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Report of the Bylaws Committee

Recommendation to the Delegate Assembly

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

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

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

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

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

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

**Highlights of FY10 Activities**
- Kathy Apple oriented the committee regarding NCSBN committee policies and procedures, the Confidentiality and Conflict of Interest Agreement, Emergency Contact Information and expense reports.
- Apple provided a brief history and background of the Bylaws Committee, including a discussion on the most recent revisions to the bylaws.
- The committee discussed their charge to develop possible revisions to the NCSBN Bylaws for consideration at the 2010 Delegate Assembly, including revisions to address the relationship of NCSBN and NLCA to ensure a united organization.
- The committee reviewed and revised the draft straw man article previously discussed by the NCSBN BOD and NLCA Executive Committee. The Bylaws Committee moved to accept the draft revision of this new article for submission to the BOD for review at the Feb. 10-12, 2010 BOD meeting.
- The committee discussed the historical background of voting by ballot versus acclamation. The committee drafted bylaw language to accommodate for acclamation. The committee moved to submit revisions to allow acclamation in the event there is only one candidate for an officer or director position on the BOD or the LSC. This revision is consistent with Robert’s Rules of Order.
- The committee reviewed and revised the recommended bylaw revision submitted by the LSC regarding nominations from the floor. The committee moved to submit the proposed revision, allowing the LSC to determine qualifications and geographic distribution of nominations from the floor for recommendations to the Delegate Assembly.
The committee reviewed and approved the 2010 Delegate Assembly Standing Rules.

The committee reported their progress to date at the Feb. 10-12, 2010, BOD meeting.

Apple presented feedback from the Feb. 10-12, 2010, BOD meeting regarding the Bylaws Committee's proposed revisions. The BOD held the proposed Article 11 revision regarding the relationship between NCSBN and the NLCA until further discussions between and among the NCSBN BOD, the NLCA and the membership at large could occur.

Goldman presented a proposed revision to the NCSBN Bylaws’ Article VII Leadership Succession Committee. The Bylaws Committee moved to approve the revision as it demonstrates consistency pertaining to the previous revision made regarding election by acclamation. The revision was brought forth for approval by the BOD on March 8, 2010, before being presented to the membership at the 2010 Midyear Meeting.

**Attachments**

A. Current Bylaws

B. Proposed Bylaws Revisions, Redline Version

C. Proposed Bylaws, Clean Copy
Section II: 2010 NCSBN Annual Meeting
Report of the Bylaws Committee - Attachment A: Current Bylaws

Attachment A
Current Bylaws

NCSBN Bylaws

Revisions adopted - 8/29/87
Amended - 8/19/88
Amended - 8/30/90
Amended - 8/01/91
Revisions adopted - 8/03/94
Amended - 8/20/97
Amended - 8/8/98
Revisions adopted – 8/11/01
Amended – 08/07/03
Revisions adopted – 08/08/07

Article I
■ Name
The name of this organization shall be the National Council of State Boards of Nursing, Inc. (NCSBN).

Article II
■ Purpose and Functions
Section 1. Purpose. The purpose of the NCSBN is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

Section 2. Functions. The NCSBN’s functions shall include but not be limited to providing services and guidance to its members in performing their regulatory functions regarding entry into nursing practice, continued safe nursing practice and nursing education programs. The NCSBN provides Member Boards with examinations and standards for licensure and credentialing; promotes uniformity in standards and expected outcomes in nursing practice and education as they relate to the protection of the public health, safety and welfare; provides information, analyses and standards regarding the regulation of nursing practice and nursing education; promotes the exchange of information and serves as a clearinghouse for matters related to nursing regulation.

Article III
■ Members
Section 1. Definitions.
a) State Board of Nursing. A state board of nursing is the governmental agency empowered to license and regulate nursing practice in any state, territory or political subdivision of the United States of America.
b) Member Board. A Member board is a state board of nursing, which is approved by the Delegate Assembly as a member of NCSBN.
c) Associate Member. An Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory, which is approved by the Delegate Assembly.

Section 2. Qualifications. To qualify for approval, as a Member Board, a state board of nursing that regulates registered nurses and/or practical/vocational nurses must use one or more NCSBN Licensing Examinations (the “NCLEX® examination”) for licensure of registered nurses and/or practical/vocational nurses, and execute a membership agreement with NCSBN specifying the terms and conditions for the use of the NCLEX® examination(s) where applicable.

Section 3. Admission. A state board of nursing shall become a member of the NCSBN and be known as a Member Board upon approval by the Delegate Assembly, as described in Article IV, payment of the required fees and execution of a contract for using the NCLEX® examination where applicable.
Section 4. Areas. The Delegate Assembly shall divide the membership into numbered geographical Areas. At no time shall the number of Areas be less than three nor more than six. New members shall be assigned to existing Areas by the Board of Directors. The purpose of this division is to facilitate communication, encourage regional dialogue on NCSBN issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. Fees. The annual membership fees, for a Member Board and an Associate Member shall be set by the Delegate Assembly and shall be payable each October 1.

Section 6. Privileges. Member Board privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. Noncompliance. Any member whose fees remain unpaid after January 15 is not in good standing. Any member who does not comply with the provisions of the bylaws, and where applicable, the membership agreement, shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. Appeal. Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. Reinstatement. A member in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

Article IV
Delegate Assembly

Section 1. Composition.

a) Designation of Delegates. The Delegate Assembly shall be comprised of no more than two (2) delegates designated by each Member Board as provided in the Standing Rules of the Delegate Assembly (“Standing Rules”). An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges.

b) Qualification of Delegates. Members and employees of Member Boards shall be eligible to serve as delegates until their term or their employment with a Member Board ends. A NCSBN officer or director may not represent a Member Board as a delegate.

c) Term. Delegates and alternates serve from the time of appointment until replaced.

Section 2. Voting.

a) Annual Meetings. Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting.

b) Special Meetings. A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the corporate secretary of the NCSBN or a delegate of another Member Board to cast its votes.

Section 3. Authority. The Delegate Assembly, the membership body of the NCSBN, shall provide direction for the NCSBN through resolutions and enactments, including adoption of the mission and
Section II: 2010 NCSBN Annual Meeting
Report of the Bylaws Committee - Attachment A: Current Bylaws

strategic initiatives, at any Annual Meeting or special session. The Delegate Assembly shall approve all new NCSBN memberships; approve the substance of all NCLEX® examination contracts between the NCSBN and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; and establish the fee for the NCLEX® examination.

Section 4. Annual Meeting. The NCSBN Annual Meeting shall be held at a time and place as determined by the Board of Directors. The Delegate Assembly shall meet each year during the Annual Meeting. The official call to that meeting, giving the time and place, shall be conveyed to each Member Board at least 90 days before the Annual Meeting. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the NCSBN.

Section 5. Special Session. The Board of Directors may call, and upon written petition of at least ten Member Boards made to the Board of Directors, shall call a special session of the Delegate Assembly. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least ten days before the date for which such special session is called.

Section 6. Quorum. The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Section 7. Standing Rules. The Board of Directors shall present and the Delegate Assembly shall adopt Standing Rules for each Delegate Assembly meeting.

Article V

Officers and Directors

Section 1. Officers. The elected officers of the NCSBN shall be a president, a vice-president and a treasurer.

Section 2. Directors. The directors of the NCSBN shall consist of four directors-at-large and a director from each Area.

Section 3. Qualifications. Board Members of Member Boards and employees of Member Boards shall be eligible to serve as NCSBN officers and directors until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 4. Qualifications for President. The president shall have served NCSBN as either a delegate, a committee member, a director or an officer before being elected to the office of President.

Section 5. Election of Officers and Directors.

a) Time and Place. Election of officers and directors shall be by ballot of the Delegate Assembly during the Annual Meeting.

b) Officers and Directors-at-Large. Officers and directors-at-large shall be elected by majority vote of the Delegate Assembly.

c) Area Directors. Each Area shall elect its Area director by majority vote of the delegates from each such Area.

d) Run-Off Balloting. If a candidate for officer or director does not receive a majority vote on the first ballot, reballoting shall be limited to the two candidates receiving the highest numbers of votes for each position. In the case of a tie on the reballoting, the final selection shall be determined by lot.
Section II: 2010 NCSBN Annual Meeting
Report of the Bylaws Committee - Attachment A: Current Bylaws

e) **Voting.** Voting for officers and directors shall be conducted in accordance with these bylaws and the Standing Rules. Write-in votes shall be prohibited.

**Section 6. Terms of Office.** The president, vice-president, treasurer, Area directors, and directors-at-large shall be elected for a term of two years or until their successors are elected. The president, vice-president, treasurer, and two directors-at-large shall be elected in even-numbered years. The Area directors and two directors-at-large shall be elected in odd-numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.

**Section 7. Limitations.** No person may hold more than one office or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the NCSBN, as determined by the Leadership Succession Committee before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors win an election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.

**Section 8. Vacancies.** A vacancy in the office of president shall be filled by the vice-president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting and a successor is elected. The Delegate Assembly shall elect a person to fill any remainder of the term.

**Section 9. Responsibilities of the President.** The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and speak on behalf of and communicate the policies of the NCSBN.

**Section 10. Responsibilities of the Vice-President.** The vice-president shall assist the president, perform the duties of the president in the president’s absence, and fill any vacancy in the office of the president until the next Annual Meeting.

**Section 11. Responsibilities of the Treasurer.** The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors, and that annual financial reports are provided to the Delegate Assembly.

**Article VI**

- **Board of Directors**

**Section 1. Composition.** The Board of Directors shall consist of the elected officers and directors of the NCSBN.

**Section 2. Authority.** The Board of Directors shall transact the business and affairs and act on behalf of the NCSBN except to the extent such powers are reserved to the Delegate Assembly as set forth in these bylaws and provided that none of the Board’s acts shall conflict with resolutions or enactments of the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly and approve the NCLEX® examination test service.

**Section 3. Meetings of the Board of Directors.** The Board of Directors shall hold its annual meeting in association with the Annual Meeting. The Board may schedule other regular meetings of the Board at other times as necessary to accomplish the work of the Board. Publication of the dates for such regular meetings in the minutes of the Board meeting at which the dates are selected shall constitute notice of the scheduled regular meetings. Special meetings of the Board of Directors may be called by the president or
shall be called upon written request of at least three members of the Board of Directors. At least twenty-four hours notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Section 4. Removal from Office. A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly or the Board of Directors. The individual shall be given 30 days’ written notice of the proposed removal.

Section 5. Appeal. A member of the Board of Directors removed by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two-thirds vote of the Delegate Assembly.

Article VII

Leadership Succession Committee

Section 1. Leadership Succession Committee

a) Composition. The Leadership Succession Committee shall be comprised of eight members elected by the Delegate Assembly. Four of the eight elected positions shall be designated members to include a past Board of Directors member, a current or former NCSBN committee chair, a board member of a Member Board and an employee of a Member Board. The remaining four members shall be elected from each of the four areas.

b) Term. The term of office shall be two years. One-half of the Committee members shall be elected in even numbered years and one-half in odd number years. A committee member shall serve no more than two consecutive terms. Members shall assume duties at the close of the Annual Meeting at which they are elected.

c) Election. The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. The Chair shall be selected by the Board of Directors.

d) Limitation. A member elected or appointed to the Leadership Succession Committee may not be nominated for an officer or director position during the term for which that member was elected or appointed.

e) Vacancy. A vacancy occurring in the committee shall be filled from the remaining candidates from the previous election, in order of votes received. If no remaining candidates can serve, the Board of Directors shall fill the vacancy with an individual who meets the qualifications of Section 1a. of this Article. The person filling the vacancy shall serve the remainder of the term.

f) Duties. The Leadership Succession Committee shall recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee’s report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

g) Eligibility. Any board member of a Member Board or employee of a Member Board is eligible to serve as a member of the Leadership Succession Committee.

Article VIII

Meetings

Section 1. Participation.

a) Delegate Assembly Session.

(i) Member Boards. Members and employees of Member Boards shall have the right, subject to the Standing Rules of the Delegate Assembly, to speak at all open sessions and forums of the Delegate Assembly, provided that only delegates shall be entitled to vote and only delegates and members of the Board of Directors may make motions at the Delegate Assembly, except the
Examination Committee may bring motions to approve test plans pursuant to Article X, Section 1(a).

(ii) Public. All sessions of the Delegate Assembly held in accordance with Sections 4 and 5 of Article IV of these bylaws shall be open to the public, except executive sessions, provided that the minutes reflect the purpose of, and any action taken in, executive session.

b) Delegate Assembly Forums. Participation in forums conducted in association with the Annual Meeting shall be governed by the Standing Rules of the Delegate Assembly.

c) Meetings. NCSBN, including all committees thereof, may establish methods of conducting its business at all other meetings provided that the meetings of the Board of Directors and committees are open to members and employees of Member Boards.

d) Interactive Communications. Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the NCSBN Office.

e) Manner of Transacting Business. To the extent permitted by law and these bylaws, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

Article IX

Chief Executive Officer

Section 1. Appointment. The Chief Executive Officer shall be appointed by the Board of Directors. The selection or termination of the Chief Executive Officer shall be by a majority vote of the Board of Directors.

Section 2. Authority. The Chief Executive Officer shall serve as the agent and chief administrative officer of the NCSBN and shall possess the authority and shall perform all duties incident to the office of Chief Executive Officer, including the management and supervision of the office, programs and services of NCSBN, the disbursement of funds and execution of contracts (subject to such limitations as may be established by the Board of Directors). The Chief Executive Officer shall serve as corporate secretary and oversee maintenance of all documents and records of the NCSBN and shall perform such additional duties as may be defined and directed by the Board.

Section 3. Evaluation. The Board of Directors shall conduct an annual written performance appraisal of the Chief Executive Officer, and shall set the Chief Executive Officer’s annual salary.

Article X

Committees

Section 1. Standing Committees. NCSBN shall maintain the following standing committees.

a) NCLEX® Examination Committee. The NCLEX® Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The committee chair shall have served as a member of the committee prior to being appointed as chair. The NCLEX® Examination Committee shall advise the Board of Directors on matters related to the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards’ need for examinations. The Examination Committee shall recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.

b) Finance Committee. The Finance Committee shall be comprised of at least four members and the treasurer, who shall serve as chair. The Finance Committee shall review the annual budget, the
NCSBN’s investments and the audit. The Finance Committee shall recommend a budget to the Board of Directors and advise the Board of Directors on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

Section 2. Special Committees. The Board of Directors may appoint special committees as needed to accomplish the mission of the NCSBN and to assist any Standing Committee in the fulfillment of its responsibilities. Special committees may include subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. Delegate Assembly Committees. The president shall appoint such Delegate Assembly Committees as provided in the Standing Rules and as necessary to conduct the business of the Delegate Assembly.

Section 4. Committee Membership.

a) Composition. Members of Standing and Special committees shall be appointed by the Board of Directors from the membership, provided, however, that Associate Members may not serve on the NCLEX® Examination, Bylaws, or Finance committees. Committees may also include other individuals selected for their special expertise to accomplish a committee’s charge. In appointing committees, one representative from each Area shall be selected unless a qualified member from each Area is not available considering the expertise needed for the committee work. The president, or president’s designee, shall be an ex-officio member of all committees except the Leadership Succession Committee. Associate Members shall have full voting rights as committee members.

b) Term. The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for re-appointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

c) Vacancy. A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

Article XI

Finance

Section 1. Audit. The financial records of the NCSBN shall be audited annually by a certified public accountant appointed by the Board of Directors. The annual audit report shall be provided to the Delegate Assembly.

Section 2. Fiscal Year. The fiscal year shall be from October 1 to September 30.

Article XII

Indemnification

Section 1. Direct Indemnification. To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney’s fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.
Section II: 2010 NCSBN Annual Meeting
Report of the Bylaws Committee - Attachment A: Current Bylaws

Section 2. Insurance. To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. Additional Rights. Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

a) not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and

b) continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIII
Parliamentary Authority

The rules contained in the current edition of Robert’s Rules of Order Newly Revised shall govern the NCSBN in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the NCSBN.

Article XIV
Amendment of Bylaws

Section 1. Amendment and Notice. These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly upon:

a) written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting; or

b) written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present and voting.

In no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.

Section 2. Bylaws Committee. A Bylaws committee composed of board members from Member Boards and/or employees of Member Boards may be appointed by the Board of Directors to review and make recommendations on proposed bylaw amendments as directed by the Board of Directors or the Delegate Assembly.

Article XV
Dissolution

Section 1. Plan. The Board of Directors at an annual, regular or special meeting may formulate and adopt a plan for the dissolution of the NCSBN. The plan shall provide, among other things, that the assets of the NCSBN be applied as follows:

Firstly, all liabilities and obligations of the NCSBN shall be paid or provided for.
Secondly, any assets held by the NCSBN which require return, transfer or conveyances, as a result of the dissolution, shall be returned, transferred or conveyed in accordance with such requirement.

Thirdly, all other assets, including historical records, shall be distributed in considered response to written requests of historical, educational, research, scientific or institutional health tax exempt organizations or associations, to be expended toward the advancement of nursing practice, regulation and the preservation of nursing history.

Section 2. Acceptance of Plan. Such plan shall be acted upon by the Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. A majority of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.

Section 3. Conformity to Law. Such plan to dissolve must conform to the law under which NCSBN is organized and to the Internal Revenue Code concerning dissolution of exempt corporations. This requirement shall override the provisions of Sections 1 and 2 herein.
Article I
- Name
The name of this organization shall be the National Council of State Boards of Nursing, Inc. (NCSBN).

Article II
- Purpose and Functions
Section 1. Purpose. The purpose of the NCSBN is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

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Section 4. Areas. The Delegate Assembly shall divide the membership into numbered geographical Areas. At no time shall the number of Areas be less than three nor more than six. New members shall be assigned to existing Areas by the Board of Directors. The purpose of this division is to facilitate communication, encourage regional dialogue on NCSBN issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. Fees. The annual membership fees, for a Member Board and an Associate Member shall be set by the Delegate Assembly and shall be payable each October 1.

Section 6. Privileges. Member Board privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. Noncompliance. Any member whose fees remain unpaid after January 15 is not in good standing. Any member who does not comply with the provisions of the bylaws, and where applicable, the membership agreement, shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. Appeal. Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. Reinstatement. A member in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

Article IV
Delegate Assembly

Section 1. Composition.

a) Designation of Delegates. The Delegate Assembly shall be comprised of no more than two (2) delegates designated by each Member Board as provided in the Standing Rules of the Delegate Assembly ("Standing Rules"). An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges.

b) Qualification of Delegates. Members and employees of Member Boards shall be eligible to serve as delegates until their term or their employment with a Member Board ends. A NCSBN officer or director may not represent a Member Board as a delegate.

c) Term. Delegates and alternates serve from the time of appointment until replaced.

Section 2. Voting.

a) Annual Meetings. Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting.

b) Special Meetings. A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the corporate secretary of the NCSBN or a delegate of another Member Board to cast its votes.
Section 3. Authority. The Delegate Assembly, the membership body of the NCSBN, shall provide direction for the NCSBN through resolutions and enactments, including adoption of the mission and strategic initiatives, at any Annual Meeting or special session. The Delegate Assembly shall approve all new NCSBN memberships; approve the substance of all NCLEX® examination contracts between the NCSBN and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; and establish the fee for the NCLEX® examination.

