THE PROCESS OF WORK RE-ENTRY FOR NURSES AFTER SUBSTANCE USE DISORDERS TREATMENT: A GROUNDED THEORY STUDY

2016 NCSBN Scientific Symposium
Chicago – October 6, 2016
Deborah Matthias-Anderson, PhD, RN, CNE
Awards received:

- National Council of State Boards of Nursing (NCSBN) Center for Regulatory Excellence (CRE) grant
- School of Graduate Studies 2014 Summer Doctoral Fellowship, UND
- 2014-2015 Sharon O. Lambeth Graduate Student Scholarship (UND College of Nursing and Professional Disciplines)
Nurses with SUDs:

- Prevalence studies indicates SUD prevalence rate in nurses is similar to general population: Around 10% - (Monroe, Kenaga, Dietrich, Carter, & Cowan, 2013).
- Certified registered nurse anesthetists have high prevalence rates of SUD - (Wright et al., 2012).
- Nurses use prescription drugs (especially opioids) at a higher rate - (Baldisseri, 2007; Cook, 2013; Dunn, 2005).
- Opioids are the most common illicit drugs of abuse for nurses who are in monitoring programs - (Bettinardi-Angres, Pickett, & Patrick, 2012).
- Gender: over 90% of RNs are females - (US Bureau of Labor Statistics, 2012)
- Stigma about SUDs versus nursing’s image
  Gallup Poll: “Americans Rate Nurses Highest on Honesty, Ethical Standards” (2014)
ADDITIONAL BACKGROUND

**Risks**

Stressful work settings  
Family history of SUD or trauma  
Nursing’s unique relationship with narcotics:  
  - Access to addicting medications  
  - Knowledgeable about pharmacology  
  - Nurses often start using opioids for legitimate reasons  
Keep SUD secret / hidden

--NCSBN (2011)

**Consequences**

Patient safety  
Impact on health / career of nurse  
Impact on the profession of nursing & healthcare systems  
Alternative-to-discipline programs in most states  
Better treatment outcomes for nurses

*Bettinardi-Angres, Pickett, & Patrick (2012)*
PAST LITERATURE: SUDS AMONG NURSES

Early Research: Attitudes, risk factors, determining prevalence

Research on Regulatory Monitoring Models: Alternative versus disciplinary (BON) programs

MISSING: Work Re-entry experiences from the perspective of the individual nurse
A Grounded Theory Study on Work Re-entry of R.N.s after SUD Treatment

Purpose of Study
To explicate a substantive theoretical model that describes the basic social processes operating when a registered nurse re-enters the workplace after substance use disorder (SUD) treatment.

Research Questions
1. What helped the registered nurse re-enter the workplace after completion of SUD treatment?
2. What acted as barriers to the registered nurse’s re-entry to the workplace after completion of SUD treatment?
3. What does a registered nurse experience in actualizing workplace re-entry after completion of SUD treatment?
INCLUSION CRITERIA & RECRUITMENT

- Current registered nurse (RN) license to practice nursing
- Completion of minimum of one SUD treatment at a state licensed or approved treatment facility
- Had re-entered nursing workplace at the professional level of entry of a registered nurse (RN)

Recruitment:
12-step program meetings and clubs, a recovery newspaper in the Twin Cities, a recovery church, announcements on treatment alumni websites and nursing specialty blogs, word of mouth (snowballing), members of Alcoholics Anonymous
DATA COLLECTION

• 22 face-to-face or phone interviews (audiotaped)
• Human subject considerations
• Demographic information
• Semi-structured interview guide
• Field Notes: Memos, reflexive journaling

• Additional Discussions:
  • Nurse leaders / managers
  • Alternative program staff
  • Board of Nursing staff
  • Lawyers who represent RNs
  • Peer support advocates
• Frequent return to literature
• Diagram development & writing
SUMMARY OF PARTICIPANT DEMOGRAPHICS

- **Mean age:** 48.6 years (National median age of RNs [HRSA, 2013]: 46 years)
- **Gender:** 81.8% female (RNs nationally [HRSA, 2013] = 91% female)
- **Race/ethnicity:** 86.4% Caucasian (RNs nationally [HRSA, 2013] = 83.3%)
- 9 out of 22 (41%) held advanced degrees in nursing
- 19 (86.4%) had 10 or more years of experience in nursing
- 9 out of the 22 (41%) had been sober / abstinent for 6 or more years
- **Regions of USA:** 81.8% from Upper Midwest
- **Alternative-to-discipline program involvement:** 86.4% had completed or were currently being monitored
### Participant Identified Drug(s) of Choice (n=22)

<table>
<thead>
<tr>
<th>Drug (single)</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>22.7</td>
<td>5</td>
</tr>
<tr>
<td>Opioids</td>
<td>41</td>
<td>9</td>
</tr>
<tr>
<td>Cocaine</td>
<td>4.5</td>
<td>1</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>9.1</td>
<td>2</td>
</tr>
</tbody>
</table>

### Combination

<table>
<thead>
<tr>
<th>Combination</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Benzodiazepines</td>
<td>4.5</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol/Opioids</td>
<td>9.1</td>
<td>2</td>
</tr>
<tr>
<td>Alcohol/THC</td>
<td>4.5</td>
<td>1</td>
</tr>
<tr>
<td>Methamphetamine/Cocaine</td>
<td>4.5</td>
<td>1</td>
</tr>
</tbody>
</table>

### Self Disclosed Medical Conditions or Trauma History (n=22)

#### Present (n=19)

<table>
<thead>
<tr>
<th>Condition</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pain</td>
<td>4.5</td>
<td>1</td>
</tr>
<tr>
<td>Headaches</td>
<td>13.6</td>
<td>3</td>
</tr>
<tr>
<td>Insomnia/Sleep Related Condition</td>
<td>13.6</td>
<td>3</td>
</tr>
<tr>
<td>Physical Condition (unspecified)</td>
<td>13.6</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health Disorder (Depression, Anxiety, PTSD, ADHD)</td>
<td>31.8</td>
<td>7</td>
</tr>
<tr>
<td>Childhood Trauma / Abuse</td>
<td>9.1</td>
<td>2</td>
</tr>
<tr>
<td>Absent or not disclosed</td>
<td>13.6</td>
<td>3</td>
</tr>
</tbody>
</table>
FINDINGS:
WHAT HELPED THE RN RE-ENTER THE WORKPLACE AFTER SUD TREATMENT?

External Facilitators:
• Recovery support
• Healthy boundary setting
• Re-evaluation of career trajectory
• Encounters with state boards of nursing & alternative-to-discipline programs

“Number one is put recovery first. That is absolutely the prime objective of the thing, because the minute that it’s not, you’re going to lose the job, you’re going to lose whatever you managed to hold onto, and it’s just going to be gone. That is the absolute first thing.”

Internal Facilitators:
• Professional nursing identity
• Acceptance of “self as addict”
• Valuing healthy self-care
• Accountability due to monitoring

• “Nursing was more than just what I did. It really was a big part of my identity; it was a source of great pride for me.”
• “I love what I do…I never thought I wasn’t going to go back to it. I guess it really is a part of my identity.” --Participant quotes
FINDINGS:
WHAT ACTED AS BARRIERS TO THE RN’S RE-ENTRY TO THE WORKPLACE AFTER SUD TREATMENT?

