PR&E Model Revisions Subcommittee
2004 PR&E Committee

Cookie Bible, BSN, RN, APN, Chair
Mary Colbath, PhD, RN
Sara Dohi, MSN, RN
Mary Sallier, MS, RN, CS
Rose Keaneus-Nunnery, RN, PhD
Barbara Knopp, RN, MSN
Theresa B. Shipp, MSN, CNM
Robin Vojt, PhD, RN, FNAP
Mary Shubbaugh, MSN, RN, Board Liaison

Staff
Wanda Sheehy, BA, RN, Director of Practice and Regulation
Nancy Spencer, MS, Executive Director, Constituencies
Deborah Young, Practice and Regulation Administrative Assistant

Relationship to Strategic Plan

Strategic Initiative II Regulatory Effectiveness

Outcome A

Effective strategies are identified to assist Member Boards to respond effectively to critical issues and trends impacting nursing education, practice and regulation.

Outcome C

Approaches and resources are developed to address issues related to assistive personnel.
2004 PR&E Activities

- Planned 2004 Patient Safety Summit
- Contributed to planning of NCSBN research looking at educational elements
- Began planning for ongoing systematic review of nursing education research
- Developed a formal collaboration with the Vermont Nurse Internship Program (VNIP), which transitions nurses from education to practice

2004 PR&E Activities

- Developed white paper on approval models for board of nursing
- Received report on proposed CCNE standards for accreditation
- Review results of a member board survey on disabled nurses
- Worked with three subcommittees

2004 PR&E Subcommittees

International Nurse Subcommittee
- Reviewed report from the subcommittee and provided feedback

PR&E Delegation Subcommittee
- Met with chair to provide direction for subcommittee
- Reviewed and provided feedback on PR&E Delegation Subcommittee two-year work plan

PR&E Models Revision Subcommittee
- Reviewed and provided comment on draft models
**International Nurse Subcommittee**

Julia E. Gould, RN, MS; GA; Area III, Chair  
G. Joan Sherwood, RN, MSN, MN; KS; Area II  
John Biren, RN, MS; OH; Area II  
Joyce A. Bonick, RN, BA, ID; KY; Area III  
Donald E. Remick, RN, MS; NV; Area I  
Noreen Clair-Rice, RN, MSN; CA; Area I

**Staff**  
Nancy Charlick, PhD, RN, CAE; Director of Credentialing  
Carin Zager, Credentialing Administrative Assistant

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**PR&E Delegation Subcommittee**

Cheryl Koski, MN, RN, CS; Area I, Chair  
Sue Doreen, RN, BSN; Area III  
Julie George, RN, MSN; Area III  
Judith Hiner, RN, CNA, BC; Area II  
Janette E. Wackerly, RN, MBA; Area I  
George Herbert, MA, RN, APN, C; Area IV  
Mark Majek, MA, PHR; Area III, Board Liaison

**Staff**  
Vickie Sheets, JD, RN, CAE; Director of Practice and Regulation  
David Herley, Practice and Regulation Administrative Assistant

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**PR&E Models Revision Subcommittee**

Barbara Newman, RN, MS; MD; Area IV, Chair  
Maura Egan, BSN, MPH, PhD; WA; Area I  
Kathryn Goldman, JD; KY; Area II  
Carol Swink, PhD, NE; Area III  
Cynthia VanWingerden, RN, NE; WI; Area IV  
Sandra Wald-Boeker, BSN, MS, PhD, IL; Area II  
Debra Scott, MS, RN, APN; NV, Area I  
Barbara Moncrief, RN, DNP, Area III  
Donna Dorsey, MD, RN, FAAN; Board Liaison

**Staff**  
Vickie Sheets, JD, RN, CAE; Director of Practice and Regulation  
David Herley, Practice and Regulation Administrative Assistant
PR&E Committee Recommendation to Delegate Assembly

Adopt the Model Nursing Practice Act and Model Nursing Administrative Rules.

Subcommittee’s Goal:
A User-Friendly and Useful Resource

- Principled
- Current and timely
- Easily accessible
- Easily updated
- Reflective of realities
- Blueprint of critical elements
- Guide for forward thinking

Highlights of Proposed Models

- New format
- International nurses
- Nursing education
- Continued competence
- Alternative to discipline
- Nurse Licensure Compact
- APRN Compact
New Format

- Model Nursing Practice Act and Model Nursing Administrative Rules presented side-by-side
- Model Act provides framework for rules
- Statute and rule language
  - Authority
  - Congruency
  - Usability

Nursing Education

- Fine-tuned nursing education standards
- Incorporated IOM competency recommendations
- Identified required components for graduate education preparing APRNs
- Nursing program approval process

Continued Competence

- Minimum practice hours requirement
- Promotes currency of practice
- 900 hours in last three years
- Subject to audit
- Licensee responsible for demonstrating to the Board how activities constitute nursing practice
Alternatives to Discipline

- Chemical dependency
- Practice remediation

Compacts

- Nurse Licensure Compact and rules
- APRN Compact and rules

Questions and Feedback