Section 4. Annual Meeting. The NCSBN Annual Meeting shall be held at a time and place as determined by the Board of Directors. The Delegate Assembly shall meet each year during the Annual Meeting. The official call to that meeting, giving the time and place, shall be conveyed to each Member Board at least 90 days before the Annual Meeting. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the NCSBN.

Section 5. Special Session. The Board of Directors may call, and upon written petition of at least ten Member Boards made to the Board of Directors, shall call a special session of the Delegate Assembly. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least ten days before the date for which such special session is called.

Section 6. Quorum. The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Section 7. Standing Rules. The Board of Directors shall present and the Delegate Assembly shall adopt Standing Rules for each Delegate Assembly meeting.

Article V

Officers and Directors

Section 1. Officers. The elected officers of the NCSBN shall be a president, a vice-president and a treasurer.

Section 2. Directors. The directors of the NCSBN shall consist of four directors-at-large and a director from each Area.

Section 3. Qualifications. Board Members of Member Boards and employees of Member Boards shall be eligible to serve as NCSBN officers and directors until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 4. Qualifications for President. The president shall have served NCSBN as either a delegate, a committee member, a director or an officer before being elected to the office of President.

Section 5. Election of Officers and Directors.

a) Time and Place. Election of officers and directors shall be by ballot of the Delegate Assembly during the Annual Meeting.

b) Officers and Directors-at-Large. Officers and directors-at-large shall be elected by majority vote of the Delegate Assembly.

c) Area Directors. Each Area shall elect its Area director by majority vote of the delegates from each such Area.
d) **Run-Off Balloting.** If a candidate for officer or director does not receive a majority vote on the first ballot, reballoting shall be limited to the two candidates receiving the highest numbers of votes for each position. In the case of a tie on the reballooting, the final selection shall be determined by lot.

e) **Voting.** Voting for officers and directors shall be conducted in accordance with these bylaws and the Standing Rules. Write-in votes shall be prohibited.

Section 6. **Terms of Office.** The president, vice-president, treasurer, Area directors, and directors-at-large shall be elected for a term of two years or until their successors are elected. The president, vice-president, treasurer, and two directors-at-large shall be elected in even-numbered years. The Area directors and two directors-at-large shall be elected in odd-numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.

Section 7. **Limitations.** No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the NCSBN, as determined by the Leadership Succession Committee before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors win an election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.

Section 8. **Vacancies.** A vacancy in the office of president shall be filled by the vice-president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting and a successor is elected. The Delegate Assembly shall elect a person to fill any remainder of the term.

Section 9. **Responsibilities of the President.** The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and speak on behalf of and communicate the policies of the NCSBN.

Section 10. **Responsibilities of the Vice-President.** The vice-president shall assist the president, perform the duties of the president in the president’s absence, and fill any vacancy in the office of the president until the next Annual Meeting.

Section 11. **Responsibilities of the Treasurer.** The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors, and that annual financial reports are provided to the Delegate Assembly.

**Article VI**

■ **Board of Directors**

**Section 1. Composition.** The Board of Directors shall consist of the elected officers and directors of the NCSBN.

**Section 2. Authority.** The Board of Directors shall transact the business and affairs and act on behalf of the NCSBN except to the extent such powers are reserved to the Delegate Assembly as set forth in these bylaws and provided that none of the Board’s acts shall conflict with resolutions or enactments of the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly and approve the NCLEX® examination test service.
Section 3. Meetings of the Board of Directors. The Board of Directors shall hold its annual meeting in association with the Annual Meeting. The Board may schedule other regular meetings of the Board at other times as necessary to accomplish the work of the Board. Publication of the dates for such regular meetings in the minutes of the Board meeting at which the dates are selected shall constitute notice of the scheduled regular meetings. Special meetings of the Board of Directors may be called by the president or shall be called upon written request of at least three members of the Board of Directors. At least twenty-four hours notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Section 4. Removal from Office. A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly or the Board of Directors. The individual shall be given 30 days’ written notice of the proposed removal.

Section 5. Appeal. A member of the Board of Directors removed by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two-thirds vote of the Delegate Assembly.

Article VII

Leadership Succession Committee

Section 1. Leadership Succession Committee

a) Composition. The Leadership Succession Committee shall be comprised of eight members elected by the Delegate Assembly. Four of the eight elected positions shall be designated members to include a past Board of Directors member, a current or former NCSBN committee chair, a board member of a Member Board and an employee of a Member Board. The remaining four members shall be elected from each of the four areas.

b) Term. The term of office shall be two years. One-half of the Committee members shall be elected in even numbered years and one-half in odd number years. A committee member shall serve no more than two consecutive terms. Members shall assume duties at the close of the Annual Meeting at which they are elected.

c) Election. The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. In the event there is only one candidate for a committee position, election for that position shall be declared by acclamation. No ballot shall be necessary. The Chair shall be selected by the Board of Directors.

d) Limitation. A member elected or appointed to the Leadership Succession Committee may not be nominated for an officer or director position during the term for which that member was elected or appointed.

e) Vacancy. A vacancy occurring in the committee shall be filled from the remaining candidates from the previous election, in order of votes received. If no remaining candidates can serve, the Board of Directors shall fill the vacancy with an individual who meets the qualifications of Section 1a. of this Article. The person filling the vacancy shall serve the remainder of the term.

f) Duties. The Leadership Succession Committee shall recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee’s report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee. The Leadership Succession Committee shall determine qualifications and geographic distribution of nominations from the floor for recommendations to the Delegate Assembly.
g) **Eligibility.** Any board member of a Member Board or employee of a Member Board is eligible to serve as a member of the Leadership Succession Committee.

## Article VIII

### Meetings

#### Section 1. Participation.

a) **Delegate Assembly Session.**

(i) **Member Boards.** Members and employees of Member Boards shall have the right, subject to the Standing Rules of the Delegate Assembly, to speak at all open sessions and forums of the Delegate Assembly, provided that only delegates shall be entitled to vote and only delegates and members of the Board of Directors may make motions at the Delegate Assembly, except the Examination Committee may bring motions to approve test plans pursuant to Article X, Section 1(a).

(ii) **Public.** All sessions of the Delegate Assembly held in accordance with Sections 4 and 5 of Article IV of these bylaws shall be open to the public, except executive sessions, provided that the minutes reflect the purpose of, and any action taken in, executive session.

b) **Delegate Assembly Forums.** Participation in forums conducted in association with the Annual Meeting shall be governed by the Standing Rules of the Delegate Assembly.

c) **Meetings.** NCSBN, including all committees thereof, may establish methods of conducting its business at all other meetings provided that the meetings of the Board of Directors and committees are open to members and employees of Member Boards.

d) **Interactive Communications.** Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the NCSBN Office.

e) **Manner of Transacting Business.** To the extent permitted by law and these bylaws, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

## Article IX

### Chief Executive Officer

#### Section 1. Appointment.

The Chief Executive Officer shall be appointed by the Board of Directors. The selection or termination of the Chief Executive Officer shall be by a majority vote of the Board of Directors.

#### Section 2. Authority.

The Chief Executive Officer shall serve as the agent and chief administrative officer of the NCSBN and shall possess the authority and shall perform all duties incident to the office of Chief Executive Officer, including the management and supervision of the office, programs and services of NCSBN, the disbursement of funds and execution of contracts (subject to such limitations as may be established by the Board of Directors). The Chief Executive Officer shall serve as corporate secretary and oversee maintenance of all documents and records of the NCSBN and shall perform such additional duties as may be defined and directed by the Board.

#### Section 3. Evaluation.

The Board of Directors shall conduct an annual written performance appraisal of the Chief Executive Officer, and shall set the Chief Executive Officer’s annual salary.

## Article X

### Committees

#### Section 1. Standing Committees.

NCSBN shall maintain the following standing committees.
a) **NCLEX® Examination Committee.** The NCLEX® Examination Committee shall be comprised of at least nine members. One of the committee members shall be a licensed practical/vocational nurse or a board or staff member of an LPN/VN board. The committee chair shall have served as a member of the committee prior to being appointed as chair. The NCLEX® Examination Committee shall advise the Board of Directors on matters related to the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards’ need for examinations. The Examination Committee shall recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.

b) **Finance Committee.** The Finance Committee shall be comprised of at least four members and the treasurer, who shall serve as chair. The Finance Committee shall review the annual budget, the NCSBN’s investments and the audit. The Finance Committee shall recommend a budget to the Board of Directors and advise the Board of Directors on fiscal policy to assure prudence and integrity of fiscal management and responsiveness to Member Board needs.

**Section 2. Special Committees.** The Board of Directors may appoint special committees as needed to accomplish the mission of the NCSBN and to assist any Standing Committee in the fulfillment of its responsibilities. Special committees may include subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

**Section 3. Delegate Assembly Committees.** The president shall appoint such Delegate Assembly Committees as provided in the Standing Rules and as necessary to conduct the business of the Delegate Assembly.

**Section 4. Committee Membership.**

a) **Composition.** Members of Standing and Special committees shall be appointed by the Board of Directors from the membership, provided, however, that Associate Members may not serve on the NCLEX® Examination, Bylaws, or Finance committees. Committees may also include other individuals selected for their special expertise to accomplish a committee’s charge. In appointing committees, one representative from each Area shall be selected unless a qualified member from each Area is not available considering the expertise needed for the committee work. The president, or president’s designee, shall be an ex-officio member of all committees except the Leadership Succession Committee. Associate Members shall have full voting rights as committee members.

b) **Term.** The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for re-appointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

c) **Vacancy.** A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

**Article XI**

**Finance**

**Section 1. Audit.** The financial records of the NCSBN shall be audited annually by a certified public accountant appointed by the Board of Directors. The annual audit report shall be provided to the Delegate Assembly.

**Section 2. Fiscal Year.** The fiscal year shall be from October 1 to September 30.

**Article XII**

**Indemnification**
Section 1. Direct Indemnification. To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney’s fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.

Section 2. Insurance. To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. Additional Rights. Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

a) not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and

b) continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIII

Parliamentary Authority

The rules contained in the current edition of Robert’s Rules of Order Newly Revised shall govern the NCSBN in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the NCSBN.

Article XIV

Amendment of Bylaws

Section 1. Amendment and Notice. These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly upon:

a) written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting; or

b) written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present and voting.

In no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.
Section 2. **Bylaws Committee.** A Bylaws committee composed of board members from Member Boards and/or employees of Member Boards may be appointed by the Board of Directors to review and make recommendations on proposed bylaw amendments as directed by the Board of Directors or the Delegate Assembly.

**Article XV**

■ **Dissolution**

**Section 1. Plan.** The Board of Directors at an annual, regular or special meeting may formulate and adopt a plan for the dissolution of the NCSBN. The plan shall provide, among other things, that the assets of the NCSBN be applied as follows:

Firstly, all liabilities and obligations of the NCSBN shall be paid or provided for.

Secondly, any assets held by the NCSBN which require return, transfer or conveyances, as a result of the dissolution, shall be returned, transferred or conveyed in accordance with such requirement.

Thirdly, all other assets, including historical records, shall be distributed in considered response to written requests of historical, educational, research, scientific or institutional health tax exempt organizations or associations, to be expended toward the advancement of nursing practice, regulation and the preservation of nursing history.

**Section 2. Acceptance of Plan.** Such plan shall be acted upon by the Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. A majority of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.

**Section 3. Conformity to Law.** Such plan to dissolve must conform to the law under which NCSBN is organized and to the Internal Revenue Code concerning dissolution of exempt corporations. This requirement shall override the provisions of Sections 1 and 2 herein.
NCSBN Bylaws

Article I
■ Name
The name of this organization shall be the National Council of State Boards of Nursing, Inc. (NCSBN).

Article II
■ Purpose and Functions
Section 1. Purpose. The purpose of the NCSBN is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

Section 2. Functions. The NCSBN’s functions shall include but not be limited to providing services and guidance to its members in performing their regulatory functions regarding entry into nursing practice, continued safe nursing practice and nursing education programs. The NCSBN provides Member Boards with examinations and standards for licensure and credentialing; promotes uniformity in standards and expected outcomes in nursing practice and education as they relate to the protection of the public health, safety and welfare; provides information, analyses and standards regarding the regulation of nursing practice and nursing education; promotes the exchange of information and serves as a clearinghouse for matters related to nursing regulation.

Article III
■ Members
Section 1. Definitions.
   a) State Board of Nursing. A state board of nursing is the governmental agency empowered to license and regulate nursing practice in any state, territory or political subdivision of the United States of America.
   b) Member Board. A Member board is a state board of nursing, which is approved by the Delegate Assembly as a member of NCSBN.
   c) Associate Member. An Associate Member is a nursing regulatory body or empowered regulatory authority from another country or territory, which is approved by the Delegate Assembly.

Section 2. Qualifications. To qualify for approval, as a Member Board, a state board of nursing that regulates registered nurses and/or practical/vocational nurses must use one or more NCSBN Licensing Examinations (the “NCLEX® examination”) for licensure of registered nurses and/or practical/vocational nurses, and execute a membership agreement with NCSBN specifying the terms and conditions for the use of the NCLEX® examination(s) where applicable.
Section 3. Admission. A state board of nursing shall become a member of the NCSBN and be known as a Member Board upon approval by the Delegate Assembly, as described in Article IV, payment of the required fees and execution of a contract for using the NCLEX® examination where applicable.

Section 4. Areas. The Delegate Assembly shall divide the membership into numbered geographical Areas. At no time shall the number of Areas be less than three nor more than six. New members shall be assigned to existing Areas by the Board of Directors. The purpose of this division is to facilitate communication, encourage regional dialogue on NCSBN issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. Fees. The annual membership fees, for a Member Board and an Associate Member shall be set by the Delegate Assembly and shall be payable each October 1.

Section 6. Privileges. Member Board privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both the NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. Noncompliance. Any member whose fees remain unpaid after January 15 is not in good standing. Any member who does not comply with the provisions of the bylaws, and where applicable, the membership agreement, shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. Appeal. Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. Reinstatement. A member in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

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Delegate Assembly

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b) Qualification of Delegates. Members and employees of Member Boards shall be eligible to serve as delegates until their term or their employment with a Member Board ends. A NCSBN officer or director may not represent a Member Board as a delegate.

c) Term. Delegates and alternates serve from the time of appointment until replaced.

Section 2. Voting.

a) Annual Meetings. Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting.

b) Special Meetings. A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the corporate secretary of the NCSBN or a delegate of another Member Board to cast its votes.
Section 3. Authority. The Delegate Assembly, the membership body of the NCSBN, shall provide direction for the NCSBN through resolutions and enactments, including adoption of the mission and strategic initiatives, at any Annual Meeting or special session. The Delegate Assembly shall approve all new NCSBN memberships; approve the substance of all NCLEX® examination contracts between the NCSBN and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; and establish the fee for the NCLEX® examination.

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Section 5. Special Session. The Board of Directors may call, and upon written petition of at least ten Member Boards made to the Board of Directors, shall call a special session of the Delegate Assembly. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least ten days before the date for which such special session is called.

Section 6. Quorum. The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Section 7. Standing Rules. The Board of Directors shall present and the Delegate Assembly shall adopt Standing Rules for each Delegate Assembly meeting.

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Section 2. Directors. The directors of the NCSBN shall consist of four directors-at-large and a director from each Area.

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Section 4. Qualifications for President. The president shall have served NCSBN as either a delegate, a committee member, a director or an officer before being elected to the office of President.

Section 5. Election of Officers and Directors.

a) Time and Place. Election of officers and directors shall be by ballot of the Delegate Assembly during the Annual Meeting.

b) Officers and Directors-at-Large. Officers and directors-at-large shall be elected by majority vote of the Delegate Assembly.

c) Area Directors. Each Area shall elect its Area director by majority vote of the delegates from each such Area.
Section II: 2010 NCSBN Annual Meeting
Report of the Bylaws Committee - Attachment C: Proposed Bylaws, Clean Copy

Section 6. Terms of Office. The president, vice-president, treasurer, Area directors, and directors-at-large shall be elected for a term of two years or until their successors are elected. The president, vice-president treasurer, and two directors-at-large shall be elected in even-numbered years. The Area directors and two directors-at-large shall be elected in odd-numbered years. Officers and directors shall assume their duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same position.

Section 7. Limitations. No person may hold more than one officer position or directorship at one time. No officer or director shall hold elected or appointed office or a salaried position in a state, regional or national association or body if the office or position might result in a potential or actual, or the appearance of, a conflict of interest with the NCSBN, as determined by the Leadership Succession Committee before election to office and as determined by the Board of Directors after election to office. If incumbent officers or directors win an election for another office or director position, the term in their current position shall terminate at the close of the Annual Meeting at which the election is held.

Section 8. Vacancies. A vacancy in the office of president shall be filled by the vice-president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting and a successor is elected. The Delegate Assembly shall elect a person to fill any remainder of the term.

Section 9. Responsibilities of the President. The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and speak on behalf of and communicate the policies of the NCSBN.

Section 10. Responsibilities of the Vice-President. The vice-president shall assist the president, perform the duties of the president in the president’s absence, and fill any vacancy in the office of the president until the next Annual Meeting.

Section 11. Responsibilities of the Treasurer. The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors, and that annual financial reports are provided to the Delegate Assembly.

Article VI
Board of Directors

Section 1. Composition. The Board of Directors shall consist of the elected officers and directors of the NCSBN.

Section 2. Authority. The Board of Directors shall transact the business and affairs and act on behalf of the NCSBN except to the extent such powers are reserved to the Delegate Assembly as set forth in these bylaws and provided that none of the Board’s acts shall conflict with resolutions or enactments of the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly and approve the NCLEX® examination test service.
Section 3. Meetings of the Board of Directors. The Board of Directors shall hold its annual meeting in association with the Annual Meeting. The Board may schedule other regular meetings of the Board at other times as necessary to accomplish the work of the Board. Publication of the dates for such regular meetings in the minutes of the Board meeting at which the dates are selected shall constitute notice of the scheduled regular meetings. Special meetings of the Board of Directors may be called by the president or shall be called upon written request of at least three members of the Board of Directors. At least twenty-four hours notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Section 4. Removal from Office. A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly or the Board of Directors. The individual shall be given 30 days’ written notice of the proposed removal.

Section 5. Appeal. A member of the Board of Directors removed by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two-thirds vote of the Delegate Assembly.

Article VII

Leadership Succession Committee

Section 1. Leadership Succession Committee

a) Composition. The Leadership Succession Committee shall be comprised of eight members elected by the Delegate Assembly. Four of the eight elected positions shall be designated members to include a past Board of Directors member, a current or former NCSBN committee chair, a board member of a Member Board and an employee of a Member Board. The remaining four members shall be elected from each of the four areas.

b) Term. The term of office shall be two years. One-half of the Committee members shall be elected in even numbered years and one-half in odd number years. A committee member shall serve no more than two consecutive terms. Members shall assume duties at the close of the Annual Meeting at which they are elected.

c) Election. The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. In the event there is only one candidate for a committee position, election for that position shall be declared by acclamation. No ballot shall be necessary. The Chair shall be selected by the Board of Directors.

d) Limitation. A member elected or appointed to the Leadership Succession Committee may not be nominated for an officer or director position during the term for which that member was elected or appointed.

e) Vacancy. A vacancy occurring in the committee shall be filled from the remaining candidates from the previous election, in order of votes received. If no remaining candidates can serve, the Board of Directors shall fill the vacancy with an individual who meets the qualifications of Section 1a. of this Article. The person filling the vacancy shall serve the remainder of the term.

f) Duties. The Leadership Succession Committee shall recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee’s report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee. The Leadership Succession Committee shall determine qualifications and geographic distribution of nominations from the floor for recommendations to the Delegate Assembly.
Article VIII

Meetings

Section 1. Participation.

a) Delegate Assembly Session.