External Barriers:
• Lack of education about SUDs
• Financial stressors
• Wait-time for license decisions
• Difficulty finding employment
• Returning to work too soon
• Co-morbid medical conditions

“Ironically, the very profession (nursing) that is supposed to be about healing and caring doesn’t get the disease concept (of SUD).”

Internal Barriers:
• Stigma
• Shame
• Fear

“Nurses aren’t disposable. I think our profession needs to understand that and do everything they can to intervene with someone who’s got a problem as soon as possible, and do it compassionately, lovingly, without the punishment, and without the shame.”

--Participant quotes
FINDINGS:
WHAT DOES A RN EXPERIENCE IN ACTUALIZING WORKPLACE RE-ENTRY AFTER SUD TREATMENT?

• Self-redefinition
• Perseverance
• Honesty with self & others
• Hope

“[First you must be] accepting of yourself as who you are in the [SUD] disease process...and then deal with the professional, because the professional is not the biggest aspect; it’s who you are and whether or not you’re willing to change that is going to affect the professional part. Because, if you don’t change, [the professional nursing part] doesn’t matter.”

--Participant quote
THEORETICAL MODEL: SUCCESSFUL WORK RE-ENTRY

Matthias-Anderson, 2015

- Self re-definition: Acceptance of self as person (and nurse) with SUD
  - Redefines personal perceptions, values, and priorities ("Puts recovery first")
    - Re-defines relationships and support (actively engages in recovery)
    - Re-defines nursing relationships (changes career trajectory)
  - SUD treatment and recovery
  - Regulatory mandates
  - Healthcare work environment
DISCUSSION: STUDY IMPLICATIONS

Nursing Regulation and Policy
- Lengthy wait time for BONs to investigate & make decisions
- Differences in alternative programs and BON policies among states

Education, Education, Education!
- Nurse managers / supervisors / worksite monitors
- Staff development / continuing education
- Nursing Education: Curriculum development
- BON member education / orientation

SUD Treatment Services
- Lack of clarity about evidence on which nurses are treated for SUDs
DISCUSSION: RECOMMENDATIONS FOR FUTURE RESEARCH STUDIES

• Nurses who choose not to return to work
• Length of time taken off before work re-entry
• Professional nursing identity and its role in recovery and work re-entry
• Co-morbid disorders and SUD development
• Alternative program & B.O.N. differences (national study)
• National study of SUD treatment facilities with nurses and/or health professional treatment tracks
• Healthcare system policies related to work re-entry of nurses and other healthcare professionals with SUDs

NEEDED: National dissemination of research findings and information to expand body of literature on these topics
STUDY LIMITATIONS

- Homogeneity among participants re: geographic locations
- Homogeneity among participants re: co-morbid conditions
- Only studied nurses with a work re-entry experience
CONCLUSIONS

- Work re-entry success after SUD treatment is possible:
  - Requires diligent attention to recovery strategies
  - Healthy self-care practices
  - Willingness to change career goals
  - Risk being honest about SUD status
- Practicing nurses in recovery self-identify that they are *better nurses*
- *Need for education* and *decreasing stigma* are priority concerns

More RESEARCH on the topic is needed
ACKNOWLEDGEMENTS

• NCSBN Center for Regulatory Excellence
• Nancy Darbro, PhD, RN, CNS, former executive director of the New Mexico Board of Nursing, NCSBN grant consultant
• Eleanor Yurkovich, EdD, RN, FAAN, professor emeritus, methods advisor, College of Nursing and Professional Disciplines, University of North Dakota

A special thank you to the 22 RN participants who shared their experiences of recovery and work re-entry after SUD treatment


National Regulatory Capacity and Nurses and Midwife Leaders’ Perceptions of the African Health Profession Regulatory Collaborative for Nurses and Midwives (ARC): Evaluation of Four Years of ARC East, Central and Southern

Maureen Kelley CNM, PhD, FAAN
Clinical Professor Emory University
ARC: Project Overview

- 4-year initiative funded through PEPFAR
- Regional collaborative – sub-Saharan Africa
- Supports nursing and midwifery leaders
- Improving regulation for HIV service delivery
- Utilizes cross-country collaboration
Key ARC Participants: “The Quad”

- Ministry of Health Chief Nursing Officer (CNO)
- Nursing and Midwifery Professional Association
- Health Professional Training Institutions
- Nursing and Midwifery Regulatory Council
- Service delivery, health policies
- Professional standards and compliance
- Pre-service and continuing education
- Voice to Government for health workers and members

The ARC Approach

Adapted from the Institute for Healthcare Improvement (IHI) model for breakthrough organisational change

Legend

AP: Action Period   LS: Learning Session

Call for Proposals
Recruit Expert Faculty

Review Country Team Proposals
Enroll Selected Country Teams

Summative Congress
AP 1  Learning Session 1
May-Jul

Action Period 1

AP 2  Learning Session 2
Jul-Nov

Action Period 2

AP 3
Nov-Feb

Action Period 3

Summative Congress
End
ARC Year 4

FEB 2015

FEB 2016
The ARC Approach

- **Cross-Country Collaboration**
  - Annual Summative Congress
  - Two learning sessions for countries awarded grants
  - Platform: lessons learned, exchange tools, technical assistance

- **Regulation Improvement Grants**
  - Annual competitive process with external peer review
  - Support to address a nationally-identified regulation priority

- **Targeted Technical Assistance**
  - For grantees and countries without grants

- **Evaluation**
  - Regulatory Function Framework - stages of change
Objectives of evaluation research study

• Categorize countries across five stages of development of regulatory function from planning to optimizing

• Describe inter- and intra-organizational relationship and networking gains achieved through the ARC-ECS initiative
The RFF comprises seven regulatory functions:

1. Legislation – creating or revising nursing/midwifery
2. Registration – systems and data use
3. Licensure
4. Scope of Practice
5. Continuing Professional Development (CPD)
6. Pre-service Accreditation
7. Misconduct and Disciplinary Powers

Regulatory Function Framework (RFF)

Each Function has Five Stages

Stage 1 → Stage 2 → Stage 3 → Stage 4 → Stage 5
## Continuing Professional Development

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
<th>Stage 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD does not exist. CPD is voluntary. CPD framework for nursing may be in planning phases.</td>
<td>Council has a mandate in law to require CPD. National CPD framework has been developed. CPD in pilot phases.</td>
<td>CPD program is finalized and nationally disseminated. CPD is mandatory for re-licensure. Strategy in place to promote and track compliance.</td>
<td>Electronic system in place track compliance. Penalties exist for CPD non-compliance. Available CPD includes content on HIV service delivery.</td>
<td>Multiple types of CPD available. CPD content aligns with regional standards or global guidelines. Regular evaluations of CPD program carried out.</td>
</tr>
</tbody>
</table>
## Regulatory Function Framework (RFF)

### Key Regulatory Functions Performed by a National Regulatory Body

<table>
<thead>
<tr>
<th>Registration and Data Collection</th>
<th>Capability Stages of Regulatory Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1 Planning</strong></td>
<td><strong>Stage 2 Developing</strong></td>
</tr>
<tr>
<td>Paper registration system; Only public sector nurses captured; Renewal of registration not required.</td>
<td>Both paper &amp; electronic system used; Renewal of registration required.</td>
</tr>
</tbody>
</table>

### Licensure System

| License not required to practice or license granted when nurses are registered; no separate licensing examination exists; private nurse clinics not licensed. | Licensure renewal is required; Licensure exam required to practice. Compliance with renewal less than 50%. | Licensure exam is separate from completion of program exam. Renewal of licence required; Compliance below 80%. | Licensure examination is updated every year. Compliance with renewal of licence is enforced. | Licensure examinations are electronic & scored immediately. Examination content aligns with regional standards or global guidelines. |

### Continuing Professional Development

| Ministerial policy for CPD in place; National CPD framework for nurses and midwives in planning stages. | National CPD framework in pilot or early stages. CPD not yet required for re-licensure. | CPD program in place across the country. CPD is required for re-licensure tracking system not yet fully electronic. | CPD content is accredited. Electronic tracking of CPD in place. Various levels of CPD compliance exist. | Multiple models of web-based CPD available. CPD content aligns with regional standards or guidelines requirement fully enforced. |

### Accreditation of Pre-Service Education Training

| Accreditation system not in place or still in planning stage; training programs or schools not accredited. | Accreditation of public school; Accreditation visits not regularly carried out; Accreditation criteria not standardized; no renewal of accreditation status required. | Between 50-90% of all training programs and schools accredited; renewal of accreditation required but low compliance; Accreditation standardized nationally. | Over 90% of all training programs and schools are accredited; renewal required; accreditation criteria are harmonized regionally and meet global standards. | Accreditation criteria align with regional standards or global guidelines. Institution scores are posted online. 100% schools have been visited. |
Initiative Impact
ARC Grants – National Investments

• 7 countries – Establish CPD programs
• 12 countries – Advance CPD programs
• 5 countries – Review and revise SOPs
• 3 countries – Review and update acts/regs
• 1 country – Decentralize council services
• 2 countries – Develop entry to practice exams
ARC Impact on CPD: Y1-Y4
ARC Year 4 Grantees

• Continuing Professional Development
  – Ethiopia, Kenya, Rwanda, Tanzania, Zambia, Lesotho, Seychelles, Zimbabwe

• Licensure
  – Mozambique (OSCE)

• Accreditation
  – South Africa (Specialty License – HIV/AIDS Care)

• Scope of Practice
  – Botswana
Advancement by Regulatory Function Stage for ARC Year 4 Grantees
Teamwork, Networking and Inter-Organizational Relationships

• Tool was developed that asked the 17 countries to what extent they engaged in these activities prior to initiation of ARC and during year 4 (using a 5 level scale)

• Open ended questions were also asked about these aspects of their work together

• Questionnaire was self-administered to each country team
QUALITATIVE RESULTS
Teamwork among National Nursing Leaders

• Teamwork: Quad members tended to work in isolation from each other prior to ARC
  – “prior to ARC each nursing pillar operated individually. There was miscommunication, a lack of coordination and wasted resources...currently the pillars are working together with a common goal”
Relationship-building between QUAD organizations

- Relations between Quad organizations prior to ARC were described as being poor to moderate, with 5 countries indicating weak or very weak ties.
- At the end of ARC Y4, all but 3 Quads described inter-organizational relationships as strong or very strong.
Relationship building with other organizations

• Prior to ARC, 5 Quads reported having moderate ties to non-ARC organizations, and 8 reported that these relationships were weak or very weak

• After 4 years of ARC engagement, Quads reported having much stronger relationships with other organizations, including local CDC offices, international NGO’s and UN groups
Networking with Quads from other ARC countries

• ARC has also promoted regional networking between Quad teams from participating countries.
  – “we now attend frequent and interactive meetings. Topics of common interest are presented and discussed, and guidance is provided to strengthen regulatory capacity. There is consultation with other nurse leaders from various countries”
Summary

• ARC initiative has demonstrated that sustained investment in a south-to-south regional collaboration can yield important and measurable impacts on health workforce regulation.

• There were significant gains in nursing leaders’ teamwork, organizational collaboration and cross-country networking.
THANK YOU
LEARNING FROM EXPERIENCE: Quantitative Analysis of Variables that Impact the Licensure of Internationally Educated Nurses

October, 2016
Internationally Educated Nurses
LFE Project Purpose

Use evidence to improve the efficiency of the IEN application process

Objectives

• be evidence-informed
• be transparent, be clear
• build capacity
LFE Project Overview

Baseline analysis of application data (characteristics, outcomes, timelines)

Policy and practice review and implementation of changes

Pre- & post-implementation data analysis, additional projects
Data Analysis

Exploratory Analysis
- Data management and cleaning
- Frequency, cross-tabulations, chi-squared tests
- Univariate and bi-variate analysis

Confirmatory Analysis
- Stepwise selection of variables
- Multi-level regression modelling

Timeline Analysis
- Average times
- Cumulative times

Exemplar Analysis
- Comparison of groups with similar characteristics
- Outcomes
- Average times
- Cumulative times
Important Characteristics

• Education Credential
• Educated Where the Scope of Practice is Similar to Canada
• Practice Currency
• Number of Years Since Last Practiced or Graduation
• Consolidation of Education
Average Times

- **656 days** to complete the IEN assessment for registration process
- **537 days** if Temporary Permit (TP) eligible on initial assessment
- **589 days** if TP eligible following SEC Assessment
- **889 days** if TP eligible following bridging education

*Does not include the time required for the applicant and source organizations to submit the documents or information to complete the application which may be an additional 1 month to 2 years.*
Policy and Practice Changes

- LFE Data Findings
- Experience and Expertise
- Existing Practice

Policy and Practice Changes
Initial Assessment

Substantial equivalence based on a combination of education and experience

- Temporary Permit Eligible
- SEC Assessment/ Bridging Education Option
- Referred for SEC Assessment
- Ineligible
STEP 1 – Ineligible Criteria
Does the applicant meet any one of these criteria?

- ☐ Not educated as an RN
- ☐ Not educated at a post-secondary equivalent level
- ☐ No RN licensure in the jurisdiction of education because did not apply for licensure or did not pass required exams
- ☐ Wrote the June 2006 Philippines nursing exam and did not re-write and pass the exam or Parts III and V of the exam
- ☐ Has not practiced as an RN in ten or more years
- ☐ Does not meet the good character and reputation requirement for registration
- ☐ Attempted a Canadian RN registration examination 3 times and did not pass and has not passed on a re-write allowed by another Canadian jurisdiction
- ☐ Has completed a competency assessment for another Canadian jurisdiction and CARN has determined that identified competency gaps are too extensive to be addressed through bridging education available to CARN applicants

If ANY of the above are checked: STOP ☐ Ineligible Letter

STEP 2 – SEC Assessment Required
Does the applicant meet any one of these criteria?

- ☐ Has not practiced since graduating from an RN program between 4 and 9 years ago
- ☐ Last practiced as an RN between 4 and 9 years ago
- ☐ Failed a nursing registration exam
- ☐ Transcripts or verification of registration not available from source due to extraordinary circumstances
- ☐ Discrepancies or gaps are found between identity documents and other required documents

If ANY of the above are checked: STOP ☐ SEC Required Email

STEP 3 – Criteria for TP Eligibility on Initial Assessment
Does the applicant meet all of these criteria?