(i) Member Boards. Members and employees of Member Boards shall have the right, subject to the Standing Rules of the Delegate Assembly, to speak at all open sessions and forums of the Delegate Assembly, provided that only delegates shall be entitled to vote and only delegates and members of the Board of Directors may make motions at the Delegate Assembly, except the Examination Committee may bring motions to approve test plans pursuant to Article X, Section 1(a).

(ii) Public. All sessions of the Delegate Assembly held in accordance with Sections 4 and 5 of Article IV of these bylaws shall be open to the public, except executive sessions, provided that the minutes reflect the purpose of, and any action taken in, executive session.

b) Delegate Assembly Forums. Participation in forums conducted in association with the Annual Meeting shall be governed by the Standing Rules of the Delegate Assembly.

c) Meetings. NCSBN, including all committees thereof, may establish methods of conducting its business at all other meetings provided that the meetings of the Board of Directors and committees are open to members and employees of Member Boards.

d) Interactive Communications. Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the NCSBN Office.

e) Manner of Transacting Business. To the extent permitted by law and these bylaws, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.

Article IX

Chief Executive Officer

Section 1. Appointment. The Chief Executive Officer shall be appointed by the Board of Directors. The selection or termination of the Chief Executive Officer shall be by a majority vote of the Board of Directors.

Section 2. Authority. The Chief Executive Officer shall serve as the agent and chief administrative officer of the NCSBN and shall possess the authority and shall perform all duties incident to the office of Chief Executive Officer, including the management and supervision of the office, programs and services of NCSBN, the disbursement of funds and execution of contracts (subject to such limitations as may be established by the Board of Directors). The Chief Executive Officer shall serve as corporate secretary and oversee maintenance of all documents and records of the NCSBN and shall perform such additional duties as may be defined and directed by the Board.

Section 3. Evaluation. The Board of Directors shall conduct an annual written performance appraisal of the Chief Executive Officer, and shall set the Chief Executive Officer’s annual salary.

Article X

Committees

Section 1. Standing Committees. NCSBN shall maintain the following standing committees.
Section II: 2010 NCSBN Annual Meeting
Report of the Bylaws Committee - Attachment C: Proposed Bylaws, Clean Copy

Section 2. Special Committees. The Board of Directors may appoint special committees as needed to accomplish the mission of the NCSBN and to assist any Standing Committee in the fulfillment of its responsibilities. Special committees may include subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. Delegate Assembly Committees. The president shall appoint such Delegate Assembly Committees as provided in the Standing Rules and as necessary to conduct the business of the Delegate Assembly.

Section 4. Committee Membership.

a) **Composition.** Members of Standing and Special committees shall be appointed by the Board of Directors from the membership, provided, however, that Associate Members may not serve on the NCLEX® Examination, Bylaws, or Finance committees. Committees may also include other individuals selected for their special expertise to accomplish a committee’s charge. In appointing committees, one representative from each Area shall be selected unless a qualified member from each Area is not available considering the expertise needed for the committee work. The president, or president’s designee, shall be an ex-officio member of all committees except the Leadership Succession Committee. Associate Members shall have full voting rights as committee members.

b) **Term.** The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for re-appointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

c) **Vacancy.** A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

Article XI

**Finance**

Section 1. **Audit.** The financial records of the NCSBN shall be audited annually by a certified public accountant appointed by the Board of Directors. The annual audit report shall be provided to the Delegate Assembly.

Section 2. **Fiscal Year.** The fiscal year shall be from October 1 to September 30.

Article XII

**Indemnification**
Section 1. Direct Indemnification. To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney’s fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.

Section 2. Insurance. To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. Additional Rights. Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

a) not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and

b) continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIII

Parliamentary Authority

The rules contained in the current edition of *Robert’s Rules of Order Newly Revised* shall govern the NCSBN in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the NCSBN.

Article XIV

Amendment of Bylaws

Section 1. Amendment and Notice. These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly upon:

a) written notice to the Member Boards of the proposed amendments at least 45 days prior to the Delegate Assembly session and a two-thirds affirmative vote of the delegates present and voting; or

b) written notice that proposed amendments may be considered at least five days prior to the Delegate Assembly session and a three-quarters affirmative vote of the delegates present and voting.

In no event shall any amendments be adopted without at least five days written notice prior to the Delegate Assembly session that proposed amendments may be considered at such session.
Section 2. **Bylaws Committee.** A Bylaws committee composed of board members from Member Boards and/or employees of Member Boards may be appointed by the Board of Directors to review and make recommendations on proposed bylaw amendments as directed by the Board of Directors or the Delegate Assembly.

**Article XV**

**Dissolution**

**Section 1. Plan.** The Board of Directors at an annual, regular or special meeting may formulate and adopt a plan for the dissolution of the NCSBN. The plan shall provide, among other things, that the assets of the NCSBN be applied as follows:

Firstly, all liabilities and obligations of the NCSBN shall be paid or provided for.

Secondly, any assets held by the NCSBN which require return, transfer or conveyances, as a result of the dissolution, shall be returned, transferred or conveyed in accordance with such requirement.

Thirdly, all other assets, including historical records, shall be distributed in considered response to written requests of historical, educational, research, scientific or institutional health tax exempt organizations or associations, to be expended toward the advancement of nursing practice, regulation and the preservation of nursing history.

**Section 2. Acceptance of Plan.** Such plan shall be acted upon by the Delegate Assembly at an Annual or legally constituted special session called for the purpose of acting upon the proposal to dissolve. A majority of all Delegates present at a meeting at which a quorum is present must vote affirmatively to dissolve.

**Section 3. Conformity to Law.** Such plan to dissolve must conform to the law under which NCSBN is organized and to the Internal Revenue Code concerning dissolution of exempt corporations. This requirement shall override the provisions of Sections 1 and 2 herein.
Report of the Continued Competence Committee

Recommendation to the Delegate Assembly

Approve the Guiding Principles for Continued Competence.

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

Background

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

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

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

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

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

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

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

8. How can we support the use of common language regarding core competencies identified by the Institute of Medicine?

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

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

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

**Highlights of FY10 Activities**

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

**Future Activities**

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

**Attachments**

A. Definitions and Core Competencies of Continued Competence

B. Guiding Principles of Continued Competence
Attachment A

Definitions and Core Competencies of Continued Competence

APPLE Criteria: An acronym for the criteria used to guide the development of a policy or regulation: Administratively feasible, Professionally acceptable, Publicly credible, Legally defensible and Economically feasible.

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

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

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

Core Competencies: Knowledge, skills and abilities identified through a practice analysis that are universal to registered nurses (RNs) or licensed practical/vocational nurses (LPN/VNs), regardless of practice setting, specialty practice area and/or years of experience.

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

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

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

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

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

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

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

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

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

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

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

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

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

RN Core Competencies: Competencies identified through a practice analysis that are universal to RNs, regardless of specialty, practice setting or geographic location.
**Secured Environment**: A designated monitored testing site that meets specific standards related to test security.

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

Guiding Principles of Continued Competence

- The individual nurse, in collaboration with the state board of nursing, nursing educators, employers and the nursing profession, has the responsibility to demonstrate continued competence through:
  - Acquisition of new knowledge and skills; and
  - Appropriate, safe application of knowledge and skills.

- A culture of continued competence is based on the premise that the competence of any nurse should be periodically evaluated.

- Requirements for continued competence should support nurse accountability for lifelong learning and foster improved nursing practice and patient safety.

- The state boards of nursing have the regulatory authority for establishing continued competence requirements.
Recommendation to the Delegate Assembly

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

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

Background
The fiscal year 2009-2010 (FY09-10) charges to the DRC included the following:
1. Develop model rules on sexual misconduct including boundaries;
2. Develop content for a model course on professional ethics and conduct for use in remediation and discipline;
3. Develop a video on the disciplinary process for nurses; and
4. Extend the work on alternative programs for practice violations by exploring how states can implement successful programs.

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

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

VIDEO ON THE DISCIPLINARY PROCESS FOR NURSES
This video was developed for BONs to use as a resource for nurses who are the subject of a complaint, students or those interested in learning about the complaint and disciplinary processes. It also includes the BON’s role in handling complaints and protecting the public, the complaint investigation and resolution process, and actions that can be taken against a nurse’s license.
video script was developed by the DRC, NCSBN's Interactive Services and the Chicago-based production company SolidLine Media helped the committee develop the storyboard. The video shoot took place on March 18-19, 2010; production was completed in April 2010. Each BON received a copy of the video, titled “The Board of Nursing Complaint Process: Investigation to Resolution.” Additionally, the film will be posted on the NCSBN Interactive Services website and YouTube.

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

Highlights of FY10 Activities
- Completion of revisions to Chapter III and Chapter XI of the NCSBN Model Practice Act and Administrative Rules on sexual misconduct, including boundaries.
- Development of content for a professional ethics course for use by BONs.
- Completion of the video, “The Board of Nursing Complaint Process: Investigation to Resolution.”
- Development of predisciplinary alternative program for substandard practice guidelines.
- Participation on Discipline Networking Conference Calls.

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

Attachment
A. Model Rules for Sexual Misconduct, Including Boundaries
Attachment A

Model Rules for Sexual Misconduct, Including Boundaries

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

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

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

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

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

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

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

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

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

Administrative Rules: 11.2.1. Principles of Professional Boundaries

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Sexual intercourse;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

p. Transmitting information via electronic media that can be reasonably interpreted as sexual or sexually demeaning by the current or former patient or key party; and
11.2.3. Former Patient
A nurse may not engage or attempt to engage in sexual or romantic conduct with a former patient if doing so creates a risk that the relationship could cause harm to or exploitation of the former patient.

a. Factors which the BON may consider in determining risk of harm or exploitation include, but are not limited to:
   1. The length of time the nurse-patient relationship existed;
   2. The circumstances of the cessation or termination of the nurse-patient relationship;
   3. The amount of time that has passed since nursing services were terminated;
   4. The nature of the patient's health status and the extent of care received;
   5. The degree of the patient's dependence and vulnerability;
   6. The extent to which there exists an ongoing nurse-patient relationship following the termination of services, and whether the patient is reasonably anticipated to become a patient of the nurse in the future; and
   7. Any statements or actions made by the nurse during the course of treatment suggesting or inviting the possibility of sexual or romantic conduct.

b. Due to the unique vulnerability of mental health patients, including patients with substance use or dependency disorders, nurses are prohibited from engaging in or attempting to engage in sexual or romantic conduct with such former patients or key parties for a period of at least two years after termination of nursing services.

11.2.4. These Rules Do Not Prohibit:

a. Providing health care services to a person with whom the nurse has a preexisting, established personal relationship where there is no evidence of, or potential for, exploiting the patient; and

b. Contact that is necessary for a health care purpose that meets the standards of the profession.
Section II: 2010 NCSBN Annual Meeting

Pioneering the Path for Public Protection
Recommendation to the Delegate Assembly

Adopt the proposed 2011 NCLEX-PN® Test Plan.

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

Background
As a standing committee of NCSBN, the NEC is charged with providing psychometrically sound and legally defensible entry-level nurse licensure assessments to NCSBN Member Boards. In order to accomplish this, the committee monitors the NCLEX-RN® and NCLEX-PN® Examination process to ensure policies, procedures and standards utilized by the program meet and/or exceed guidelines proposed by the testing and measurement profession. The NEC investigates potential future enhancements to the NCLEX, evaluates additional international testing locations for the Board of Directors (BOD) and monitors all aspects of the NCLEX examination process, including item development, examination security, psychometrics and examination administration to ensure consistency with Member Boards’ need for examinations. The NEC recommends test plans to the Delegate Assembly.

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

Highlights of FY10 Activities

2010 NCLEX-RN® Test Plan
At the October 2009 meeting, the NEC reviewed the results of the Report of Findings from the 2009 LPN/VN Practice Analysis: Linking the NCLEX-PN® Examination to Practice. Empirical data from the 2009 LPN/VN Practice Analysis was used to evaluate the 2008 NCLEX-PN® Test Plan to determine if changes were needed. After indepth discussion and careful deliberation, the committee decided to retain the client needs framework and minor revisions were made throughout the document to provide clarity. Using the data from the practice analysis and psychometric considerations, the NEC determined changes to the percentage of test items allocated to each category and subcategory.
Client Needs

<table>
<thead>
<tr>
<th>Safe and Effective Care Environment</th>
<th>Percentage of Items from Each Category/Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coordinated Care</td>
<td>2008: 12-18%</td>
</tr>
<tr>
<td>• Safety and Infection Control</td>
<td>2011: 13-19%</td>
</tr>
<tr>
<td>Health Promotion and Maintenance</td>
<td>2008: 7-13%</td>
</tr>
<tr>
<td></td>
<td>2011: 7-13%</td>
</tr>
<tr>
<td>Psychosocial Integrity</td>
<td>2008: 8-14%</td>
</tr>
<tr>
<td></td>
<td>2011: 7-13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physiological Integrity</th>
<th>Percentage of Items from Each Category/Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Basic Care and Comfort</td>
<td>2008: 11-17%</td>
</tr>
<tr>
<td>• Pharmacological Therapies</td>
<td>2011: 9-15%</td>
</tr>
<tr>
<td>• Reduction of Risk Potential</td>
<td>2008: 10-16%</td>
</tr>
<tr>
<td>• Physiological Adaptation</td>
<td>2011: 9-15%</td>
</tr>
</tbody>
</table>

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

**Joint Research Committee (JRC)**

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

Several new pieces of research have either been completed or are near the final draft stage. Examples include an investigation into the cognitive processing and memorability of various innovative item types; effects of sample size on the properties of the separate calibration t-test in the detection of differential item functioning; an examination of decision rules; alternate item scoring methodology; enemy items identifying algorithm; establishing pretest statistical criteria specific for alternate item types; and optimal item pool design.

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

**TUNING Survey**

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

Following the methodology used in the original E.U. study, NCLEX staff conducted a study to determine how U.S. nursing programs compare to those in Europe in regard to 47 core nursing education competencies identified in the E.U. TUNING Project. To ensure comparability, staff replicated the methodology and sampling processes as much as possible.
In summer 2009, NCSBN surveyed recent NCLEX registrants, nurses that passed the NCLEX within the past year, nursing educators and nursing supervisors. A five-stage mailing process was used to engage participants in the study. Adjusted return rates among the four participant groups ranged from 25.4 percent to 50.2 percent. A total of 5,021 nursing professionals took part in the survey.

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

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

**Canadian Surveys in Ontario and British Columbia**

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

**Ontario Survey**

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

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

**British Columbia Survey**

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

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

NCSBN has been working to reduce the amount of time it takes to bring examination items from conception to operational usage. Rather than having operational item pools deployed for six months, a three-month deployment could reduce the amount of time it takes to place new items into operational usage. Security could also be enhanced by reducing the window of availability for any given operational item pool. In 2009, the JRC conducted a series of studies to develop optimal NCLEX quarterly item pool design. The guiding principle for these studies is that the NCLEX examinations generated from quarterly pools will be comparable to the semiannual pools and will not show significant adverse impacts in terms of measurement precision, decision consistency, content validity or overall item exposure rates. Rigorous planning and research have been conducted to permit the transition from semiannual to quarterly pool rotation. As of April 1, 2010, the NCLEX operational item pools are to be deployed quarterly.

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

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

On Nov. 4-6, 2009, a panel of 19 subject matter experts (SMEs) met in Chicago to participate in a criterion-referenced standard setting exercise for PTE Academic. Pearson staff members facilitated the panel. Using actual PTE Academic items, the panel made preliminary recommendations for performance benchmarks on the examination. Results from this criterion-referenced standard-setting exercise were presented to the NEC and the NCSBN BOD for consideration.

After reviewing the standard-setting process and recommendations from the standard-setting panel, historical data from the previous NCSBN English proficiency passing standard and other available evidence, such as comparability and impact data, NCSBN policy groups recommended that a total score of 55, with no individual section score below 50, was necessary on the PTE Academic in order to demonstrate the minimum degree of English proficiency necessary to be a safe and effective entry-level nurse. Making this legally defensible standard available to Member Boards will be beneficial. In addition to being legally defensible, the use of this passing standard by Member Boards would allow PTE Academic scores to be portable across jurisdictions. However, the final decision of whether to adopt the recommended passing standard rests on each individual board of nursing (BON). Each BON should carefully consider the applicability of the recommended standard to circumstances unique to their jurisdiction. This recommendation regarding the PTE Academic passing standard will be communicated to Member Boards, as well as other stakeholders. Additional information regarding the PTE Academic standard setting is available on the NCSBN website.

NCLEX® Alternate Item Types

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

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

Pearson VUE has begun to phase in palm vein technology at PPCs. This technology is very accurate and allows NCSBN to more precisely identify people trying to take the NCLEX under assumed testers’ identities. By preventing proxy testers, the technology helps NCSBN maintain the integrity of the NCLEX examination. The palm vein device serves as a second level of security; it does not replace fingerprinting.

Pearson VUE will be opening four new PPCs and expanding seating capacity at 17 other centers in 2010. Member Boards are notified of these PPC changes prior to implementation. Information on PPC updates are featured in NCSBN’s Council Connector newsletter.

Evaluated and Monitored NCLEX® Examination Policies and Procedures

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

MONITORED ASPECTS OF EXAMINATION DEVELOPMENT

Conducted NEC and NIRSC Sessions

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

Assistance from the NIRSC continues to reduce the NEC’s item review workload, facilitating its efforts toward achieving defined goals. As the item pools continue to grow, review of operational items is critical to ensure that the item pools reflect current entry-level nursing practice. At this time, the number of volunteers serving on the NIRSC is 19, with representation from all four NCSBN geographic areas. Orientation to the NIRSC occurs annually and at each meeting.