- ☐ Baccalaureate degree in nursing considered comparable to an Alberta baccalaureate degree (generalist, 3-4 years of post-secondary nursing education following 12 years of primary and secondary education) received where the scope of registered nurse practice is similar to that in Canada
- ☐ Meets the currency of practice requirement (1125 hours or graduated in the past 5 years)
- ☐ Not more than 12 months elapsed since graduation from their nursing education program or since last practice as an RN

STEP 4 – Criteria to be Eligible for the Direct to Bridging Option
Does the applicant meet any one of these criteria?

- ☐ Nursing education not considered comparable to an Alberta baccalaureate degree (not generalist education and does not have 3-4 years of post-secondary nursing education following 12 years of primary and secondary education)
- ☐ Nursing education received where the scope of nursing practice is not similar to Canada
- ☐ Graduated between 24 and 48 months ago and does not have any registered nurse work experience
- ☐ Last practiced as a registered nurse between 24 and 48 months ago

If none of the above in Step 4 is evident BUT the applicant took more than one year to start working after graduation, give the file to the Registrar who will review the file to determine course of action for assessment

STEP 5

Applicant Name: ____________________________
Stakeholder #: ______________________________
Start Date: ___________ End Date: ____________
Assessment Completed By: ____________________

If ANY of the above are checked: ☐ SEC Required Email

If ALL of the above are checked: ☐ TP Eligible Letter

If ANY of the above are checked: ☐ Ineligible Letter

If NONE of the above are checked: ☐ SEC Required Email
Bridging Education

Managed by CARNA

Self-Managed
Application Time Limits

2 year rolling

Phased Approach
Communications

Website
Self-assessment tool
Email
Letters
Video
Evaluation of Changes

- Established and clarified expectations
- Bridging education logistics and capacity
- Demographics reflect recruitment initiatives
- Outcomes reflected applicants active process
- Checklist and communication tools embedded in practice
- Evidence-informed
- Shorter timelines
- Travel costs
- Data findings and knowledge products useful decision-making
- Enter workforce sooner
Recommendations
Impact
Internationally Educated Health Professionals Initiative

Research Partners

Expert caring makes a difference®
Cathy Giblin, Registrar/Director, Quality Assurance

cgiblin@nurses.ab.ca
Regulation of internationally qualified nurses and midwives

Tanya Vogt, Executive Officer, Nursing and Midwifery
National Registration and Accreditation Scheme
The National Scheme

• Established in 2010
• Health Practitioner Regulation National Law Act as in force in each state and territory (The National Law)
• 14 health profession boards (National Boards)
• National Boards work in partnership with the Australian Health Practitioner Regulation Agency (AHPRA)

Public protection is at the heart of everything we do
The objectives of the National Law

• **Protection of the public**
• Workforce mobility within Australia
• High quality education and training
• Rigorous and responsive assessment of overseas trained practitioners
• Facilitate access to services in accordance with the public interest
• Enable a flexible, responsive and sustainable health workforce and innovation
National Scheme in numbers (June 2016)

- 657,621 practitioners across the 14 professions
- 380,208 nurses and midwives (57.8%)
- 89,620 nursing students and 3949 midwifery students
- 283,555 - Registered nurses (74.5%)
- 63,115 - Enrolled nurses (LPN) (16.6%)
- 29,656 - RN/EN and midwives (7.8%)
- 4,182 – Midwives (1.1%)
Nursing and Midwifery Board of Australia
Role of NMBA

• Develop registration standards, codes and guidelines for nurses and midwives
• Approve accreditation standards and accredited programs of study
• **Oversee assessment of internationally qualified nurses and midwives**
• Oversee registration and notification functions related to nurses and midwives (management delegated to AHPRA and state/territory boards)
Assessment of IQNMs in Australia
IQNM applications received by Australia

- Philippines - 22.9%
- India & Nepal - 29.7%
- United Kingdom - 29.0%
- USA - 3.8%
- Canada - 3.2%
- South Africa - 1.4%
Criticism of assessment of IQNMs in 2013

2013
Tribunal decisions that were critical of NMBA policy of assessing international applicants:
• Palatty (WA)
• Shankaran (SA)

Led to NMBA seeking legal advice:
• Previous *Framework* for assessing international applicants inconsistent with the National Law
• Work experience only relevant for Recency of Practice
## Previous framework vs current interim model

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<thead>
<tr>
<th>Previous framework</th>
<th>Interim model (current)</th>
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<tbody>
<tr>
<td>Post-qualification work experience considered during assessment of equivalence of qualification</td>
<td>Considers qualification only in establishing equivalence under s53(b)</td>
</tr>
<tr>
<td>Country-specific framework</td>
<td>Eight qualification criteria that test the fundamentals of each qualification</td>
</tr>
<tr>
<td>Potential for country bias</td>
<td>More equitable assessment approach</td>
</tr>
</tbody>
</table>

### Has led to

- **less favourable** outcomes for applicants from some countries (e.g. UK and Ireland)
- **more favourable** outcomes for applicants from other countries (e.g. Pakistan, Hong Kong)
Current interim model

- Registration standards **define the requirements** that applicants must meet to be considered **fit to practise** as nurses and midwives.

- Qualification criteria **define the minimum acceptable education and training** that international applicants must have undertaken. These criteria are different for registered nurses, midwives and enrolled nurses.
# Interim IQNM assessment model

## Registration standards

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<tr>
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<tbody>
<tr>
<td>1</td>
<td>English language skills</td>
</tr>
<tr>
<td>2</td>
<td>Criminal history</td>
</tr>
<tr>
<td>3</td>
<td>Continuing professional development</td>
</tr>
<tr>
<td>4</td>
<td>Professional indemnity insurance arrangements</td>
</tr>
<tr>
<td>5</td>
<td>Recency of practice</td>
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## Qualification criteria

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<tbody>
<tr>
<td>1</td>
<td>Qualification leads to registration</td>
</tr>
<tr>
<td>2</td>
<td>Accredited education provider</td>
</tr>
<tr>
<td>3</td>
<td>Accredited program of study</td>
</tr>
<tr>
<td>4</td>
<td>AQF level (1–10)</td>
</tr>
<tr>
<td>5</td>
<td>Clinical experience hours (direct)</td>
</tr>
<tr>
<td></td>
<td>Continuity of care episodes (MW)</td>
</tr>
<tr>
<td>6</td>
<td>Course curriculum</td>
</tr>
<tr>
<td>7</td>
<td>Course completion</td>
</tr>
<tr>
<td>8</td>
<td>Evidence of pharmacology</td>
</tr>
<tr>
<td>Criterion</td>
<td>Requirement</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 1 | Qualification leads to registration as a:  
- registered nurse for RN applications  
- midwife for MW applications  
- enrolled nurse for EN applications |
| 2 | Accreditation of education institution |
| 3 | Accreditation of program of study |
| 4 | Level of qualification:  
- Bachelor degree (AQF level 7) for RN and MW applications  
- Diploma (AQF level 5) for EN applications |
| 5 | Workplace experience (as a part of the qualification)  
- 800 hours for RNs  
- Professional experience for MWs (specific)  
- 400 hours for ENs |
| 6 | Course curriculum primarily related to:  
- Nursing for RNs and ENs  
- Midwifery for MWs |
| 7 | All components of course successfully completed |
| 8 | Medication management content |
N MBA-approved outcomes for IQNMs