Monitored Item Production

Under the direction of the NEC, RN and PN pretest items were written and reviewed by NCLEX® Item Development Panels, who’s productivity can be seen in Tables 1 and 2. As part of the contractual requirements with the test service, items that use alternate formats (i.e., any format other than multiple choice) have been developed and deployed in item pools. Information about items using alternate formats has been made available to Member Boards and candidates in the NCLEX® Candidate Bulletin, candidate tutorial and on the NCSBN website.
NCSBN Item Development Sessions Held at Pearson VUE

Table 1. RN Item Development Productivity Comparison

<table>
<thead>
<tr>
<th>Year</th>
<th>Writing Sessions</th>
<th>Item Writers</th>
<th>Items Written</th>
<th>Review Sessions</th>
<th>Items Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 02 – March 03</td>
<td>4</td>
<td>47</td>
<td>2611</td>
<td>7</td>
<td>1542</td>
</tr>
<tr>
<td>April 03 – March 04</td>
<td>2</td>
<td>23</td>
<td>1097</td>
<td>5</td>
<td>1446</td>
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<tr>
<td>April 04 – March 05</td>
<td>1</td>
<td>12</td>
<td>301</td>
<td>4</td>
<td>1415</td>
</tr>
<tr>
<td>April 05 – March 06</td>
<td>5</td>
<td>66</td>
<td>2514</td>
<td>7</td>
<td>2885</td>
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<tr>
<td>April 06 – March 07</td>
<td>3</td>
<td>47</td>
<td>1835</td>
<td>6</td>
<td>3195</td>
</tr>
<tr>
<td>April 07 – March 08</td>
<td>3</td>
<td>47</td>
<td>1815</td>
<td>5</td>
<td>2556</td>
</tr>
<tr>
<td>April 08 – March 09</td>
<td>3</td>
<td>39</td>
<td>1724</td>
<td>5</td>
<td>3036</td>
</tr>
<tr>
<td>April 09 – March 10</td>
<td>6</td>
<td>66</td>
<td>1931</td>
<td>14</td>
<td>7948</td>
</tr>
</tbody>
</table>

Table 2. PN Item Development Productivity Comparison

<table>
<thead>
<tr>
<th>Year</th>
<th>Writing Sessions</th>
<th>Item Writers</th>
<th>Items Written</th>
<th>Review Sessions</th>
<th>Items Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 02 – March 03</td>
<td>3</td>
<td>33</td>
<td>1476</td>
<td>6</td>
<td>1547</td>
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<tr>
<td>April 03 – March 04</td>
<td>2</td>
<td>24</td>
<td>968</td>
<td>5</td>
<td>1611</td>
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<tr>
<td>April 04 – March 05</td>
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<td>430</td>
<td>3</td>
<td>2124</td>
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<tr>
<td>April 05 – March 06</td>
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<td>1938</td>
<td>5</td>
<td>3682</td>
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<td>April 06 – March 07</td>
<td>3</td>
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<td>2453</td>
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<td>April 07 – March 08</td>
<td>3</td>
<td>48</td>
<td>2378</td>
<td>6</td>
<td>3304</td>
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<tr>
<td>April 08 – March 09</td>
<td>1</td>
<td>16</td>
<td>551</td>
<td>6</td>
<td>2829</td>
</tr>
<tr>
<td>April 09 – March 10</td>
<td>2</td>
<td>24</td>
<td>869</td>
<td>5</td>
<td>1578</td>
</tr>
</tbody>
</table>

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

Monitored Item Sensitivity Review

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

Evaluated Item Development Process and Progress

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

Monitored Development of Operational NCLEX® Item Pools

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

**Member Board Review of Items**

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

**Item-related Incident Reports (IRs)**

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

**MONITOR EXAMINATION ADMINISTRATION**

**Monitored Procedures for Candidate Tracking: Candidate-matching Algorithm**

The committee continued to monitor the status and effectiveness of the candidate-matching algorithm. On a semiannual basis, Pearson VUE conducts a check for duplicate candidate records on all candidates who have tested within the last six months.

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

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

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

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

The NEC monitors compliance with the 30-/45-day scheduling rule. For the period of Jan. 1, 2009, to Dec. 31, 2009, all candidates were able to be tested in compliance. A dedicated department at Pearson VUE continues to analyze PPC utilization levels in order to project future testing volumes and meet the testing needs of all testing clients. As an early indicator of PPC usage, Pearson VUE reports to NCSBN staff on a weekly basis when sites exceed 80.0 percent capacity levels.

**Responded to Member Board Inquiries Regarding NCLEX® Examination Administration**

As part of its activities, the NEC and the NCSBN NCLEX® Examinations department responded to Member Boards’ questions and concerns regarding administration of the NCLEX exams.
More specific information regarding the performance of Pearson VUE can be found in the Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX®), available in Attachment D of this report.

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

EDUCATE STAKEHOLDERS

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

NCSBN and test service staff also participated in the 7th Conference of the International Test Commission (ITC) in Hong Kong. There were two papers, “Setting Minimal English Proficiency Standard for Entry-level Healthcare Professionals: A Comparison of Standard Setting Methods” and “Developing Effective Statistical Screening Criteria for Pretest Items on a Computerized Adaptive Test,” as well as a poster presentation, “Comparing Item Performance Between Domestic and International Examinees on a High Stakes Licensure Computerized Adaptive Test,” that were selected by the conference. The ITC is an association of national psychological associations, test commissions, publishers and other testing organizations that provides a venue where researchers and practitioners come together to improve practice, and advance the field of testing and measurement. Acceptance in these programs not only helps NCSBN share expertise on best testing practices worldwide, but also allows NCSBN to move ahead in psychometric testing solutions through the collective strength of internal and external stakeholders. Furthermore, collaborating on psychometric testing issues with external communities allows NCSBN to remain at the forefront of the testing industry.

Presentations and Publications
NCSBN NCLEX® Examinations staff conducted numerous NCLEX informational presentations, webinars and workshops, including:

- “Nursing Mobility and the NCLEX Examinations” at the Philippine Nurses Association International Conference in Cebu, Philippines;
- “Developing Item Variants: An Empirical Study” and “Innovative Items Memorability and Cognitive Processing: A Pilot Study” at the 2010 American Educational Research Association (AERA) Annual Meeting in Denver, Colo.; and
In order to ensure NCSBN membership was kept current on the NCLEX program, the NCLEX Examinations department hosted four informational webinars for Member Boards. Additionally, as part of the department’s outreach activities, content staff conducted three NCLEX Regional Workshops. Regional workshops are presented for the purpose of providing information to educators preparing students to take the NCLEX examination. The BONs that hosted a regional workshop were California-RN, Illinois and Wisconsin. These opportunities assist the NCSBN NCLEX Examinations department with educating stakeholders about the examination, as well as recruit for NCSBN item development panels.

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

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

- “Keeping the NCLEX-RN current,” Nurse Educator, 35(1);
- “Developing models that impact item development,” CLEAR Exam Review, 20(2); and

**NCLEX® Member Board Manual**

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

**NCLEX® Invitational**

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

**NCLEX® Program Reports**

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

**NCLEX® Unofficial Quick Results Service**

BONs, through NCSBN, offer candidates the opportunity to learn their unofficial results (official results are only available from the BONs directly) through the NCLEX® Quick Results Service. A candidate may call or use the Internet to access their unofficial result two business days after completing their examination. Currently, 46 BONs participate in offering this service to their candidates. In 2009, 146,147 candidates utilized this service.

**Future Activities**

- Complete the continuous online LPN/VN practice analysis.
- Conduct a PN standard-setting workshop.
Continue to monitor all administrative, test development and psychometric aspects of the NCLEX examination program.

Evaluate all aspects of the NCLEX program and initiate additional quality assurance processes, as needed.

Evaluate NCLEX informational initiatives, such as the NCLEX® Invitational, NCLEX® Regional Workshops and other presentations.

Evaluate ongoing international testing.

Host the 2010 NCLEX® Invitational.

Introduce additional alternate format item types, which may include multimedia, such as sound and video for the NCLEX examinations.

Explore additional item-writing strategies for the NCLEX.

Conduct the RN practice analysis.

**Attachments**

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

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

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

D. Annual Report of Pearson VUE for the NCLEX®
Comparison of 2008 to the proposed 2011 NCLEX-PN® Test Plan

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

NCLEX-PN® Test Plan 2011

National Council Licensure Examination for Practical/Vocational Nurses

(INTERNATIONAL EXAMINATION)

Introduction

Entry into the practice of nursing is regulated by the licensing authorities within each of the National Council of State Boards of Nursing (NCSBN) member jurisdiction. To ensure public protection, each jurisdiction requires candidates for licensure to meet set requirements that include passing an examination that measures the competencies needed to perform safely and effectively as a newly licensed entry-level practical/vocational nurse. NCSBN develops a licensure examination, the National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-PN® Examination), which is used by member boards to assist in making licensure decisions.

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

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

Beliefs

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

Nursing is both an art and a science, founded on a professional body of knowledge that integrates concepts from the liberal arts and the biological, physical, psychological and social sciences. It is a learned profession based on an understanding of the human condition across the life span and the relationships of an individual with others and with the environment. Nursing is a dynamic, continually evolving discipline that employs critical thinking to integrate increasingly complex knowledge, skills, technologies, and client care activities into evidence-based nursing practice. The goal of nursing for client care is preventing illness; promoting comfort; protecting, promoting, and restoring health; and promoting dignity in dying.

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

**Classification of Cognitive Levels**

Bloom’s taxonomy for the cognitive domain is used as a basis for writing and coding items for the examination (Bloom et al., 1956; Anderson & Krathwohl, 2001). The practice of practical/vocational nursing requires application of knowledge, skills and abilities, therefore the majority of items are written at the application or higher levels of cognitive ability.

**Test Plan Structure**

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

**Client Needs**

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

- Safe and Effective Care Environment
  - Coordinated Care
  - Safety and Infection Control
- Health Promotion and Maintenance
- Psychosocial Integrity
- Physiological Integrity
  - Basic Care and Comfort
  - Pharmacological Therapies
  - Reduction of Risk Potential
  - Physiological Adaptation

**Integrated Processes**

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

- Clinical Problem-Solving Process (Nursing Process) – a scientific approach to client care that includes data collection, planning, implementation and evaluation.
- Caring – interaction of the practical/vocational nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the practical/vocational nurse provides support and compassion to help achieve desired therapeutic outcomes.
- Communication and Documentation – verbal and nonverbal interactions between the practical/vocational nurse and the client, as well as other members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.
- Teaching and Learning – facilitation of the acquisition of knowledge, skills and attitudes to assist in promoting a change in behavior.
Distribution of Content

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

Client Needs Categories

- Safe and Effective Care Environment
- Coordinated Care
- Safety and Infection Control
- Health Promotion and Maintenance
- Psychosocial Integrity
- Physiological Integrity
  - Basic Care and Comfort
  - Pharmacological Therapies
  - Reduction of Risk Potential
  - Physiological Adaptation

Percentage of Items from each Category/Subcategory

<table>
<thead>
<tr>
<th>Client Needs Category</th>
<th>Percentage of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe and Effective Care Environment</td>
<td>*13-19%</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>*11-17%</td>
</tr>
<tr>
<td>Safety and Infection Control</td>
<td>*7-13%</td>
</tr>
<tr>
<td>Health Promotion and Maintenance</td>
<td>*7-13%</td>
</tr>
<tr>
<td>Psychosocial Integrity</td>
<td>*9-15%</td>
</tr>
<tr>
<td>Physiological Integrity</td>
<td>*11-17%</td>
</tr>
<tr>
<td>Basic Care and Comfort</td>
<td>*8-14%</td>
</tr>
<tr>
<td>Pharmacological Therapies</td>
<td>*10-16%</td>
</tr>
<tr>
<td>Reduction of Risk Potential</td>
<td>*11-17%</td>
</tr>
<tr>
<td>Physiological Adaptation</td>
<td>*9-15%</td>
</tr>
</tbody>
</table>
Overview of Content

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

Safe and Effective Care Environment

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

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

  Related content includes but is not limited to:

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

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

  Related content includes but is not limited to:

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

Health Promotion and Maintenance

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

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

Deleted:
- Staff Education
- Medical and Surgical Asepsis
- Internal and External Disaster Plans
- Other Precautions
- Family Planning
- Screening Programs
- Human Sexuality
- Disease Prevention
- Immunizations
- Expected Body Image Changes
Psychosocial Integrity
The practical/vocational nurse provides care that assists with promotion and support of the emotional, mental and social well-being of clients.

Related content includes but is not limited to:
- Abuse or Neglect
- Behavioral Management
- Chemical and other dependencies
- Coping Mechanisms
- Crisis Intervention
- Cultural Awareness
- End of Life Concepts
- Grief and Loss
- Mental Health, Concepts
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Stress Management
- Support Systems
- Therapeutic Communication
- Therapeutic Environment

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

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

Related content includes but is not limited to:
- Assistive Devices
- Elimination
- Mobility/Immobility
- Non-Pharmacological Comfort Interventions
- Nutrition and Oral Hydration
- Personal Hygiene
- Rest and Sleep

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

Related content includes but is not limited to:
- Adverse Effects/Contraindications/Side Effects/Interactions
- Dosage Calculations
- Expected Actions/Outcomes
- Medication Administration
- Pharmacological Pain Management

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

Related content includes but is not limited to:
- Changes/Abnormalities in Vital Signs
- Diagnostic Tests
- Laboratory Values
- Potential for Alterations in Body Systems
- Potential for Complications of Diagnostic Tests/Treatments Procedures
- Therapeutic Procedures

Updated by__
Administration of the NCLEX-PN® Examination

The NCLEX-PN® Examination is administered to candidates by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. With CAT, each candidate’s examination is unique because it is assembled interactively as the examination proceeds. Computer technology selects items to administer that match the candidate’s ability. The items, which are stored in a large item pool, have been classified by test plan category and level of difficulty. After the candidate answers an item, the computer calculates an ability estimate based on all of the previous answers the candidate selected. The next item administered is chosen to measure the candidate’s ability in the appropriate test plan category. This process is repeated for each item, creating an examination tailored to the candidate’s knowledge and skills while fulfilling all NCLEX-PN® Test Plan requirements. The examination continues with items selected and administered in this way until a pass or fail decision is made.

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

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


Attachment B

Proposed 2011 NCLEX-PN® Test Plan-Clean Copy

1 NCLEX-PN® Test Plan 2011

2 National Council Licensure Examination for Practical/Vocational Nurses
3 (NCLEX-PN® Examination)

4 Introduction

5 Entry into the practice of nursing is regulated by the licensing authorities within each of the National Council of State Boards of
6 Nursing (NCSBN) member board jurisdictions (state, commonwealth, and territorial boards of nursing). To ensure public
7 protection, each jurisdiction requires candidates for licensure to meet set requirements that include passing an examination that
8 measures the competencies needed to perform safely and effectively as a newly licensed, entry-level practical/vocational nurse.
9 NCSBN develops a licensure examination, the National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-
10 PN® Examination), which is used by member board jurisdictions to assist in making licensure decisions.
11
12 Several steps occur in the development of the NCLEX-PN® Test Plan. The first step is conducting a practice analysis that is used
13 to collect data on the current practice of entry-level practical/vocational nurses (Report of Findings from the 2009 LPN/VN
14 Practice Analysis: Linking the NCLEX-PN® Examination to Practice [NCSBN, 2009]). Newly licensed practical/vocational nurses
15 are asked about the frequency and priority of performing 150 nursing care activities. Nursing care activities are then analyzed in
16 relation to the frequency of performance, impact on maintaining client safety and client care settings where the activities are
17 performed. This analysis guides the development of a framework for entry-level nursing practice that incorporates specific client
18 needs as well as processes that are fundamental to the practice of nursing. The next step is the development of the NCLEX-PN®
19 Test Plan, which guides the selection of content and behaviors to be tested. Variations in jurisdiction laws and regulations are
20 considered in the development of the test plan.

21 The NCLEX-PN® Test Plan provides a concise summary of the content and scope of the licensing examination. It serves as a
22 guide for examination development as well as candidate preparation. Each examination assesses the knowledge, skills and
23 abilities that are essential for the entry-level practical/vocational nurse to use in order to meet the needs of clients requiring the
24 promotion, maintenance or restoration of health. The following sections describe beliefs about people and nursing that are
25 integral to the examination, cognitive abilities that will be tested in the examination, and specific components of the NCLEX-PN®
26 Test Plan.

27 Beliefs

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

33 Nursing is both an art and a science, founded on a professional body of knowledge that integrates concepts from the liberal arts
34 and the biological, physical, psychological and social sciences. It is a learned profession based on an understanding of the
35 human condition across the life span and the relationships of an individual with others and within the environment. Nursing is a
36 dynamic, continually evolving discipline that employs critical thinking to integrate increasingly complex knowledge, skills,
37 technologies, and client care activities into evidence-based nursing practice. The goal of nursing for client care is preventing
38 illness; promoting comfort; protecting, promoting, and restoring health; and promoting dignity in dying.

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

Bloom’s taxonomy for the cognitive domain is used as a basis for writing and coding items for the examination (Bloom et al., 1956; Anderson & Krathwohl, 2001). The practice of practical/vocational nursing requires application of knowledge, skills and abilities; therefore, the majority of items are written at the application or higher levels of cognitive ability.

Test Plan Structure

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

Client Needs

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

- Safe and Effective Care Environment
  - Coordinated Care
  - Safety and Infection Control
- Health Promotion and Maintenance
- Psychosocial Integrity
- Physiological Integrity
  - Basic Care and Comfort
  - Pharmacological Therapies
  - Reduction of Risk Potential
  - Physiological Adaptation

Integrated Processes

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

- Clinical Problem-Solving Process (Nursing Process) – a scientific approach to client care that includes data collection, planning, implementation and evaluation.
- Caring – interaction of the practical/vocational nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the practical/vocational nurse provides support and compassion to help achieve desired therapeutic outcomes.
- Communication and Documentation – verbal and nonverbal interactions between the practical/vocational nurse and the client, as well as other members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.
- Teaching and Learning – facilitation of the acquisition of knowledge, skills and attitudes to assist in promoting a change in behavior.
Distribution of Content

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

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</tr>
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<td>9-15%</td>
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<tr>
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<td>9-15%</td>
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Overview of Content

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

Safe and Effective Care Environment

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

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

  Related content includes but is not limited to:
  - Advance Directives
  - Advocacy
  - Client Care Assignments
  - Client Rights
  - Collaboration with Interdisciplinary Team
  - Concepts of Management and Supervision
  - Confidentiality/Information Security
  - Continuity of Care
  - Establishing Priorities
  - Ethical Practice
  - Informed Consent
  - Information Technology
  - Legal Responsibilities
  - Performance Improvement (Quality Improvement)
  - Referral Process
  - Resource Management

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

  Related content includes but is not limited to:
  - Accident/Error/Injury Prevention
  - Emergency Response Plan
  - Ergonomic Principles
  - Handling Hazardous and Infectious Materials
  - Home Safety
  - Reporting of Incident/Event/Regular Occurrence/Variance
  - Restraints and Safety Devices
  - Safe Use of Equipment
  - Security Plan
  - Standard Precautions/Transmission-Based Precautions/Surgical Asepsis

Health Promotion and Maintenance

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

- Aging Process
- Antenatal/Intrapartum/Postpartum and Newborn Care
- Data Collection Techniques
- Developmental Stages and Transitions

- Health Promotion/Disease Prevention
- High Risk Behaviors
- Lifestyle Choices
- Self-Care
Psychosocial Integrity

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

Related content includes but is not limited to:

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

Physiological Integrity

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

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

Related content includes but is not limited to:

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

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

Related content includes but is not limited to:

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

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

Related content includes but is not limited to:

- Changes/Abnormalities in Vital Signs
- Diagnostic Tests
- Laboratory Values
- Potential for Alterations in Body Systems
- Potential for Complications of Diagnostic Tests/Treatments/Procedures
- Potential for Complications from Surgical Procedures and Health Alterations
- Therapeutic Procedures
Physiological Adaptation – The practical/vocational nurse participates in providing care for clients with acute, chronic or life-threatening physical health conditions.

Related content includes but is not limited to:
- Alterations in Body Systems
- Basic Pathophysiology
- Fluid and Electrolyte Imbalances
- Medical Emergencies
- Radiation Therapy
- Unexpected Response to Therapies

Administration of the NCLEX-PN® Examination

The NCLEX-PN® Examination is administered to candidates by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. With CAT, each candidate’s examination is unique because it is assembled interactively as the examination proceeds. Computer technology selects items to administer that match the candidate’s ability. The items, which are stored in a large item pool, have been classified by test plan category and level of difficulty. After the candidate answers an item, the computer calculates an ability estimate based on all of the previous answers the candidate selected. The next item administered is chosen to measure the candidate’s ability in the appropriate test plan category. This process is repeated for each item, creating an examination tailored to the candidate’s knowledge and skills while fulfilling all NCLEX-PN® Test Plan requirements. The examination continues with items selected and administered in this way until a pass or fail decision is made.

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

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


## Attachment C

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2009</td>
<td>NCLEX® Examination Committee reviews PN practice analysis results and makes recommendations to the test plan.</td>
</tr>
<tr>
<td>November 2009</td>
<td>Proposed test plan is sent to Member Boards for feedback.</td>
</tr>
<tr>
<td>March 2010</td>
<td>NCLEX® Examination Committee presents the proposed test plan at the NCSBN Midyear Meeting.</td>
</tr>
<tr>
<td>April 2010</td>
<td>NCLEX® Examination Committee reviews feedback on the test plan and submits recommendations to the Delegate Assembly.</td>
</tr>
<tr>
<td>August 2010</td>
<td>Delegate Assembly action is provided.</td>
</tr>
<tr>
<td>September 2010</td>
<td>PN test plan is published and placed on the NCSBN website.</td>
</tr>
<tr>
<td>September 2010</td>
<td>Panel of Judges meets to recommend the passing standard.</td>
</tr>
<tr>
<td>December 2010</td>
<td>NCSBN Board of Directors evaluates the passing standard.</td>
</tr>
<tr>
<td>April 2011</td>
<td>Implementation of the test plan and passing standard.</td>
</tr>
</tbody>
</table>
Attachment D

Annual Report of Pearson VUE for the NCLEX®

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

Pearson VUE Organizational Changes

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

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

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

Test Development

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

NCLEX® Examinations Operations

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

Pearson VUE visits to NCSBN

- Jan. 20-22, 2009, NCLEX® Examination Committee Business Meeting
- March 2-4, 2009, Midyear Meeting
- April 15-17, 2009, NCLEX® Examination Committee Business Meeting
- April 18, 2009, NCLEX® Development Group Meeting
- April 27, 2009, Alternate Item Group Meeting
- May 7, 2009, Medical Illustrator Vendor Meeting/Presentation
- May 21, 2009, Audio Vendor Meeting/Presentation
- June 11, 2009, Production Schedule Meeting
- July 13, 2009, Test Content Contract Evaluation Meeting
- July 14, 2009, NCLEX® Development Group Meeting
- July 20, 2009, Animation Vendor Meeting/Presentation
■ Aug. 11-14, 2009, Delegate Assembly
■ Aug. 26, 2009, General NCLEX Meeting
■ Sept. 18, 2009, NCLEX® Development Group Meeting
■ Oct. 27-29, 2009, NCLEX® Examination Committee Business Meeting
■ Oct. 30, 2009, Contract Evaluation Meeting
■ Dec. 17, 2009, NCLEX® Development Meeting

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

Summary of NCLEX® Examination Results for the 2009 Calendar Year

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

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

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

1Data for October to December 2009 are preliminary pending updated data from stat extract files.
A total of 56.0 percent of the candidates chose to take a break during their examinations (compared to 59.4 percent last year).

Overall, 2.2 percent of the total group and 1.0 percent of the reference group ran out of time before completing the test. These percentages of candidates timing out were approximately the same as the corresponding percentages for candidates during the 2008 testing year (2.2 percent and 1.1 percent, respectively).

In general, the NCLEX-RN Examination summary statistics for the 2009 testing period indicated patterns that were similar to those observed for the 2008 testing period. These results provide continued evidence that the administration of the NCLEX-RN Examination is psychometrically sound.

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

Overall, 80,854 PN candidates tested in 2009, as compared to 77,835 PN candidates tested during 2008. This represents an increase of approximately 3.9 percent.

The candidate population reflected 63,534 first-time, U.S.-educated candidates who tested in 2009, as compared to 61,773 for the 2008 testing year (an increase of approximately 2.9 percent).

The overall passing rate was 75.9 percent in 2009 compared to 76.2 percent in 2008, and the reference group passing rate was 85.7 percent in 2009 compared to 85.6 percent in 2008.

There were 55.1 percent of the total group and 59.6 percent of the reference group who ended their tests after a minimum of 85 items were administered. These figures are slightly higher than those from the 2008 testing year, in which 54.4 percent of the total group and 58.8 percent of the reference group took minimum-length exams.

The percentage of maximum-length test takers was 16.5 percent for the total group and 14.1 percent for the reference group. These figures are slightly lower than last year’s percentages (17.3 percent for the total group and 14.9 percent for the reference group).

The average time needed to take the NCLEX-PN Examination during the 2009 testing period was 2.3 hours for the overall group and 2.1 hours for the reference group (very similar to last year’s times of 2.2 and 2.1 hours, respectively).

Overall, 2.0 percent of the total group and 1.0 percent of the reference group ran out of time before completing the test (slightly higher than last year’s figures of 1.8 percent and 0.9 percent, respectively).

In general, the NCLEX-PN Examination summary statistics for the 2009 testing period indicated patterns that were similar to those observed for the 2008 testing period. These results provide continued evidence that the administration of the NCLEX-PN Examination is psychometrically sound.
### Table 1: Longitudinal Technical Summary for the NCLEX-RN® Examination: Group Statistics for 2009 Testing Year

<table>
<thead>
<tr>
<th></th>
<th>Jan 09 - Mar 09</th>
<th>Apr 09 - Jun 09</th>
<th>Jul 09 - Sep 09</th>
<th>Oct 09 - Dec 09</th>
<th>Cumulative 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number Testing</strong></td>
<td>46,891</td>
<td>31,060</td>
<td>52,565</td>
<td>35,468</td>
<td>73,790</td>
</tr>
<tr>
<td><strong>Percent Passing</strong></td>
<td>71.8</td>
<td>88.1</td>
<td>74.8</td>
<td>90.8</td>
<td>77.9</td>
</tr>
<tr>
<td><strong>Ave. # Items Taken</strong></td>
<td>120.8</td>
<td>115.2</td>
<td>118.4</td>
<td>110.9</td>
<td>120.8</td>
</tr>
<tr>
<td><strong>% Taking Min # Items</strong></td>
<td>41.4</td>
<td>12.3</td>
<td>13.4</td>
<td>11.2</td>
<td>14.5</td>
</tr>
<tr>
<td><strong>Ave. Test Time</strong></td>
<td>2.5</td>
<td>2.2</td>
<td>2.4</td>
<td>2.1</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>% Taking Break</strong></td>
<td>56.3</td>
<td>48.8</td>
<td>53.4</td>
<td>43.0</td>
<td>54.3</td>
</tr>
<tr>
<td><strong>% Timing Out</strong></td>
<td>2.0</td>
<td>1.0</td>
<td>2.1</td>
<td>0.7</td>
<td>1.9</td>
</tr>
</tbody>
</table>

### Table 2: Longitudinal Technical Summary for the NCLEX-RN® Examination: Group Statistics for 2008 Testing Year

<table>
<thead>
<tr>
<th></th>
<th>Jan 08 - Mar 08</th>
<th>Apr 08 - Jun 08</th>
<th>Jul 08 - Sep 08</th>
<th>Oct 08 - Dec 08</th>
<th>Cumulative 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number Testing</strong></td>
<td>46,863</td>
<td>29,465</td>
<td>52,513</td>
<td>32,404</td>
<td>78,337</td>
</tr>
<tr>
<td><strong>Percent Passing</strong></td>
<td>70.5</td>
<td>87.1</td>
<td>70.7</td>
<td>89.3</td>
<td>74.7</td>
</tr>
<tr>
<td><strong>Ave. # Items Taken</strong></td>
<td>122.5</td>
<td>119.3</td>
<td>118.7</td>
<td>111.6</td>
<td>120.4</td>
</tr>
<tr>
<td><strong>% Taking Min # Items</strong></td>
<td>49.5</td>
<td>51.8</td>
<td>53.1</td>
<td>57.9</td>
<td>51.6</td>
</tr>
<tr>
<td><strong>Ave. Test Time</strong></td>
<td>2.6</td>
<td>2.4</td>
<td>2.4</td>
<td>2.2</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>% Taking Break</strong></td>
<td>60.4</td>
<td>52.8</td>
<td>57.4</td>
<td>45.5</td>
<td>57.9</td>
</tr>
<tr>
<td><strong>% Timing Out</strong></td>
<td>2.2</td>
<td>1.1</td>
<td>2.3</td>
<td>0.9</td>
<td>1.9</td>
</tr>
</tbody>
</table>

### Table 3: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2009 Testing Year*

#### Operational Item Statistics

<table>
<thead>
<tr>
<th></th>
<th>Jan 09 - Mar 09</th>
<th>Apr 09 - Jun 09</th>
<th>Jul 09 - Sep 09</th>
<th>Oct 09 - Dec 09</th>
<th>Cumulative 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Point-Biserial</strong></td>
<td>0.20</td>
<td>0.21</td>
<td>0.21</td>
<td>0.20</td>
<td>0.20</td>
</tr>
<tr>
<td><strong>Ave. Item Time (secs)</strong></td>
<td>71.8</td>
<td>73.9</td>
<td>72.8</td>
<td>76.6</td>
<td>76.4</td>
</tr>
</tbody>
</table>

#### Pretest Item Statistics

<table>
<thead>
<tr>
<th></th>
<th># of Items</th>
<th>Ave. Sample Size</th>
<th>Mean Point-Biseral</th>
<th>Mean P+</th>
<th>Mean B-Value</th>
<th>SD B-Value</th>
<th>Total Number Flagged</th>
<th>% Items Flagged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>826</td>
<td>532</td>
<td>0.08</td>
<td>0.52</td>
<td>0.17</td>
<td>1.79</td>
<td>368</td>
<td>44.6</td>
</tr>
</tbody>
</table>

*Data does not include research and retest items.
Table 4: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2008 Testing Year*

<table>
<thead>
<tr>
<th>Operational Item Statistics</th>
<th>Jan 08 - Mar 08</th>
<th>Apr 08 - Jun 08</th>
<th>Jul 08 - Sep 08</th>
<th>Oct 08 - Dec 08</th>
<th>Cumulative 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point-Biserial</td>
<td>0.20</td>
<td>0.20</td>
<td>0.20</td>
<td>0.19</td>
<td>0.19</td>
</tr>
<tr>
<td>Ave. Item Time (secs)</td>
<td>72.7</td>
<td>74.0</td>
<td>72.9</td>
<td>75.2</td>
<td>75.2</td>
</tr>
<tr>
<td># of Items</td>
<td>890</td>
<td>851</td>
<td>1,322</td>
<td>245</td>
<td>3,308</td>
</tr>
<tr>
<td>Ave. Sample Size</td>
<td>496</td>
<td>571</td>
<td>513</td>
<td>653</td>
<td>534</td>
</tr>
<tr>
<td>Mean Point-Biserial</td>
<td>0.10</td>
<td>0.09</td>
<td>0.08</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td>Mean P+</td>
<td>0.57</td>
<td>0.52</td>
<td>0.56</td>
<td>0.57</td>
<td>0.55</td>
</tr>
<tr>
<td>Mean B-Value</td>
<td>-0.13</td>
<td>0.23</td>
<td>-0.09</td>
<td>-0.19</td>
<td>-0.03</td>
</tr>
<tr>
<td>SD B-Value</td>
<td>1.63</td>
<td>1.76</td>
<td>1.63</td>
<td>1.61</td>
<td>1.67</td>
</tr>
<tr>
<td>Total Number Flagged</td>
<td>295</td>
<td>345</td>
<td>604</td>
<td>96</td>
<td>1,340</td>
</tr>
<tr>
<td>% Items Flagged</td>
<td>33.1</td>
<td>40.5</td>
<td>45.7</td>
<td>39.2</td>
<td>40.5</td>
</tr>
</tbody>
</table>

*Data do not include research and retest items.

Table 5: Longitudinal Technical Summary for the NCLEX-PN® Group Statistics for 2009 Testing Year

<table>
<thead>
<tr>
<th>Jan 09 - Mar 09</th>
<th>Apr 09 - Jun 09</th>
<th>Jul 09 - Sep 09</th>
<th>Oct 09 - Dec 09</th>
<th>Cumulative 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Testing</td>
<td>18,684</td>
<td>16,873</td>
<td>26,849</td>
<td>22,572</td>
</tr>
<tr>
<td>% Passing</td>
<td>74.1</td>
<td>72.2</td>
<td>80.4</td>
<td>74.5</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>116.6</td>
<td>111.5</td>
<td>112.7</td>
<td>117.4</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>53.7</td>
<td>51.6</td>
<td>58.6</td>
<td>52.3</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>16.9</td>
<td>17.6</td>
<td>15.0</td>
<td>17.3</td>
</tr>
<tr>
<td>Ave. Test Time</td>
<td>2.2</td>
<td>2.1</td>
<td>2.1</td>
<td>2.4</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>53.7</td>
<td>57.4</td>
<td>50.8</td>
<td>54.3</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>1.8</td>
<td>1.2</td>
<td>1.7</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Table 6: Longitudinal Technical Summary for the NCLEX-PN® Group Statistics for 2008 Testing Year

<table>
<thead>
<tr>
<th>Jan 08 - Mar 08</th>
<th>Apr 08 - Jun 08</th>
<th>Jul 08 - Sep 08</th>
<th>Oct 08 - Dec 08</th>
<th>Cumulative 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Testing</td>
<td>18,047</td>
<td>15,452</td>
<td>26,497</td>
<td>22,506</td>
</tr>
<tr>
<td>% Passing</td>
<td>76.8</td>
<td>72.0</td>
<td>80.8</td>
<td>72.2</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>115.1</td>
<td>114.6</td>
<td>114.5</td>
<td>111.1</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>56.1</td>
<td>56.7</td>
<td>60.1</td>
<td>51.8</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>16.0</td>
<td>16.3</td>
<td>16.1</td>
<td>14.1</td>
</tr>
<tr>
<td>Ave. Test Time</td>
<td>2.2</td>
<td>2.3</td>
<td>2.1</td>
<td>2.0</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>52.9</td>
<td>56.6</td>
<td>49.6</td>
<td>57.5</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>2.1</td>
<td>1.9</td>
<td>0.8</td>
<td>0.7</td>
</tr>
</tbody>
</table>
### Table 7: Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2009 Testing Year*

<table>
<thead>
<tr>
<th></th>
<th>Jan 09 - Mar 09</th>
<th>Apr 09 - Jun 09</th>
<th>Jul 09 - Sep 09</th>
<th>Oct 09 - Dec 09</th>
<th>Cumulative 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Dev.</td>
<td>Mean</td>
<td>Std. Dev.</td>
<td>Mean</td>
</tr>
<tr>
<td>Point-Biserial</td>
<td>0.20</td>
<td>0.07</td>
<td>0.20</td>
<td>0.08</td>
<td>0.20</td>
</tr>
<tr>
<td>Ave. Item Time (secs)</td>
<td>65.8</td>
<td>16.5</td>
<td>69.2</td>
<td>27.5</td>
<td>66.0</td>
</tr>
</tbody>
</table>

#### Pretest Item Statistics

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># of Items</td>
<td>303</td>
<td>572</td>
<td>866</td>
<td>356</td>
</tr>
<tr>
<td>Ave. Sample Size</td>
<td>1,157</td>
<td>489</td>
<td>651</td>
<td>493</td>
</tr>
<tr>
<td>Mean Point-Biserial</td>
<td>0.11</td>
<td>0.11</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td>Mean P+</td>
<td>0.51</td>
<td>0.47</td>
<td>0.41</td>
<td>0.42</td>
</tr>
<tr>
<td>Mean B-Value</td>
<td>0.05</td>
<td>0.35</td>
<td>0.70</td>
<td>0.55</td>
</tr>
<tr>
<td>SD B-Value</td>
<td>1.63</td>
<td>1.69</td>
<td>1.56</td>
<td>1.46</td>
</tr>
<tr>
<td>Total Number Flagged</td>
<td>102</td>
<td>218</td>
<td>387</td>
<td>149</td>
</tr>
<tr>
<td>% Items Flagged</td>
<td>33.7</td>
<td>38.1</td>
<td>44.7</td>
<td>41.9</td>
</tr>
</tbody>
</table>

*Data do not include research and retest items.

### Table 8: Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2008 Testing Year*

<table>
<thead>
<tr>
<th></th>
<th>Jan 08 - Mar 08</th>
<th>Apr 08 - Jun 08</th>
<th>Jul 08 - Sep 08</th>
<th>Oct 08 - Dec 08</th>
<th>Cumulative 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Dev.</td>
<td>Mean</td>
<td>Std. Dev.</td>
<td>Mean</td>
</tr>
<tr>
<td>Point-Biserial</td>
<td>0.20</td>
<td>0.07</td>
<td>0.20</td>
<td>0.08</td>
<td>0.20</td>
</tr>
<tr>
<td>Ave. Item Time (secs)</td>
<td>66.1</td>
<td>17.0</td>
<td>68.3</td>
<td>23.2</td>
<td>64.8</td>
</tr>
</tbody>
</table>

#### Pretest Item Statistics

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># of Items</td>
<td>582</td>
<td>496</td>
<td>1,072</td>
<td>378</td>
</tr>
<tr>
<td>Ave. Sample Size</td>
<td>620</td>
<td>573</td>
<td>493</td>
<td>760</td>
</tr>
<tr>
<td>Mean Point-Biserial</td>
<td>0.13</td>
<td>0.13</td>
<td>0.09</td>
<td>0.11</td>
</tr>
<tr>
<td>Mean P+</td>
<td>0.53</td>
<td>0.53</td>
<td>0.47</td>
<td>0.52</td>
</tr>
<tr>
<td>Mean B-Value</td>
<td>-0.03</td>
<td>-0.07</td>
<td>0.39</td>
<td>0.04</td>
</tr>
<tr>
<td>SD B-Value</td>
<td>1.66</td>
<td>1.63</td>
<td>1.83</td>
<td>1.69</td>
</tr>
<tr>
<td>Total Number Flagged</td>
<td>157</td>
<td>147</td>
<td>455</td>
<td>134</td>
</tr>
<tr>
<td>% Items Flagged</td>
<td>27.0</td>
<td>29.6</td>
<td>42.4</td>
<td>35.4</td>
</tr>
</tbody>
</table>

*Data do not include research and retest items.
International Testing Update

Pearson VUE has a total of 217 Pearson Professional Centers (PPCs) in the U.S. and 18 PPCs internationally in Australia, Canada, Germany, Hong Kong, India, Japan, Mexico, the Philippines, Puerto Rico, Taiwan and the United Kingdom, for a total of 235 test centers globally.