- **RN/MW:** AQF 7 qual and meets all other criteria  
  **EN:** AQF 5 qual and meets all other criteria

- **RN:** AQF 6 qual solely in mental health/ paediatric/ disability nursing and meets all other criteria

- **RN/MW:** AQF 7 and meets all requirements except medication management (criterion 8)  
  **EN:** AQF 5 and meets all requirements except medication management (criterion 8)

- **MW:** AQF 7 and meets all requirements except continuity of care experience (criterion 5)

- **RN/MW:** AQF 6 qual and meets all criteria except 4  
  **EN:** AQF 4 qual and meets all criteria except 4

- **RN/MW:** Meets criteria 1, 4, 5 & 7 (AQF 7 qual)  
  **EN:** Meets criteria 1, 4, 5 & 7 (AQF 5 qual)

- **RN:** AQF 7 and meets all requirements except workplace experience (criterion 5)  
  **EN:** AQF 5 and meets all requirements except workplace experience (criterion 5)

- **RN/MW:** AQF 5 qual or lower  
  **EN:** Less than AQF 4 or unassessable

- **Refuse**
Processing of IQNM applications

- AHPRA has offices located in each capital city
- IQNM applications are processed in two locations
  - Sydney
  - Perth
Positive outcomes of current interim approach

- Consistent with legislation - National law
- Improved governance
- Apply minimum necessary regulatory response
  - Regulatory Principles
- More rigorous, fair and transparent
- Reduces workforce barriers and increases mobility
Outcomes based assessment
IQNM assessment challenges and complexities

- No universal assessment tool/framework
- Standard of education and accreditation varies
- Labour intensive for AHPRA and the Board(s)
- Need for complex knowledge across multiple countries
Outcomes based assessment (OBA) project

Objective:

To explore the factors to consider and the requirements to establish an outcomes-based assessment of competence to practise for all internationally qualified registered nurses, midwives and enrolled nurses (IQNMs)
Methodology

• Review of published peer-reviewed and grey literature, focusing particularly on literature relating to regulatory requirements and processes.

• A domestic environmental scan of the processes for OBA for competence to practice, currently being used by other regulatory boards within AHPRA.

• An international environmental scan of models of OBA used by nursing and midwifery regulators.
Overall recommendations:

• That the overall assessment process include a **cognitive** and **behavioural** component

• That the OBA process be established exclusively as a high stakes assessment for regulatory purposes not for educational or ‘bridging’ purposes

• That the OBA process be stepped i.e. must pass cognitive before behavioural attempted
Overall recommendations:

• That the **cognitive assessment** component be a computerised innovative item Multiple Choice Questions (MCQ) examination

• That the model of **behavioural assessment** be an Objective Structured Clinical Examination (OSCE)
Cognitive assessment options

**Multiple Choice Questions (MCQ) (recommended)**

**Strengths**
- Valid objective, reliable, time and cost effective
- Allows computerised delivery
- Can include innovative items

**Weaknesses**
- Limited ability to assess the higher level cognitive processes

**CAT MCQ (not recommended unless using existing)**

**Strengths**
- Provides more certainty for candidates who only achieve the minimum standard

**Weaknesses**
- Requires a large bank of testing

**Short answer (not recommended)**

**Strengths**
- Easier to construct, reduce cueing or guessing

**Weaknesses**
- Time consuming, difficult to grade, subjective, not used in most high stake examinations
Behavioural assessment options

**OSCE**
- **Strengths**
  - High ability to assess communication, critical thinking and reasoning and planning
- **Weaknesses**
  - Unfamiliarity with the assessment process can affect performance
  - Complex to design
  - Labour intensive

**WPBA - structured**
- **Strengths**
  - Seen as a more natural clinical environment
  - Can be taken over a significant period of time
- **Weaknesses**
  - Labour and time intensive
  - Competing for clinical placements
  - Serious challenges in ensuring it is objective, fair and valid if unstructured

**Bridging as assessment**
- **Strengths**
  - Ability to ensure all aspects of practice covered
  - Can include orientation to domestic and local content
- **Weaknesses**
  - Lengthy, expensive
  - Difficulty meeting volume of applicants
  - Assumes all applicants need extensive assessment
Assessment framework

• Ensures strong alignment between assessment content and chosen model
• Ensures models recommended are capable of measuring activities and indicators required
• Based on NMBA–approved documents
Proposed OBA assessment

- IQNM applicant
- Determine equivalency
- MCQ
- Register
- Re-sit
- OSCE
- Register
- Re-sit
- ? Education course
- Register
- ? Future targeted courses/bridging to address gaps

Orienting to the Australian context
Next steps
Where can I find more information?

www.nursingmidwiferyboard.gov.au
References and resources

• Section 53 of the National Law, published on the AHPRA website
• Outcomes-based assessment of competence to practise and orientation requirements for IQNMs in Australian healthcare context - Final Report
Retrospective Review of Criminal Convictions in Nursing 2012-2013

Elizabeth H. Zhong, PhD

2016 NCSBN Scientific Symposium, October 6, 2016, Chicago, IL
Outline

1. Introduction
2. Methods
3. Main Findings
4. Conclusions
Introduction - Aims

1. Describe the demographic and licensure characteristics of nurses and nurse applicants who were disciplined by boards of nursing (BONs) for criminal convictions during 2012-2013.

2. Describe the types of crimes that nurses and nurse applicants were convicted of and the actions taken by BONs in response during 2012-2013.

3. Describe whether nurses and nurse applicants with criminal convictions disclosed their criminal histories to BONs.
Research Methods

Retrospective review of nurse and nurse applicant records in Nursys.

Case Selection Criterion

**Case Inclusion:** Any disciplinary actions taken by BONs for a criminal conviction between January 1, 2012 and December 31, 2013 were evaluated.

**Case Exclusion:** Revisions to previous BON actions or reciprocal actions taken by a BON were excluded.
Main Findings

- Licensure Status
- Demographic Characteristics
- Type of Crimes Committed and the Corresponding Disciplinary Actions Taken by BONs
- Disclosure of Criminal Conviction History to BONs
Licensure Status of Study Subjects 
(N=4,819)

- RN (45%)
- LPN/VN (38%)
- APRN (0.1%, not shown in the chart)
- Multiple licenses (5%)
- Applicant (12%)
Licensure

Nurses with LPN/VN licenses were over-represented in the disciplined group with criminal conviction histories.

*Excluding applicants, APRNs, and nurses with multiple licenses

**The National Nursing Database (NCSBN, 2015)
Gender

The majority (77%) of the licensed nurses with criminal conviction were female; 23% were male.

* The National Nursing Workforce Survey, NCSBN, 2015
Among the study group, the incidence of criminality in males is 3 fold higher than in females, while in the criminal offender population, it is 7 times higher than in females.
Age

Nearly half (49%) of the study subjects (n=2,292) were aged 30-44 years.