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

<table>
<thead>
<tr>
<th>Member Board</th>
<th>Total</th>
<th>Sydney, Australia</th>
<th>Burnaby, Canada</th>
<th>Montreal, Canada</th>
<th>Toronto, Canada</th>
<th>Frankfurt, Germany</th>
<th>Hong Kong, Hong Kong</th>
<th>Bangalore, India</th>
<th>Chennai, India</th>
<th>Hyderabad, India</th>
<th>Mumbai, India</th>
<th>New Delhi, India</th>
<th>Chiyoda-ku (Tokyo), Japan</th>
<th>Yokohama City, Japan</th>
<th>Mexico City, Mexico</th>
<th>Manila, Philippines</th>
<th>San Juan, Puerto Rico</th>
<th>Taipei, Taiwan</th>
<th>London, United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
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<td>Arizona</td>
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<td>0</td>
<td>58</td>
</tr>
<tr>
<td>California - RN</td>
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<td>36</td>
<td>64</td>
<td>17</td>
<td>87</td>
<td>28</td>
<td>316</td>
<td>21</td>
<td>26</td>
<td>124</td>
<td>2</td>
<td>29</td>
<td>26</td>
<td>32</td>
<td>3</td>
<td>154</td>
<td>439</td>
<td>3</td>
<td>8354</td>
</tr>
<tr>
<td>California - VN</td>
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<td>0</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
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*Only Member Boards with international test center candidate data are represented.
### Table 10: NCLEX® International Test Center Volume by Country of Education Jan. 1–Dec. 31, 2009

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

Raw data represents the total number of examinations delivered/total number of examinations posed. Parenthetical data represents the passing rate for the month indicated.

| Site ID | City     | Country | Total Taken | Total Passed | Jan   | Feb   | Mar   | Apr   | May   | Jun   | Jul   | Aug   | Sep   | Oct   | Nov   | Dec   |
|---------|----------|---------|-------------|--------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 50482   | Sydney   | Australia | 95          | 43           | 50.00%| 45.45%| 66.67%| 50.00%| 33.33%| 37.50%| 40.00%| 50.00%| 55.67%| 51.72%| 53.57%| 34.48%|
| 50486   | Burnaby  | Canada   | 159         | 76           | 20.00%| 66.67%| 64.71%| 41.67%| 57.14%| 58.82%| 35.71%| 55.56%| 40.00%| 50.00%| 33.33%| 33.33%|
| 50485   | Montreal | Canada   | 46          | 17           | 0.00% | 0.00% | 33.33%| 50.00%| 33.33%| 33.33%| 66.67%| 60.00%| 20.00%| 0.00% | 75.00%| 33.33%|
| 50484   | Toronto  | Canada   | 285         | 119          | 16.67%| 36.36%| 12.50%| 25.00%| 48.00%| 28.82%| 43.48%| 43.48%| 38.33%| 44.44%| 27.12%| 12.44%|
| 50491   | Frankfurt| Germany  | 78          | 44           | 100.00%| 50.00%| 57.14%| 50.00%| 71.43%| 70.00%| 50.00%| 75.00%| 57.14%| 16.67%| 50.00%| 10.50%|
| 50493   | Hong Kong| Hong Kong| 813         | 388          | 54.10%| 41.51%| 51.76%| 36.78%| 41.54%| 52.78%| 39.39%| 48.94%| 62.22%| 81.39%| 48.15%| 52.94%|
| 50497   | Bangalore| India    | 245         | 121          | 37.93%| 76.19%| 57.58%| 38.89%| 57.89%| 47.06%| 72.73%| 66.67%| 66.67%| 33.33%| 66.67%| 52.94%|
| 50498   | Chennai  | India    | 205         | 107          | 50.56%| 70.00%| 48.00%| 37.50%| 60.00%| 55.56%| 60.00%| 55.56%| 62.50%| 12.50%| 62.50%| 57.14%|
| 50495   | Delhi    | India    | 331         | 107          | 38.89%| 22.50%| 16.22%| 35.29%| 40.00%| 41.38%| 33.33%| 42.83%| 47.06%| 37.50%| 25.00%| 20.50%|
| 50496   | Hyderabad| India    | 28          | 8            | 50.00%| 33.33%| 33.33%| 25.00%| 33.33%| 25.00%| 50.00%| 50.00%| 50.00%| 66.67%| 0.00% | 0.00% |
| 50494   | Mumbai   | India    | 126         | 76           | 77.71%| 53.33%| 68.75%| 30.00%| 62.50%| 58.33%| 62.50%| 57.14%| 62.50%| 57.14%| 9.50% | 55.56%|
| 50500   | Chiyoda-ku| Japan   | 634         | 367          | 59.26%| 79.10%| 58.46%| 53.97%| 61.54%| 55.56%| 55.56%| 60.38%| 44.90%| 45.16%| 59.18%| 55.56%|
| 50501   | Yokohama| City     | 16          | 8            | 0.00% | 100.00%| 100.00%| 100.00%| 100.00%| 66.67%| 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| 50503   | Mexico City| Mexico | 5           | 3            | 0.00% | 0.00% | 100.00%| 100.00%| 100.00%| 100.00%| 100.00%| 100.00%| 100.00%| 100.00%| 100.00%| 100.00%|
| 54555   | Manila   | Philippines | 12810   | 5954         | 46.08%| 46.77%| 45.38%| 45.51%| 48.76%| 45.36%| 43.08%| 47.32%| 48.15%| 48.15%| 1186/57 | 48.15%|
| 47108   | San Juan| Puerto Rico| 51        | 10           | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| 50506   | Taipei   | Taiwan   | 339         | 143          | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 36.36%| 34.48%|

Note: The numbers in parentheses represent the pass rate for the month.
Table 12: NCLEX® International Testing Volume Pass Rate by Month: Jan. 1–Dec. 31, 2009

Raw data represents the total number of examinations delivered/total number of examinations posed. Parenthetical data represents the passing rate for the month indicated.

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Report of the APRN Committee

Background
During the development of the Consensus Model for APRN Regulation, the APRN Committee worked closely with the APRN Consensus Group. The model APRN legislative language, which parallels the Consensus Model for APRN Regulation, was also developed by the APRN Committee and adopted during the 2008 Delegate Assembly.

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

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

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

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

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

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

Highlights of FY10 Activities
- Held the APRN Roundtable in Chicago on May 19, 2010.
- Continued developing articles on how each APRN role will be affected by the Consensus Model of APRN Regulation and NCSBN Model Legislative Language.
- Revised the Legislative APRN Fact Sheet.
- Presented a plan for an APRN Summit in FY11.
<table>
<thead>
<tr>
<th>Strategic Initiative C</th>
<th>Provided feedback to LACE on the FAQ document and other issues related to the Consensus Model of APRN Regulation.</th>
</tr>
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<tbody>
<tr>
<td>NCSBN advances evidence-based nursing regulation and regulatory solutions for public protection.</td>
<td>Developed draft definitions of terms.</td>
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<td>Strategic Objective 2</td>
<td>Met with representatives of the Convenient Care Association and AARP to discuss possible methods for collaboration.</td>
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<td>Provide models and resources for evidence-based regulation to Member Boards.</td>
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**Future Activities**

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

**Attachments**

None
Report of the Awards Committee

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

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

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

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

Highlights of FY10 Activities
- Reviewed the 2009 Awards Program and recommended the awards program be held as a dinner event in 2010.
- Recommended that membership be allowed to bring guests to the awards dinner.
- Reported the 2010 awards recipients as selected by the Awards Committee to the BOD.
- Conducted a blind review of the award nominations.
- Recommended the description and criteria for a new award, the Distinguished Achievement Award, to the BOD.
- Identified boards of nursing celebrating their centennial in 2010.
- Identified executive officers who are eligible for the Executive Officer Recognition Award for 5, 10, 15 and 25 years of service.
- Reviewed the award symbols for each award category. No changes were recommended.
- Sent official notification to award nominees and their nominators, confirming their selection by the Awards Committee as 2010 award recipients.
- Awards Committee members confirmed that they plan to read award recipient biographies at the awards dinner.

2010 AWARD RECIPIENTS:

Meritorious Service Award
Ann L. O’Sullivan, PhD, MSN, CRNP, CPNP, FAAN, board president, Pennsylvania State Board of Nursing

Regulatory Achievement Award
Texas Board of Nursing

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

Exceptional Contribution Award
Valerie Smith, MS, RN, FRE, board staff, Arizona State Board of Nursing
Sue Tedford, MNSc, RN, board staff, Arkansas State Board of Nursing
Executive Officer Recognition Awards

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

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

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

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

**MEMBER BOARDS CELEBRATING 100 YEARS OF NURSING REGULATION**
- Massachusetts Board of Registration in Nursing
- South Carolina State Board of Nursing

**Future Activities**
- Select the 2011 awards recipients.

**Attachment**
A. Awards Brochure
2010 NCSBN Awards Program
The NCSBN awards will be announced at the 2010 Annual Meeting to recognize the outstanding achievements of NCSBN Member Boards. The awards are designed to celebrate significant contributions to nursing regulation.

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

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

- Entries must be submitted in one complete e-mail; partial entries will not be considered. All entries must be e-mailed no later than Feb. 12, 2010, to Alicia Byrd, Director, Member Relations, at abyrd@ncsbn.org.
- Individuals may nominate themselves or others. For the Regulatory Achievement Award, Member Boards may nominate themselves or another board.
- Two letters of support are required. Entries must include one letter of support from the executive officer or designee. For the Regulatory Achievement Award, entries must include one letter of support from another Member Board or a representative of a regulatory agency.
- Entries must be typed and presented in a professional manner on the respective award template.
- Entries must be accompanied by the official award template. Narratives should be no more than 500 words.
- Electronic submission of all materials is required. If you use any program other than Microsoft Word, please call to be sure it is readable at NCSBN.

If you have questions about the Awards Program, contact Alicia Byrd at 312.525.3666.
AWARDS REVIEW AND SELECTION

- To ensure a fair and equitable review and selection process, each individual nomination is subjected to a blind review by each Awards Committee member. The committee then makes the final decision about all award recipients.

- Awards Committee members are not permitted to nominate award recipients, participate in the nomination process or write letters of support during their tenure on the Awards Committee.

- Awards Committee members recuse themselves from both the blind review and the final decisions for the award recipient(s) in categories where their particular board of nursing, board members or board staff are nominated, or in cases where they feel that they cannot be objective about the nominee.

- Entries are evaluated using uniform guidelines for each award category.

- Awards will not necessarily be given in each category.

- Award recipients will be notified prior to the NCSBN Annual Meeting and will be honored at the Annual Meeting.

- The Awards Committee can recommend that a nominee be given an award that is different from the award for which he/she was originally nominated. If this decision were made, a committee member would contact the nominator to determine if he/she is agreeable to having the nominee be given a different award.
R. LOUISE MCMANUS AWARD

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

ELIGIBILITY
Board member or staff member of a board of nursing

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

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

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One
MERITORIOUS SERVICE AWARD

ELIGIBILITY
Board member or staff member of a board of nursing

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

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

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One
EXCEPTIONAL CONTRIBUTION AWARD

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

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

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

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
Unlimited
REGULATORY ACHIEVEMENT AWARD

ELIGIBILITY
A board of nursing

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

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

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One
DISTINGUISHED ACHIEVEMENT AWARD

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

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

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
Unlimited
EXCEPTIONAL LEADERSHIP AWARD

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

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

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

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One
EXECUTIVE OFFICER RECOGNITION AWARD

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

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

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

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
As applicable
Past NCSBN Award Recipients

**R. LOUISE MCMANUS AWARD**

2009 – Faith Fields  
2008 – Shirley Brekken  
2007 – Polly Johnson  
2006 – Laura Poe  
2005 – Barbara Morvant  
2004 – Joey Ridenour  
2003 – Sharon M. Weisenbeck  
2002 – Katherine Thomas  
2001 – Charlie Dickson  
1999 – Donna Dorsey  
1998 – Jennifer Bosma  
Elaine Ellibee  
Marcia M. Rachel  
1997 – Jean Caron  
1996 – Joan Bouchard  
1995 – Corinne F. Dorsey  
1992 – Renatta S. Loquist  
1989 – Marianna Bacigalupi  
1986 – Joyce Schowalter  
1983 – Mildred Schmidt

**MERITORIOUS SERVICE AWARD**

2009 – Sheila Exstrom  
2008 – Sandra Evans  
2007 – Mark Majek  
2005 – Marcia Hobbs  
2004 – Ruth Ann Terry  
2001 – Shirley Brekken

2000 – Margaret Howard  
1999 – Katherine Thomas  
1998 – Helen P. Keefe  
Gertrude Malone  
1997 – Sister Teresa Harris  
Helen Kelley  
1996 – Tom O’Brien  
1995 – Gail M. McGuill  
1994 – Billie Haynes  
1993 – Charlie Dickson  
1991 – Sharon M. Weisenbeck  
1990 – Sister Lucie Leonard  
1988 – Merlyn Mary Maillian  
1987 – Eileen Dvorak

**REGULATORY ACHIEVEMENT AWARD**

2009 – Ohio Board of Nursing  
2008 – Kentucky Board of Nursing  
2007 – Massachusetts Board of Registration in Nursing  
2006 – Louisiana State Board of Nursing  
2005 – Idaho Board of Nursing  
2003 – North Carolina Board of Nursing  
2002 – West Virginia State Board of Examiners for Licensed Practical Nurses  
2001 – Alabama Board of Nursing
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<tr>
<th>Award</th>
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<td><strong>MEMBER BOARD AWARD</strong></td>
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<td>2000 – Arkansas Board of Nursing</td>
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<td>1990 – Texas Board of Nurse Examiners</td>
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<td>1987 – Kentucky Board of Nursing</td>
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<td><strong>EXCEPTIONAL LEADERSHIP AWARD</strong></td>
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<td>2007 – Judith Hiner</td>
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<td>2006 – Karen Gilpin</td>
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<td>2005 – Robin Vogt</td>
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<td>2004 – Christine Alichnie</td>
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<td>2003 – Cookie Bible</td>
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<td>2002 – Richard Sheehan</td>
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<td>2001 – June Bell</td>
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<td><strong>NCSBN 30TH ANNIVERSARY SPECIAL AWARD</strong></td>
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<td>2008 – Joey Ridenour</td>
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<td>2008 – Sharon Weisenbeck Malin</td>
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<td>2008 – Mildred S. Schmidt</td>
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<td><strong>EXCEPTIONAL CONTRIBUTION AWARD</strong></td>
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<td>2009 – Nancy Murphy</td>
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<td>2008 – Lisa Emrich</td>
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<td>2008 – Barbara Newman</td>
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<td>2007 – Calvina Thomas</td>
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<td>2005 – William Fred Knight</td>
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<td>2004 – Janette Pucci</td>
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<td>2003 – Sandra MacKenzie</td>
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<td>2002 – Cora Clay</td>
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<td>2001 – Julie Gould</td>
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<td>2001 – Lori Scheidt</td>
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<td>2001 – Ruth Lindgren</td>
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<tr>
<td><strong>SILVER ACHIEVEMENT AWARD</strong></td>
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<td>2000 – Nancy Wilson</td>
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<td>1998 – Joyce Schowalter</td>
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* **NCSBN SPECIAL AWARD**

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<th>Year</th>
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<tr>
<td>2008</td>
<td>Thomas Abram</td>
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<td>2004</td>
<td>Robert Waters</td>
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<td>2002</td>
<td>Patricia Benner</td>
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Report of the Chemical Dependency Committee

Background
There are currently 41 jurisdictions that have an alternative to discipline program. The objectives of these programs are to: (1) ensure the health and safety of the public through a program that closely monitors licensees whose ability to safely and competently practice may be impaired due to dependency on drugs or alcohol; (2) achieve earlier intervention with intent to accomplish decreased time between the licensee’s acknowledgement of chemical dependency and entry into the recovery process, and provide a means of returning the licensee to safe and effective practice in a more efficient and rapid manner, minimizing financial impact, than was achieved through the disciplinary process; and (3) provide a process for licensees to recover from impairment in a therapeutic and nonpunitive process.

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

Highlights of FY10 Activities

- Disciplinary programs for nurses whose competency may be impaired because of the use of drugs and/or alcohol were surveyed. The information was used to provide a comparison with the alternative to discipline programs surveyed in 2009, and identify the differences and similarities in how the two approaches address nurses with substance use disorders.

- A set of model guidelines was developed. The purpose of these guidelines is to provide practical and evidence-based guidelines for evaluating, treating, monitoring and managing health care professionals with substance use disorders. The guidelines are based on a review of the most current research and knowledge synthesized from the literature and from the field.

- These guidelines were developed and written with the primary focus on alternative programs. These programs are known as alternative or diversion programs because nurses are diverted to treatment rather than to disciplinary action. These programs rest on the rationale that they can provide a path to recovery for nurses with substance use disorders, can help to retain them in the workforce and with proper monitoring, help avert harm to the public while the licensee receives help. The guidelines’ underlying principles, however, are applicable to traditional discipline monitoring programs as well.

- Implementing these guidelines presents a number of opportunities, including best practices, so programs can focus on developing better services. Guidelines also set benchmarks for performance and quality; however, in order to adopt these guidelines it may be necessary to make changes in state laws, regulations and policies.

- The Substance Use Disorders Guidelines Forum was held in April 2010 to:
  - Review discipline and alternative programs;
  - Provide recommended regulatory practices for licensees with substance use disorders; and
  - Discuss the in-development guidelines based on the most current research and evidence that will provide recommendations on best practices for detection, prevention and intervention of substance use disorders cases.

- The forum was aimed at increasing the acceptance and implementation of the guidelines by boards of nursing (BONs), alternative to discipline programs and other relevant stakeholders.

Members
Nancy Darbro, PhD, RN, CNS
New Mexico, Area I, Chair
Joan Bainer, MN, RN, NE, BC
South Carolina, Area III
Tom Dilling, JD
Ohio, Area II
Karl A. Hoehn, JD
Washington, Area I
Anjeanette Lindle, JD
Montana, Area I
Valerie Smith, MS, RN, FRE
Arizona, Area I
Carol Stanford
California-RN, Area I
Kate Driocoll Malliarakis, MS, CNP, NCADC II
External Member
Michael Van Doren, MSN, CARN
External Member
Kathy Thomas, MN, RN
Area III, Board Liaison

Staff
Kevin Kenward, PhD, MS
Director, Research
Lindsey Gross
Administrative Assistant, Research

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

Relationship to Strategic Plan

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

Strategic Objective 1
Review discipline and alternative programs and provide recommended regulatory practices for chemically dependent licensees for the purpose of public protection.
A handbook is being written which will provide recommendations on best practices for detection, prevention and intervention of chemical dependency cases based on the most current research and evidence. While nurse managers will be able to use the handbook as a resource to utilize when handling chemical dependency cases, the focus of the handbook will be on presenting evidence-based models and best practices so that BONs and alternative to discipline programs can improve and better evaluate their own programs.

**Future Activities**
None

**Attachments**
None
Report of the Commitment to Ongoing Regulatory Excellence (CORE) Committee

Background
CORE was approved by the fiscal year 2002 (FY02) Board of Directors (BOD) to provide an ongoing performance measurement system for nursing regulators. CORE utilizes data collected periodically from boards of nursing (BONs) and stakeholders, and identifies best practices in the provision of regulatory services. By promoting excellence in the provision of regulatory services, BONs can improve their management and delivery of safe, effective nursing care to the public.

BONs have been surveyed four times: 2000, 2006, 2008 and 2010. BONs are surveyed regarding five BON functions: (1) discipline; (2) practice; (3) education program approval; (4) licensure; and (5) governance. There were three groups of stakeholders directly affected by BON actions that were also surveyed: (1) employers; (2) nursing programs; and (3) nurses. Random samples of these stakeholders were surveyed to gain their perspectives about interactions with their BON and about the effectiveness of nursing regulation in general.

Highlights of FY10 Activities
- NCSBN conducted a focus group with representatives from 10 BONs (Attachment A). The purpose of the focus group was to discover best practices that were common among BONs with consistently high ratings on the CORE survey in the area of discipline.