<table>
<thead>
<tr>
<th>Licensee Group</th>
<th>&lt;=30</th>
<th>31-40</th>
<th>41-50</th>
<th>&gt;=51</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs with criminal conviction</td>
<td>14%</td>
<td>29%</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>RN General Workforce*</td>
<td>11%</td>
<td>20%</td>
<td>21%</td>
<td>48%</td>
</tr>
<tr>
<td>LPN/VNs with criminal conviction</td>
<td>16%</td>
<td>37%</td>
<td>28%</td>
<td>19%</td>
</tr>
<tr>
<td>LPN/VN General Workforce*</td>
<td>12%</td>
<td>20%</td>
<td>24%</td>
<td>44%</td>
</tr>
</tbody>
</table>

### Types of Crimes Committed \((N=6,879)\)

<table>
<thead>
<tr>
<th>Type of Crime</th>
<th>%  (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driving under the influence</td>
<td>29% (1,990)</td>
</tr>
<tr>
<td>Violation of Controlled Substances Act</td>
<td>17% (1,187)</td>
</tr>
<tr>
<td>Theft</td>
<td>16% (1,082)</td>
</tr>
<tr>
<td>Fraud</td>
<td>10% (700)</td>
</tr>
<tr>
<td>Domestic violence/assault</td>
<td>6% (410)</td>
</tr>
<tr>
<td>Sexual offense</td>
<td>2% (110)</td>
</tr>
<tr>
<td>Other</td>
<td>18% (1,220)</td>
</tr>
<tr>
<td>Unknown</td>
<td>3% (180)</td>
</tr>
</tbody>
</table>
## Crimes Involving Patients

*(N=346)*

<table>
<thead>
<tr>
<th>Type of Crime</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theft</td>
<td>22% (76)</td>
</tr>
<tr>
<td>Violation of Controlled Substances Act</td>
<td>21% (73)</td>
</tr>
<tr>
<td>Fraud</td>
<td>20% (70)</td>
</tr>
<tr>
<td>Neglect or abuse of child/adult</td>
<td>9% (31)</td>
</tr>
<tr>
<td>Driving under the influence</td>
<td>8% (28)</td>
</tr>
<tr>
<td>Other</td>
<td>19% (67)</td>
</tr>
<tr>
<td>Unknown</td>
<td>&lt;1% (1)</td>
</tr>
</tbody>
</table>
### Types of Disciplinary Actions

*(N=7,415)*

<table>
<thead>
<tr>
<th>Type of BON Action</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probation of license</td>
<td>22% (1,612)</td>
</tr>
<tr>
<td>Revocation of license</td>
<td>15% (1,101)</td>
</tr>
<tr>
<td>Unspecified licensure action</td>
<td>15% (1,094)</td>
</tr>
<tr>
<td>Fine/Monetary penalty</td>
<td>13% (987)</td>
</tr>
<tr>
<td>Suspension of license</td>
<td>12% (870)</td>
</tr>
<tr>
<td>Reprimand or censure</td>
<td>8% (561)</td>
</tr>
<tr>
<td>Other</td>
<td>16% (1,190)</td>
</tr>
</tbody>
</table>
Nonviolent Crime and Disciplinary Action
(Single Action Against Single Crime)

<table>
<thead>
<tr>
<th>Criminal Conviction</th>
<th>Type of BON Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>DUI (N=304)</td>
<td>Probation of license (49%)</td>
</tr>
<tr>
<td></td>
<td>Unspecified licensure action (15%)</td>
</tr>
<tr>
<td>Violation of Controlled Substances Act (N=140)</td>
<td>Suspension of license (28%)</td>
</tr>
<tr>
<td></td>
<td>Probation of license (24%)</td>
</tr>
<tr>
<td>Theft (N=129)</td>
<td>Unspecified licensure action (23%)</td>
</tr>
<tr>
<td></td>
<td>Probation of license (16%)</td>
</tr>
</tbody>
</table>
## Sexual Offense and Disciplinary Actions
*(Single Action Against Single Crime)*

<table>
<thead>
<tr>
<th>Sexual offense (N=39)</th>
<th>Type of BON Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revocation of license (36%)</td>
</tr>
<tr>
<td></td>
<td>Voluntary surrender of license (26%)</td>
</tr>
<tr>
<td></td>
<td>Suspension of license (21%)</td>
</tr>
<tr>
<td></td>
<td>Reprimand of license (5%)</td>
</tr>
<tr>
<td></td>
<td>Other unspecified license action (5%)</td>
</tr>
<tr>
<td></td>
<td>Probation of license (3%)</td>
</tr>
<tr>
<td></td>
<td>Summary or emergency suspension of license (3%)</td>
</tr>
<tr>
<td></td>
<td>Denial of license renewal (3%)</td>
</tr>
</tbody>
</table>
Disciplinary Action Taken on Patient-Related Crime (*Single Action Against Single Crime*)

<table>
<thead>
<tr>
<th>Action Taken</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revocation of license</td>
<td>41%</td>
</tr>
<tr>
<td>Suspension of license</td>
<td>27%</td>
</tr>
<tr>
<td>Voluntary surrender</td>
<td>14%</td>
</tr>
<tr>
<td>Denial of initial license</td>
<td>5%</td>
</tr>
<tr>
<td>Denial of license renewal</td>
<td>5%</td>
</tr>
<tr>
<td>Censure</td>
<td>5%</td>
</tr>
<tr>
<td>Probation of license</td>
<td>5%</td>
</tr>
</tbody>
</table>

Termination of license (91%, n=20)

Nontermination of license (9%, n=2)
## Types of Single Crimes that Led to Denial of Initial License (N=74)

<table>
<thead>
<tr>
<th>Type of Crime</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theft</td>
<td>23% (17)</td>
</tr>
<tr>
<td>Driving under the influence</td>
<td>22% (16)</td>
</tr>
<tr>
<td>Fraud</td>
<td>14% (10)</td>
</tr>
<tr>
<td>Violation of Controlled Substances Act</td>
<td>11% (8)</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>5% (4)</td>
</tr>
<tr>
<td>Other</td>
<td>4% (3)</td>
</tr>
<tr>
<td>Unknown</td>
<td>22% (16)</td>
</tr>
</tbody>
</table>
## Disclosure of Criminal Conviction History

*(N=4,819)*

<table>
<thead>
<tr>
<th>Disclosure</th>
<th>Licensees</th>
<th>Applicants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported criminal conviction</td>
<td>81% (3,455)</td>
<td>92% (517)</td>
<td>82% (3,972)</td>
</tr>
<tr>
<td>Failed to report criminal conviction</td>
<td>19% (796)</td>
<td>7% (41)</td>
<td>18% (837)</td>
</tr>
<tr>
<td>Unknown</td>
<td>&lt;1% (9)</td>
<td>&lt;1% (1)</td>
<td>&lt;1% (10)</td>
</tr>
</tbody>
</table>
Conclusions

- Male nurses and LPN/VNs were overrepresented in the group of nurses with criminal convictions.
- The most frequent criminal convictions were DUI, violation of Controlled Substances Act, and theft.
- Probation of license was the most common board action; actions in response to crimes involving patients were most severe.
- 18% of nurses and nurse applicants in the study did not disclose criminal histories to BONs.
Areas for Future Research

- Prospective cohort study with current subjects to track subsequent violations
- Longitudinal study of nurses with criminal convictions to determine associations between certain types of crimes and future violations
- Comparison of practice records of nurses who failed to disclose their criminal convictions as compared to those who self-disclosed
Acknowledgements

NCSBN

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Contact Information

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Research Associate
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Thank you!
A Study of the Over-Representation of Males in the Population of Disciplined Nurses

Richard A. Smiley, MS, MA
Maryann Alexander, PhD, RN, FAAN
Carey McCarthy, PhD, MPH, RN
Background

• Criminal Convictions Study (2016): Among the 3,360 study subjects who had been licensed, 23% (n=759) were male, which is more than twice their proportion (8%) in the nursing workforce.

• TERCAP (2015): Among the 2,696 nurses board actions for committing a practice breakdown, 85% of them were female and 15% were male.

• A review of ten years (2003-2013) of NCSBN disciplinary data indicated that 17% of discipline involved male nurses.
Why are men over-represented in studies of nursing discipline?
Literature Review

• Men commit more crimes than women (Surowiec, 2011)
• Evidence of bias, discrimination, and inequalities faced by male nurses in comparison to female nurses (Anthony, 2004; Armstrong, 2002; Burtt, 1998; Evans, 2002; Nilsson, 2005).
• Men in professions traditionally seen as “women’s” are not perceived as competent as women. (Gordon and Draper, 2010)
Literature Review

• Evangelista and Sims-Giddens (2014): Gender Differences in the Discipline of Nursing in Missouri

When compared with female respondents...

– Males had higher rates of discipline
– Males were disciplined more severely
– Males surrendered their license more frequently
Expert Panel: Background and Objectives

- In February 2015 a panel of researchers with expertise in the areas of forensic psychology, sociology, discipline, and gender differences in nursing convened
- The general goal was to understand the contributing factors which result in a violation of the nurse practice act for male nurses
- The specific purposes were to help guide NCSBN staff towards:
  - revealing causes of over-representation of males in disciplined
  - identifying best ways to formulate research questions
  - determining how the conclusions may apply to regulation
Expert Panel: Recommendations

• The panel recommended that vignettes be composed and incorporated into survey questionnaires that could be administered to nurse managers, administrators, nursing board members, the public (patients), nurses, investigators, and attorneys.

• Random assignment of nurse gender in vignettes write-ups would be used to ascertain whether gender bias is present in the administration of discipline.

• The vignettes would be developed to link to specific violations of the Nurse Practice Act in order to identify which violations are more likely to exhibit bias.
Research Question 1

Are there differences in the way nurses and nurse managers/executives perceive the actions of male vs. female nurses?
Methods

• This question was studied by the administration of surveys containing hypothetical vignettes involving possible violations of the Nurse Practice Act (NPA)

• A short vignette was constructed that described a situation in which a nurse’s action (or non-action) could be considered a violation of the NPA

• A sentence followed the vignette and stated whether or not the nurse in the vignette was reported to the BON
Methods (cont.)

• Respondents indicated on a five point Likert-type scale whether they agreed or disagreed with the decision to report (or not report) the nurse

• Three variations of each vignette were prepared: gender not stated, nurse identified as a female, and nurse identified as a male
Survey Instrument

• A total of ten vignettes were composed which addressed the following circumstances under which the Nurse Practice Act could be violated:
  -- Medication Administration
  -- Patient Neglect/Abandonment
  -- Scope of Practice
  -- Substance Abuse
  -- Unprofessional Conduct
Vignette Example

• The “Leaves Room” Vignette: A nurse is assisting a doctor with a procedure and makes a mistake (dropping something on the floor, handing the doctor the wrong item, etc.). The doctor verbally abuses the nurse and the nurse storms out of the room in the middle of the procedure.

• After reading this vignette respondents were asked their level of agreement with the decision to not report the nurse
Survey Implementation

• A random sample of 6,000 nurses was drawn from a national marketing list.
• Every nurse in the sample was mailed a survey randomly selected from one of thirty variations of the survey.
• Each questionnaire included five vignettes.
• Each questionnaire consisted of standard demographic questions about the respondents.
• 543 responses were received for an overall response rate of 9.9%. 
“Should Be Reported” Mean Scores for Nurses (Part 1)

<table>
<thead>
<tr>
<th>Event</th>
<th>Male</th>
<th>Female</th>
<th>Neutral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong Drug</td>
<td>1.00</td>
<td>1.50</td>
<td>2.00</td>
</tr>
<tr>
<td>Wrong Dosage</td>
<td>1.00</td>
<td>1.50</td>
<td>2.00</td>
</tr>
<tr>
<td>Cigarette Break</td>
<td>1.00</td>
<td>1.50</td>
<td>2.00</td>
</tr>
<tr>
<td>Leaves Room</td>
<td>1.00</td>
<td>1.50</td>
<td>2.00</td>
</tr>
</tbody>
</table>

*Note: n values for each category are provided in parentheses.*
“Should Be Reported” Mean Scores for Nurses (Part 2)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Neutral (n=54)</th>
<th>Female (n=109)</th>
<th>Male (n=101)</th>
<th>Female (n=129)</th>
<th>Male (n=94)</th>
<th>Neutral (n=52)</th>
<th>Female (n=103)</th>
<th>Male (n=112)</th>
<th>Neutral (n=43)</th>
<th>Female (n=105)</th>
<th>Male (n=128)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can't Read Telemetry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNA Takes Charge</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Alcohol On Breath</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Switches Urine Sample</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
“Should Be Reported” Mean Scores for Nurses (Part 3)
“Should Be Reported” Scores for Managers and Nurse Executives (Part 1)

<table>
<thead>
<tr>
<th>Event</th>
<th>Neutral (n=8)</th>
<th>Female (n=14)</th>
<th>Male (n=6)</th>
<th>Neutral (n=8)</th>
<th>Female (n=13)</th>
<th>Male (n=13)</th>
<th>Neutral (n=2)</th>
<th>Female (n=14)</th>
<th>Male (n=12)</th>
<th>Neutral (n=8)</th>
<th>Female (n=13)</th>
<th>Male (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong Drug</td>
<td>3.00</td>
<td>4.50</td>
<td>4.00</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
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<td>2.50</td>
<td>3.00</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
</tr>
<tr>
<td>Wrong Dosage</td>
<td>2.50</td>
<td>4.00</td>
<td>3.50</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
</tr>
<tr>
<td>Cigarette Break</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
<td>1.50</td>
<td>2.00</td>
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</tr>
<tr>
<td>Leaves Room</td>
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<td>3.00</td>
<td>3.50</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
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<td>3.00</td>
<td>2.00</td>
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</tr>
</tbody>
</table>
### "Should Be Reported" Scores for Managers and Nurse Executives (Part 2)