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

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

- The CORE Committee asked two performance-measurement experts to evaluate the program. The independent review will help determine the extent to which specified goals and objectives are being met, identify where corrections need to be made, and gain general and theoretical insights, which will apply to future efforts.
One of the experts has completed her review (Attachment A). Her recommendations include the following:

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

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

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

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

**Attachments**
A. Focus Group Report
Attachment A

Focus Group Report

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

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

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

FOCUS GROUP PARTICIPANTS
Focus group participants consisted of the following:

Gender: Nine women and one man

Size of BON: Four BONs with less than 20,000 licensees; two BONs with between 20,000 to 49,999 licensees; one BON with between 50,000 to 99,999 licensees; two BONs with between 100,000 to 199,999 licensees; and one BON with 200,000 or more licensees

Area: Three BONs from Area I, three BONs from Area II and four BONs from Area III

BON Structure: Two umbrella BONs and eight independent BONs

Position: Three executive officers and seven board staff members (one attorney)

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

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

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

**Staff Autonomy**

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

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

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

**Prioritization and Intake Triage of Complaints**

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

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

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

**Staffing**

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

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

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

**Train and Mentor Investigative Staff in a Systematic and Consistent Manner**

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

**Administrative Support**

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

**Audits**

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

**Standardization**

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

**Tracking Systems**

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

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

**Management Timelines and Other Protocols**

High performing BONs have formal management timelines by which BONs can measure the progress of cases through the disciplinary process. For example, the goal may be 10 days for intake and screening or 100 days to complete a routine investigation. The management timelines are somewhat artificial, but still useful markers for internal management and external accountability.
Coordination Across Stages of Discipline
In order to avoid fragmentation and a large number of handoffs as a case moves through the stages of the disciplinary process, it was recommended that BONs maintain authority over all disciplinary activities, including investigative, legal and compliance work. In other words, BONs need to be able to manage and control the caseload of investigators and attorneys. This approach facilitates achieving consistent results and allows BONs to set more measurable performance objectives. Participants assert teamwork is more difficult to achieve across the line of demarcation between BONs and offices of the attorney general, even though individual assistant attorneys general are often assigned in whole or in part to the BON.

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

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

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

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

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

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

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

Collect Data Upfront—Focus group participants advised that the investigation process should begin promptly. Investigators should request needed information upfront and collect it
aggressively. The participants recommend compiling readily available background information first to obtain a quick read of the situation and to have information available before the nurse is interviewed. Participants further recommend interviewing the nurse for whom a complaint has been filed and informing the nurse of the procedures for the investigation. They felt that it is important to get the nurse’s side of the story in order to establish facts.

Summary Suspension for Noncompliance or Nonresponse

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

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

RECOMMENDED CHANGES TO THE CORE SURVEY

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

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

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

SUMMARY

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

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

Using a tracking system to monitor where a case is in the process and how long it has been there;

Providing BONs with authority to direct and control investigators and attorneys;

Conducting criminal background checks and searching sex offender and child abuser databases;

Using a preponderance of evidence as the degree of proof required to determine whether or not disciplinary action should be taken or not (as opposed to beyond a reasonable doubt, clear and convincing evidence or reasonable doubt);

Collecting information up-front and in writing, when investigating a complaint; and

Issuing summary suspensions for noncompliance or nonresponse.

**Implications**

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

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

Background
The Finance Committee advises the Board of Directors (BOD) on the overall direction and control of the finances of the organization. The committee reviews and recommends a budget to the BOD. The committee monitors income, expenditures and program activities against projections, and presents quarterly financial statements to the BOD.

The Finance Committee oversees the financial reporting process, the systems of internal accounting and financial controls, the performance and independence of the auditors and the annual independent audit of NCSBN financial statements. The committee recommends to the BOD the appointment of a firm to serve as auditors.

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

Highlights of FY10 Activities
- Reviewed and discussed the organization’s audited financial statements for the fiscal year ended Sept. 30, 2009, with management and the organization’s independent accountant. With and without management present, the committee discussed and reviewed the results of the independent accountant’s examination of internal controls and financial statements. Based on the review and discussions referenced above, the Finance Committee recommended to the BOD that the financial statements and the Report of the Auditors be accepted and provided to the membership.
- Recommended the engagement of Blackman Kallick LLP to audit the NCSBN financial statements for the period ending Sept. 30, 2010.
- Reviewed and discussed the long-range financial reserve forecast.
- Reviewed and discussed the financial statements and supporting schedules quarterly, and made recommendations that the reports be accepted by the BOD.
- Reviewed and discussed the performance of NCSBN investments quarterly with NCSBN staff and the organization’s investment consultant, Becker Burke. Informed the BOD that the current investment policy and strategy appear to be appropriate for NCSBN.
- Reviewed and discussed the property and professional liability coverage for NCSBN with the insurance brokers from USI Midwest. Informed the BOD that the organization is appropriately insured.
- Recommended revisions to financial policies.

Future Activities

Attachments
B. Report of the Independent Auditors FY09
Attachment A

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

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

Revenue

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

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

Learning Extension sales revenue increased slightly by two percent for the first six months of FY10 compared to the same period for the prior year. Enrollments declined by two percent for the NCLEX-RN® Review Course, which is expected to generate 61 percent of the e-learning sales revenue. Enrollment increased by 26 percent for the NCLEX-PN® Review Course. The combined sales for the two review courses are expected to generate 90 percent of the total revenue for online courses.

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

Expenditures

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

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

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

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

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

Financial Position

As in the past, the third quarter will be critical as NCSBN typically receives 39 percent of its annual NCLEX fee income (the primary source of revenue) during that period.
Positive cash flow is projected for FY10. The net cash position is projected to equal $119 million by Sept. 30, 2010, and is expected to grow to $125 million by October 2010.

**Six-Month Summary**

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

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Year to Date Actual at 3/31/10</th>
<th>Annual Budget</th>
<th>Projected Actual</th>
<th>Favorable/(Unfavorable)</th>
<th>Variance</th>
<th>Year to Date as a % of Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>NCLEX revenue</td>
<td>24,758,200</td>
<td>60,899,600</td>
<td>60,545,000</td>
<td>(354,600)</td>
<td>-1%</td>
<td>41%</td>
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<tr>
<td>NCLEX Program Reports royalty</td>
<td>69,210</td>
<td>71,000</td>
<td>83,000</td>
<td>12,000</td>
<td>17%</td>
<td>97%</td>
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<td>NCLEX Quick Results</td>
<td>215,726</td>
<td>440,000</td>
<td>532,000</td>
<td>92,000</td>
<td>21%</td>
<td>49%</td>
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<td>Learning Extension</td>
<td>1,043,426</td>
<td>2,258,600</td>
<td>2,179,000</td>
<td>(79,600)</td>
<td>-4%</td>
<td>46%</td>
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<td>Nursys license verification fees</td>
<td>1,427,423</td>
<td>2,220,000</td>
<td>2,700,000</td>
<td>480,000</td>
<td>22%</td>
<td>64%</td>
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<td>Meeting revenue</td>
<td>27,925</td>
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<td>127,100</td>
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<td>22%</td>
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<td>Publication sales</td>
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<td>Membership fees</td>
<td>186,000</td>
<td>186,000</td>
<td>186,000</td>
<td>0</td>
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<td>100%</td>
</tr>
<tr>
<td>NCLA fees</td>
<td>43,000</td>
<td>43,000</td>
<td>43,000</td>
<td>0</td>
<td>0%</td>
<td>100%</td>
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<td>Government grants other income</td>
<td>1,737</td>
<td>1,737</td>
<td>1,737</td>
<td>0</td>
<td>0%</td>
<td></td>
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<tr>
<td><strong>Total Revenue</strong></td>
<td>27,775,909</td>
<td>66,345,500</td>
<td>66,497,037</td>
<td>151,537</td>
<td>0%</td>
<td>42%</td>
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<td><strong>Expense</strong></td>
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</tr>
<tr>
<td><strong>Expense</strong></td>
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<td>Salaries</td>
<td>3,039,748</td>
<td>6,915,400</td>
<td>6,738,417</td>
<td>176,983</td>
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<td>44%</td>
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<td>Fringe benefits</td>
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<td>47,587</td>
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<td>43%</td>
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<td>NCLEX processing costs</td>
<td>14,725,686</td>
<td>35,147,700</td>
<td>36,005,000</td>
<td>(857,300)</td>
<td>-2%</td>
<td>42%</td>
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<td>Other professional service fees</td>
<td>2,344,956</td>
<td>8,225,400</td>
<td>7,415,000</td>
<td>810,400</td>
<td>10%</td>
<td>29%</td>
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<td>Supplies &amp; materials</td>
<td>30,680</td>
<td>76,100</td>
<td>76,100</td>
<td>0</td>
<td>0%</td>
<td>40%</td>
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<td>Meetings &amp; travel</td>
<td>1,173,694</td>
<td>3,889,600</td>
<td>3,736,600</td>
<td>153,000</td>
<td>4%</td>
<td>30%</td>
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<td>Telephone &amp; communications</td>
<td>161,791</td>
<td>391,500</td>
<td>391,500</td>
<td>0</td>
<td>0%</td>
<td>41%</td>
</tr>
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<td>Postage &amp; shipping</td>
<td>55,558</td>
<td>169,900</td>
<td>169,900</td>
<td>0</td>
<td>0%</td>
<td>33%</td>
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<td>Occupancy</td>
<td>467,793</td>
<td>944,900</td>
<td>944,900</td>
<td>0</td>
<td>0%</td>
<td>50%</td>
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<td>Printing, copying &amp; publications</td>
<td>183,786</td>
<td>748,400</td>
<td>720,000</td>
<td>28,400</td>
<td>4%</td>
<td>25%</td>
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<td>Library/memberships</td>
<td>82,583</td>
<td>131,500</td>
<td>131,500</td>
<td>0</td>
<td>0%</td>
<td>63%</td>
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<td>Insurance</td>
<td>66,677</td>
<td>59,600</td>
<td>66,677</td>
<td>(7,077)</td>
<td>-12%</td>
<td>112%</td>
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<td>Equipment rental &amp; maintenance</td>
<td>1,113,422</td>
<td>1,735,000</td>
<td>1,735,000</td>
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<td>0%</td>
<td>64%</td>
</tr>
<tr>
<td>Depreciation &amp; amortization</td>
<td>1,400,666</td>
<td>3,487,500</td>
<td>3,487,500</td>
<td>0</td>
<td>0%</td>
<td>40%</td>
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<td>External research grants</td>
<td>699,894</td>
<td>2,500,000</td>
<td>2,500,000</td>
<td>0</td>
<td>0%</td>
<td>28%</td>
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<td>JRC &amp; other expenses</td>
<td>54,355</td>
<td>604,000</td>
<td>254,000</td>
<td>350,000</td>
<td>58%</td>
<td>9%</td>
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<td><strong>Total Expense</strong></td>
<td>26,399,059</td>
<td>66,885,200</td>
<td>66,183,207</td>
<td>701,993</td>
<td>1%</td>
<td>39%</td>
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<td><strong>Surplus/(deficit)</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Investment Income</strong></td>
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</tr>
<tr>
<td><strong>Capital</strong></td>
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</tr>
</tbody>
</table>

### Revenue Summary

- **Total Revenue**: 27,775,909
- **Revenue**:
  - NCLEX revenue: 24,758,200
  - NCLEX Program Reports royalty: 69,210
  - NCLEX Quick Results: 215,726
  - Learning Extension: 1,043,426
  - Nursys license verification fees: 1,427,423
  - Meeting revenue: 27,925
  - Publication sales: 3,262
  - Membership fees: 186,000
  - NCLA fees: 43,000
  - Government grants other income: 1,737
- **Surplus/(deficit)**: 1,376,950
- **Investment Income**: 4,946,899
- **Capital**: 991,813

### Expense Summary

- **Total Expense**: 26,399,059
- **Expense**:
  - Salaries: 3,039,748
  - Fringe benefits: 797,770
  - NCLEX processing costs: 14,725,686
  - Other professional service fees: 2,344,956
  - Supplies & materials: 30,680
  - Meetings & travel: 1,173,694
  - Telephone & communications: 161,791
  - Postage & shipping: 55,558
  - Occupancy: 467,793
  - Printing, copying & publications: 183,786
  - Library/memberships: 82,583
  - Insurance: 66,677
  - Equipment rental & maintenance: 1,113,422
  - Depreciation & amortization: 1,400,666
  - External research grants: 699,894
  - JRC & other expenses: 54,355
- **Surplus/(deficit)**: 1,376,950
- **Investment Income**: 4,946,899
- **Capital**: 991,813

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Attachment B

Report of the Independent Auditors FY09

LEGACY
PROFESSIONALS LLP
CERTIFIED PUBLIC ACCOUNTANTS

REPORT OF INDEPENDENT AUDITORS

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

We have audited the accompanying statements of financial position of National Council of State
Boards of Nursing, Inc. (NCSBN) as of September 30, 2009 and 2008, and the related statements
of activities and of cash flows for the years then ended. These financial statements are the
responsibility of the NCSBN’s management. Our responsibility is to express an opinion on these
financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects,
the financial position of National Council of State Boards of Nursing, Inc. as of September 30,
2009 and 2008, and the changes in its net assets and its cash flows for the years then ended in
conformity with accounting principles generally accepted in the United States of America.

December 10, 2009
# National Council of State Boards of Nursing, Inc.

## Statements of Financial Position

**September 30, 2009 and 2008**

### Assets

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$29,246,205</td>
<td>$48,621,831</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>108,618</td>
<td>190,115</td>
</tr>
<tr>
<td>Due from test vendor</td>
<td>5,811,596</td>
<td>5,840,113</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>560,601</td>
<td>507,712</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>1,450,468</td>
<td>1,317,641</td>
</tr>
<tr>
<td>Investments</td>
<td>101,666,473</td>
<td>66,896,909</td>
</tr>
<tr>
<td>Property and equipment - net</td>
<td>4,670,912</td>
<td>4,130,203</td>
</tr>
<tr>
<td>Intangible asset - net</td>
<td>1,156,250</td>
<td>-</td>
</tr>
<tr>
<td>Cash held for others</td>
<td>409,060</td>
<td>291,443</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td><strong>$145,080,183</strong></td>
<td><strong>$127,795,967</strong></td>
</tr>
</tbody>
</table>

### Liabilities and Net Assets

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts payable</td>
<td>$1,071,956</td>
<td>$1,294,055</td>
</tr>
<tr>
<td>Accrued payroll, payroll taxes and compensated absences</td>
<td>568,047</td>
<td>548,109</td>
</tr>
<tr>
<td>Due to test vendor</td>
<td>10,260,493</td>
<td>9,941,741</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>311,552</td>
<td>338,410</td>
</tr>
<tr>
<td>Grants payable</td>
<td>562,570</td>
<td>1,321,647</td>
</tr>
<tr>
<td>Deferred rent credits</td>
<td>248,962</td>
<td>323,661</td>
</tr>
<tr>
<td>Cash held for others</td>
<td>409,060</td>
<td>291,443</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td><strong>13,432,640</strong></td>
<td><strong>14,059,066</strong></td>
</tr>
</tbody>
</table>

### Unrestricted Net Assets

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrestricted net assets</td>
<td>131,647,543</td>
<td>113,736,901</td>
</tr>
</tbody>
</table>

**Total liabilities and net assets**

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total liabilities and net assets</strong></td>
<td><strong>$145,080,183</strong></td>
<td><strong>$127,795,967</strong></td>
</tr>
</tbody>
</table>

See accompanying notes to financial statements.
NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

STATEMENTS OF ACTIVITIES

YEARS ENDED SEPTEMBER 30, 2009 AND 2008

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

See accompanying notes to financial statements.
NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

STATEMENTS OF CASH FLOWS

YEARS ENDED SEPTEMBER 30, 2009 AND 2008

CASH FLOWS FROM OPERATING ACTIVITIES

<table>
<thead>
<tr>
<th>Description</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net increase</td>
<td>$17,910,642</td>
<td>$12,883,843</td>
</tr>
<tr>
<td>Adjustments to reconcile net increase to net</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cash provided by operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>2,503,815</td>
<td>2,158,840</td>
</tr>
<tr>
<td>Net realized and unrealized loss on investments</td>
<td>722,547</td>
<td>7,471,337</td>
</tr>
<tr>
<td>(Increase) decrease in assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>81,497</td>
<td>91,652</td>
</tr>
<tr>
<td>Due from test vendor</td>
<td>28,517</td>
<td>(24,825)</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>(52,889)</td>
<td>161,484</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>(132,827)</td>
<td>(93,420)</td>
</tr>
<tr>
<td>Increase (decrease) in liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>(222,099)</td>
<td>556,173</td>
</tr>
<tr>
<td>Accrued payroll, payroll taxes and compensated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>absences</td>
<td>19,938</td>
<td>145,390</td>
</tr>
<tr>
<td>Due to test vendor</td>
<td>318,752</td>
<td>(314,634)</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>(26,858)</td>
<td>96,106</td>
</tr>
<tr>
<td>Grants payable</td>
<td>(759,077)</td>
<td>(320,719)</td>
</tr>
<tr>
<td>Deferred rent credits</td>
<td>(74,699)</td>
<td>(74,698)</td>
</tr>
<tr>
<td>Net cash provided by operating activities</td>
<td>20,317,259</td>
<td>22,736,529</td>
</tr>
</tbody>
</table>

CASH FLOWS FROM INVESTING ACTIVITIES

<table>
<thead>
<tr>
<th>Description</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchases of property and equipment</td>
<td>(2,950,774)</td>
<td>(2,665,996)</td>
</tr>
<tr>
<td>Purchase of intangible assets</td>
<td>(1,250,000)</td>
<td></td>
</tr>
<tr>
<td>Purchases of investments</td>
<td>(73,142,286)</td>
<td>(28,323,891)</td>
</tr>
<tr>
<td>Proceeds on sale of investments</td>
<td>37,650,175</td>
<td>13,478,890</td>
</tr>
<tr>
<td>Net cash (used in) investing activities</td>
<td>(39,692,885)</td>
<td>(17,510,997)</td>
</tr>
</tbody>
</table>

NET INCREASE (DECREASE)

<table>
<thead>
<tr>
<th>Description</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net increase (decrease)</td>
<td>(19,375,626)</td>
<td>5,225,532</td>
</tr>
</tbody>
</table>

CASH

<table>
<thead>
<tr>
<th>Description</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning of year</td>
<td>48,621,831</td>
<td>43,396,299</td>
</tr>
<tr>
<td>End of year</td>
<td>$29,246,205</td>
<td>$48,621,831</td>
</tr>
</tbody>
</table>

See accompanying notes to financial statements.
NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 2009 AND 2008

NOTE 1. DESCRIPTION OF THE ORGANIZATION

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

The program services of NCSBN are defined as follows:

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

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

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

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Basis of Presentation - Financial statement presentation follows the recommendations of the Financial Accounting Standards Board in its Statement of Financial Accounting Standards (SFAS) No. 117, Financial Statements of Not-for-Profit Organizations. Under SFAS No. 117, NCSBN is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets and permanently restricted net assets. Net assets are generally reported as unrestricted unless assets are received from donors with explicit stipulations that limit the use of the asset. NCSBN does not have any temporarily or permanently restricted net assets.
NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Accounts Receivable - Represents amounts owed to NCSBN for services dealing with board membership fees, meeting fees and royalties. Accounts receivable at September 30, 2009 and 2008 were $108,618 and $190,115 respectively. An allowance for doubtful accounts was not considered necessary.

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

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

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

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

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

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

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

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

Dividend income is recorded on the ex dividend date. Interest income is recorded on the accrual basis.
NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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

Due from Test Vendor - Due from test vendor represents amounts owed by Pearson VUE for candidate applications received as well as rebates calculated on vendor performance and volume per contract. The amounts owed by Pearson VUE at September 30, 2009 and 2008 were $5,811,596 and $5,840,113 respectively.

Pearson VUE performs substantially all testing services for NCSBN.