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Neutral (n=5)</th>
<th>Female (n=12)</th>
<th>Male (n=11)</th>
<th>Neutral (n=4)</th>
<th>Female (n=15)</th>
<th>Male (n=15)</th>
<th>Neutral (n=7)</th>
<th>Female (n=10)</th>
<th>Male (n=11)</th>
<th>Neutral (n=10)</th>
<th>Female (n=13)</th>
<th>Male (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can't Read Telemetry</td>
<td>Neutral</td>
<td>Female</td>
<td>Male</td>
<td>Neutral</td>
<td>Female</td>
<td>Male</td>
<td>Neutral</td>
<td>Female</td>
<td>Male</td>
<td>Neutral</td>
<td>Female</td>
<td>Male</td>
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<tr>
<td></td>
<td>(n=5)</td>
<td>(n=12)</td>
<td>(n=11)</td>
<td>(n=4)</td>
<td>(n=15)</td>
<td>(n=15)</td>
<td>(n=7)</td>
<td>(n=10)</td>
<td>(n=11)</td>
<td>(n=10)</td>
<td>(n=13)</td>
<td>(n=11)</td>
</tr>
<tr>
<td>Should not be reported</td>
<td>1.50</td>
<td>2.00</td>
<td>2.50</td>
<td>3.00</td>
<td>3.50</td>
<td>4.00</td>
<td>4.50</td>
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<tr>
<td>Should be reported</td>
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<td>2.50</td>
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</table>
### "Should Be Reported" Scores for Managers and Nurse Executives (Part 3)

<table>
<thead>
<tr>
<th></th>
<th>Neutral (n=6)</th>
<th>Female (n=6)</th>
<th>Male (n=16)</th>
<th>Neutral (n=4)</th>
<th>Female (n=14)</th>
<th>Male (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massages Patient</td>
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<td><strong>2.00</strong></td>
<td><strong>2.50</strong></td>
<td><strong>3.00</strong></td>
<td><strong>3.50</strong></td>
</tr>
<tr>
<td>Should not be reported</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Should be reported</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks For Loan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Should not be reported</td>
<td><strong>1.00</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Should be reported</td>
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<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Research Question 2.

Are there differences in the way that BON staff/members (primarily investigators and attorneys) perceive the actions of male vs. female nurses?
Methods

- The methods and survey instrument were the same as what was used to survey nurses and nurse managers.
- The survey was sent to the NCSBN Disciplinary Knowledge Network.
- Every member of the DKN received a Qualtrics survey using the same five vignettes with variations of nurse gender.
- Each questionnaire consisted of standard demographic questions about the respondents.
- 122 responses were received for an overall response rate of 23.6%.
“Should Be Reported” Mean Scores for Disciplinary Knowledge Network

- **Wrong Dosage**
  - Female (n=84)
  - Male (n=38)

- **Leaves Room**
  - Female (n=38)
  - Male (n=84)

- **CNA Takes Charge**
  - Neutral (n=45)
  - Female (n=38)
  - Male (n=39)

- **Switches Urine Sample**
  - Neutral (n=39)
  - Female (n=45)
  - Male (n=38)

- **Asks For Loan**
  - Neutral (n=38)
  - Female (n=39)
  - Male (n=45)
Summary – Research Questions 1 and 2

• For the most part, the data from the survey of nurses did not uncover systematic gender differences in the reporting of nurses to the BONs.

• The only statistically significant difference -- the “leaves room” vignette -- suggested that a slight bias in favor of males might occur in a similar situation.

• The survey of members of the Disciplinary Knowledge Network also uncovered no systematic gender differences.
Research Question 3

3. Are there differences in the disciplinary/board actions, administered by the BONs, to Male and Female nurses who have committed comparable practice violations?
ANALYSIS OF BOARD ACTIONS IN THE TERCAP DATABASE
### Distribution of BON Outcomes By Gender

*Source: NCSBN TERCAP Database*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dismissal (n=507)</td>
<td>15.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Non-disiplinary Action (n=466)</td>
<td>17.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Alternative to Discipline (n=356)</td>
<td>13.0%</td>
<td>6.0%</td>
</tr>
<tr>
<td>BON Disciplinary Action (n=1,581)</td>
<td>48.0%</td>
<td>41.0%</td>
</tr>
</tbody>
</table>

The chart above illustrates the distribution of BON outcomes by gender, with the source indicated as the NCSBN TERCAP Database.
Distribution of BON Outcomes by Gender and Level of Patient Harm (Part 1)

*Source: NCSBN TERCAP Database*
Distribution of BON Outcomes by Gender and Level of Patient Harm (Part 2)

*Source: NCSBN TERCAP Database*
Research Question 4

4. Are there differences in the disciplinary/board actions, administered by the BONs, to male and female nurses who have committed a comparable crime?
CRIMINAL CONVICTION CASE REVIEW
Methods – Direct Comparison

• Sample: Nurses who received a disciplinary action or were denied a license by a BON for a criminal conviction in 2012 or 2013.
  – Cases in which a BON action was taken in response to an action by a BON in another state were excluded from the analysis.
  – Cases missing data on gender and/or age were dropped from the analysis.
• To start with, we did an overall comparison of the actions taken by the Boards against male and female nurses.
Distribution of Disciplinary Actions by Gender

Source: NCSBN 2012-13 Criminal Conviction Case Review

- Probation of license
- Revocation of license
- Unspecified licensure action
- Fine/monetary penalty
- Suspension of license
- Reprimand or censure
- Other

Female (n=2,601) vs Male (n=759)

Distribution by Gender:
- Probation of license: 20%
- Revocation of license: 15%
- Unspecified licensure action: 10%
- Fine/monetary penalty: 15%
- Suspension of license: 10%
- Reprimand or censure: 5%
- Other: 20%
Distribution of Denial of Initial License Action for Crimes, by Gender

Source: NCSBN 2012-13 Criminal Conviction Case Review

- Theft
- Driving Under The Influence
- Fraud
- Violation of Controlled Substances Act
- Domestic violence/assault
- Other

Female (n=42)  Male (n=16)
Methods – In-depth Analysis

• Same sample as prior analysis
• Four sub-files were created based on the most common crimes: Driving Under the Influence (DUI), Substance Abuse, Fraud and Theft
• Each of the four sub-files were analyzed in the following manner:
  – The population of male nurses was used to form the study group.
  – A comparison group of the exact same size was chosen from the population of female nurses based on propensity score matching techniques.
  – The disciplinary actions taken on the study group were compared to the disciplinary actions taken on the comparison group to see if any differences could be found.
Comparison of Disciplinary Actions by Gender for DUI
(n=646)
Comparison of Disciplinary Actions by Gender for Substance Abuse
(n=318)

- Revocation
- Probation
- Suspension
- Restriction
- Reprimand
- Surrender
- Denial
- Fine
- Other
Comparison of Disciplinary Actions by Gender for Fraud
(n=154)
Comparison of Disciplinary Actions by Gender for Theft
(n= 200)
Summary – Research Questions 3 and 4

• The frequency of disciplinary actions assigned to male and female nurses who had criminal convictions for driving under the influence, fraud, and theft were quite similar.

• For substance abuse convictions, a distinct difference in discipline patterns by gender in favor of male nurses was observed:
  – Male nurses received probation, reprimand, fines, and licensure denial more often than female nurses
  – Female nurses had their licenses revoked more often than male nurses.
  – Among the differences, only being fined was statistically significant.
Conclusion

• The study did not uncover any evidence of gender bias against male nurses in the reporting of nurses to the Boards of Nursing.

• The study did not uncover any evidence of gender bias against male nurses in the approach to the reporting of nurses by members of the Disciplinary Knowledge Network.

• The study did not uncover any evidence of gender differences against male nurses in the disciplinary actions by Boards of Nursing.