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

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

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

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

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

Grants Payable - Represents Nurse Practice and Regulatory Outcome research grants that are generally available for periods of one to two years. NCSBN awarded four grants ranging in amounts from $35,000 to $300,000 during the current year. At September 30, 2009, the amount remaining to be paid on grants awarded for 2009 and 2008 is $297,439 and $265,131, respectively.
NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Deferred Rent Credits - Deferred rent credits were established in conjunction with taking possession of new leased office space in 2003. The landlord abated a portion of the monthly rent and made cash disbursements to NCSBN in connection with the lease. These amounts are amortized to reduce rent expense over the term of the lease.

Statement of Cash Flows - For purposes of the statement of cash flows, NCSBN considers all marketable securities as investments. Cash includes only monies held on deposit at banking institutions, petty cash and certificates of deposit with an initial maturity date of less than three months when purchased. It does not include cash held for others.

Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

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

NOTE 3. TAX STATUS

NCSBN is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (Code) and is exempt from federal income taxes on income related to its exempt purpose pursuant to Section 501(a) of the Code and has been classified as an organization which is not a private foundation under Section 509(a).

NOTE 4. CASH CONCENTRATIONS

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

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>JP Morgan Chase</td>
<td>5,153,039</td>
<td>782,906</td>
</tr>
<tr>
<td>Checking account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money market account</td>
<td>23,372,418</td>
<td>15,153,219</td>
</tr>
<tr>
<td>Certificates of deposit</td>
<td></td>
<td>32,086,910</td>
</tr>
<tr>
<td>Wells Fargo Bank</td>
<td>672,777</td>
<td>562,158</td>
</tr>
<tr>
<td>Checking account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harris Bank</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Checking account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit card merchant accounts</td>
<td>47,621</td>
<td>36,388</td>
</tr>
<tr>
<td>Petty cash</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>Total</td>
<td>$ 29,246,205</td>
<td>$ 48,621,831</td>
</tr>
</tbody>
</table>
NOTE 4. CASH CONCENTRATIONS (CONTINUED)

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

NOTE 5. INVESTMENTS

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

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

NCSBN assets are invested in various securities, including United States government securities, corporate debt instruments, and unit investment trust securities. Investment securities, in general, are exposed to various risks, such as interest rate risk, credit risk, and overall market volatility. NCSBN invests in securities with contractual cash flows, such as asset backed securities, collateralized mortgage obligations and commercial mortgage backed securities. The value, liquidity and related income of these securities are sensitive to changes in economic conditions, including real estate value, delinquencies or defaults, or both and may be adversely affected by shifts in the market's perception of the issuers and changes in interest rates. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the financial statements.
NOTE 6. FAIR VALUE MEASUREMENTS

As of October 1, 2008, NCSBN adopted SFAS No. 157, Fair Value Measurements. SFAS 157 establishes a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under SFAS 157 are described below:

Basis of Fair Value Measurement

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities</td>
</tr>
<tr>
<td>Level 2</td>
<td>Quoted prices in markets that are not considered to be active or financial instruments for which all significant inputs are observable, either directly or indirectly</td>
</tr>
<tr>
<td>Level 3</td>
<td>Prices or valuations that require inputs that are both significant to the fair value measurement and unobservable</td>
</tr>
</tbody>
</table>

The following table sets forth, by level within the fair value hierarchy, NCSBN's investment assets at fair value as of September 30, 2009. As required by SFAS 157, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. Total NCSBN investment assets at fair value classified within Level 3 were $2,741,621 at September 30, 2009, which consist of NCSBN's real estate holding. Such amounts were approximately 3% of total investments as reported on the statement of net assets available for benefits at fair value as of September 30, 2009.
### NOTE 6. FAIR VALUE MEASUREMENTS (CONTINUED)

#### Fair Value Measurements at 9/30/09 Using

<table>
<thead>
<tr>
<th>Quoted Prices in Active Markets for Identical Assets</th>
<th>Significant Other Observable Inputs</th>
<th>Significant Unobservable Inputs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Level 1)</td>
<td>(Level 2)</td>
</tr>
<tr>
<td>U.S. Government and Government</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency obligations</td>
<td>$ 27,869,551</td>
<td>$ 14,780,961</td>
</tr>
<tr>
<td>Corporate bonds</td>
<td>12,207,601</td>
<td>-</td>
</tr>
<tr>
<td>Mutual funds</td>
<td>31,335,468</td>
<td>31,335,468</td>
</tr>
<tr>
<td>International equity fund - limited liability company</td>
<td>3,163,536</td>
<td>-</td>
</tr>
<tr>
<td>Real estate investment trust</td>
<td>2,741,621</td>
<td>-</td>
</tr>
<tr>
<td>Money market funds</td>
<td>494,316</td>
<td>494,316</td>
</tr>
<tr>
<td>Certificates of deposits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harris Bank CDARS program</td>
<td>23,091,937</td>
<td>-</td>
</tr>
<tr>
<td>Harris Bank certificate of deposits</td>
<td>762,443</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$ 101,666,473</td>
<td>$ 46,610,745</td>
</tr>
</tbody>
</table>

The table below sets forth a summary of changes in the fair value of the Plan’s Level 3 assets for the year ended September 30, 2009.

#### Fair Value Measurements Using Significant Unobservable Inputs (Level 3)

<table>
<thead>
<tr>
<th></th>
<th>Real Estate Investment Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 10/1/08</td>
<td>$ 5,224,499</td>
</tr>
<tr>
<td>Net realized and unrealized loss on investments</td>
<td>(2,580,399)</td>
</tr>
<tr>
<td>Interest and dividend income</td>
<td>148,478</td>
</tr>
<tr>
<td>Sale of investments</td>
<td>(50,957)</td>
</tr>
<tr>
<td>Balance at 9/30/09</td>
<td>$ 2,741,621</td>
</tr>
</tbody>
</table>
NOTE 7. PROPERTY AND EQUIPMENT

The composition of property and equipment at September 30, 2009 and 2008 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td>$ 1,437,879</td>
<td>$ 1,356,482</td>
</tr>
<tr>
<td>Course development costs</td>
<td>271,729</td>
<td>271,729</td>
</tr>
<tr>
<td>Computer hardware and software</td>
<td>16,288,240</td>
<td>13,418,864</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>440,183</td>
<td>440,183</td>
</tr>
<tr>
<td></td>
<td>18,438,031</td>
<td>15,487,258</td>
</tr>
<tr>
<td>Less accumulated depreciation and amortization</td>
<td>(13,767,119)</td>
<td>(11,357,055)</td>
</tr>
<tr>
<td>Net property and equipment</td>
<td>$ 4,670,912</td>
<td>$ 4,130,203</td>
</tr>
</tbody>
</table>

Depreciation and amortization expense was $2,410,065 and $2,158,840 for the years ended September 30, 2009 and 2008, respectively. In 2009, there is an also $93,750 amortization expense on the intangible asset (not included in the above amount).

NOTE 8. OPERATING LEASE

NCSBN has a lease agreement for office space which expires January 31, 2013. The following is a summary by year of future minimum lease payments required under the office lease as of September 30, 2009:

<table>
<thead>
<tr>
<th>Year ending September 30,</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$ 522,343</td>
</tr>
<tr>
<td>2011</td>
<td>538,011</td>
</tr>
<tr>
<td>2012</td>
<td>554,276</td>
</tr>
<tr>
<td>2013</td>
<td>186,668</td>
</tr>
<tr>
<td>Total</td>
<td>$ 1,801,298</td>
</tr>
</tbody>
</table>

Rent expense for the years ended September 30, 2009 and 2008 was $905,797 and $841,392, respectively. Rent expense includes both base rent and common area maintenance expenses.

NOTE 9. RETIREMENT PLANS

NCSBN maintains a 403(b) defined contribution pension plan covering all employees who complete six months of employment. Contributions are made at 8% of participants’ compensation. NCSBN’s policy is to fund accrued pension contributions. In the year ended September 30, 2007, NCSBN instituted a 457(b) non-qualified deferred compensation plan. Eligibility is limited as it is considered a top hat plan. Retirement plans expense was $479,696 and $433,749 for the years ended September 30, 2009 and 2008, respectively.
NOTE 10. COMMITMENTS

NCSBN has entered into contracts for services and accommodations for future meetings. These contracts include penalty clauses which would require NCSBN to pay certain amounts if a meeting were to be canceled or guarantees for room blocks are not fulfilled. At September 30, 2009, the requirements to fulfill these commitments approximated $329,400.

NCSBN has also entered into various contracts for future services. At September 30, 2009, the requirements to fulfill these commitments approximate $425,200 and are expected to be completed within one year.
Report of the Institute of Regulatory Excellence (IRE) Committee

Background

2009-2010 was the seventh year of the Institute of Regulatory Excellence (IRE). This program remains dedicated to the leadership development of nurse regulators. In addition to the Annual IRE Conference, which focuses on various aspects of regulation, participants enhance their knowledge and skills in research design, evidence-based regulation and project management.

The committee evaluates the program, as well as the progress of participants, on an ongoing basis. Currently, a total of 21 Fellows participate in the program. These individuals belong to the following cohorts:

- Year 4 (2007 cohort): two Fellows (includes one Fellow from the 2006 cohort)
- Year 3 (2008 cohort): five Fellows
- Year 2 (2009 cohort): seven Fellows
- Year 1 (2010 cohort): seven Fellows

The following is a report on the committee’s 2010 charges.

- Select 2010 IRE Fellowship participants and mentors, and approve fellowship project proposals and final reports.
  - There were seven individuals who applied to the program for the 2010 cohort. The committee reviewed all applications for admission into the program and determined that they all met the qualifications for an IRE fellowship. This was the first year that Associate Members have applied to the program and were accepted as IRE Fellows.
  - The committee decided that mentors would be chosen during the second year of the fellowship after the participants have had an opportunity to develop a learning plan and literature review. This would allow enough time to ensure successful mentor-fellow matchups, as mentors lay the groundwork to understand each Fellow’s future direction.
  - Final project reports for the 2007 cohort were due June 1, 2010. IRE Committee members will review the projects and determine eligibility for fellowship induction. Proposals from the 2008 cohort have been reviewed and feedback has been provided.

- Advise staff on issues related to the implementation of the IRE Fellowship Program.
  - Evaluation of the fellowship program occurs on an ongoing basis and the committee is constantly striving to make improvements.
    - A Fellow Success Toolkit and Syllabus was developed for the IRE that clearly outlines the program and expectations of Fellows.
    - The committee recommended assistance be provided to Fellows in obtaining Institutional Review Board (IRB) approval. Fellows who do not have access to an internal IRB will be referred to the New England IRB. This is an independent IRB that does timely and comprehensive reviews. Fellows can use part of their IRE resource funds to pay for this service.
Advise staff regarding the content of the IRE Annual Conference and annual induction ceremony.

The theme of the 2010 conference was Continued Competence.

- The IRE preconference/orientation day for Fellows was held for the second time. This year, Fellows were divided into breakout sessions that allowed them to hear presentations geared specifically to their needs according to their year in the program. Presentations included how to write a learning plan, conduct a literature review and write a proposal. One session was devoted to presentations by Fellows about their projects. Many felt this session was not only a great learning experience, but they also enjoyed the opportunity to participate and share their ideas and perspectives.
- An IRE toolkit was distributed to every participant; it contained valuable references and resources for project development and writing a proposal.
- The conference was well-received by participants who all gave high ratings to the speakers and felt the conference met the objectives.

The induction ceremony was addressed by the Awards Committee and it was decided that this would remain part of the Annual Meeting Awards Dinner.

Discussions on the 2011 conference, which will take place in Orlando, Fla., and focus on organizational management and behavior, have begun.

Overall, the IRE continues to improve on an annual basis and provide a unique learning experience for those who participate. There is no other program/conference that is so aptly geared toward meeting the learning needs of nursing regulators. The committee will continue to evaluate the program and progress of participants to make this a worthwhile and enriching experience for all who participate.

**Highlights of FY10 Activities**

- The addition of seven new IRE Fellows in the 2010 IRE cohort.
- Participation by Associate Members.
- The 2010 IRE Annual Conference on Continued Competence, including the IRE preconference day with sessions devoted to presentations by the IRE Fellows about their literature reviews and projects.
- Development of new and improved resource materials for IRE Fellows.

**Future Activities**

- Select 2011 IRE Fellows and mentors, and approve project proposals and final reports.
- Advise staff on issues related to the implementation of the IRE Fellowship Program.
- Approve the content of the IRE Annual Conference.

**Attachments**

None
Report of the National Nurse Aide Assessment Program (NNAAP™) and the Medication Aide Certification Examination (MACE™) Department

Background

In August 2008, NCSBN acquired exclusive ownership of the intellectual property for the National Nurse Aide Assessment Program (NNAAP™) and the Medication Aide Certification Examination (MACE™) program. NNAAP is a two-part examination consisting of a written or oral examination and a skills demonstration.

NNAAP has been administered to more than 2.5 million candidates and is the leading nurse aide assessment instrument in the U.S. MACE is a new national examination that NCSBN developed for boards of nursing (BONs) and became effective Jan. 1, 2010. MACE will help to evaluate the competence of unlicensed individuals allowed to administer medications to clients in long-term care settings.

Pearson VUE is the exclusive test administrator for NNAAP and MACE and continues to be responsible for all delivery, administration, publishing (electronic and paper), sales and market development activities associated with the exams. In addition, Pearson VUE provides the following testing services for NNAAP: eligibility screening and registration; test site scheduling; test administration (test site and Registered Nurse Evaluator management); scoring; and reporting. The registry services provided by Pearson VUE include initial certification, recertification and reciprocity management, as well as public access registry verifications through the Internet.

NNAAP is consistent with the training requirements for nurse aides/nursing assistants (NAs) delineated in the Omnibus Budget Reconciliation Act (OBRA) of 1987, 1989. This act states that anyone working as an NA must complete a competency evaluation program. The competency evaluation program must be state approved, consist of a minimum of 75 hours of training and include 16 hours of supervised clinical training.

The Model Nursing Practice Act and Model Nursing Administrative Rules, developed by NCSBN and its Member Boards, along with the Medication Assistant-Certified (MA-C) Model Curriculum, are two resources used to develop content for MACE. Subject matter experts (SMEs) are selected to participate in item writing and review workshops, using criteria delineated in the above-stated resources. MACE is designed to assess entry-level competence of unlicensed direct care providers who have been approved by their state/jurisdiction to administer medications in long-term care settings.

NCSBN continues to serve as the premier organization that advances regulatory excellence for public protection. States participating in these examination programs, through NCSBN, will continue to provide support to licensed health care professionals who need more qualified staff at the bedside to assist in the delivery of safe, competent care.

Highlights of FY10 Activities

- In October 2009, the NNAAP™ & MACE™ Examinations department conducted its first nurse aide job analysis. The nurse aide job analysis survey was mailed to 6,500 health care facilities. The survey closed in December 2009. It was published in summer 2010.
- In October 2009, the Nurse Aide Knowledge, Skills and Abilities/Knowledge Statements Workshop was held.
- In November 2009, the director of the NNAAP™ & MACE™ Examinations department and the senior program manager for Health & Professional Services from Pearson VUE visited Maine to discuss the NNAAP program.
- In November 2009, there was a site visit to an NA training center in Charlotte, N.C.
In November 2009, an online application and database for licensed nurses who want to participate in test development opportunities for the NNAAP and MACE programs was deployed. As of March 2010, 124 volunteers have signed up to participate.

In late November 2009, a Facebook page was created and is now followed by 67 fans.

In January 2010, six new NNAAP written forms went into operational use; a total of 120 items will be pretested annually.

In February 2010, the department conducted its first NA knowledge survey, which was mailed to 6,500 health care settings.

In February 2010, the department hosted its first NNAAP™ Test Plan/Test Specifications Workshop.

In February 2010, the department conducted the North Carolina MACE™ Standard-Setting Workshop via webinar.

In March 2010, the second annual NNAAP™ Item Writing and Review Workshop took place.

In April 2010, the NNAAP™ Written or Oral Examination Standard-Setting Workshop was held.

NNAAP e-push subscribers increased from 58 to 294 since April 2008.

MACE e-push subscribers increased from 55 to 268 since April 2008.

From April 2009 to March 2010, 79 volunteers were recruited and approved to participate in test development activities.

In June 2010, the first two-day Unlicensed Nursing Assistive Personnel Workshop was held in Chicago.

**Program Highlights and Test Development Activities**

**NNAAP™ JOB ANALYSIS AND KNOWLEDGE SURVEYS**

In October 2009 the department conducted its first NA job analysis survey. In preparation for the survey, a job analysis workshop was held July 21–22, 2009. A panel of 10 registered nurses (RNs) and one certified entry-level NA was assembled to assist with the job analysis. Panel members worked with and/or supervised the work of certified entry-level NAs one year postcertification. The SMEs asked the certified entry-level NAs whom they supervised to submit detailed daily logs describing the activities they performed on the job. Additionally, SMEs were asked to submit job descriptions, orientation and professional evaluations from their work settings. Using activity logs, past activity statements, job descriptions, performance evaluation documents, as well as their own knowledge of certified entry-level NA work, the SMEs identified the category structure describing the types of activities performed by certified entry-level NAs. They were careful to review and modify the current category structure to ensure that it was clear, understandable and logical.

Once the list of categories was created, the SMEs worked to create a list of activities performed by the certified entry-level NA. Each activity was reviewed for applicability to certified entry-level work and the relationship to the delivery of safe nursing care to members of the public. Care was taken to create the activity statements at approximately the same level of specificity and to avoid redundancy. There were 115 NA activity statements that were incorporated into a job analysis survey.

In February 2010, the department also conducted its first nurse aide knowledge survey to identify appropriate knowledge required for each of the work activities established in the job analysis survey. In preparation for the survey, NCSBN hosted a workshop Oct. 20–22, 2009. A panel of 14 RNs and one certified entry-level NA was assembled to assist with the knowledge statement job analysis.
During the workshop, SMEs reviewed entry-level NA work activities and identified the knowledge necessary to perform each of the work activities. The SMEs then reviewed the existing list of activity statements required for entry-level NA job performance/work to ensure that all activities were connected to some required knowledge. Once this review was complete, the SMEs were able to develop a complete list of knowledge, skills and abilities (KSA) statements for safe and effective entry-level NA work.

**NNAAP™ TEST SPECIFICATIONS WORKSHOP**

On Feb. 17-18, 2010, the NNAAP™ & MACE™ Examinations department hosted a NNAAP™ Test Specifications Workshop with SMEs from the four NCSBN geographic regions. During the meeting, the SMEs reviewed the 2010 NNAAP™ Written (Oral) Content Outline and activity statements from the 2009 Job Analysis of Nurse Aides Employed in Nursing Homes/Long-term Care, Hospitals/Acute Care and Community/Home Health Care Settings. There were 119 NA activity statements identified in the 2005 NA Job Analysis Study and 115 in the 2009 NA Job Analysis Study. There were two activity statements eliminated by SMEs: filling out a meal menu and preparing for a diagnostic test.

The SMEs found no major changes in the existing content categories and recommended the adoption of a 2011 NNAAP™ Written or Oral Content Outline based on the review of data from the 2009 NA Job Analysis Study findings. With the review and validation of the data obtained from the mailed and nonresponder survey results, the inclusion of the activity statements from the 2009 NA Job Analysis Study and the NNAAP curricula for current and prospective clients, the exam will continue to meet the educational needs of candidates interested or currently participating in NNAAP.

**NNAAP™ ITEM WRITING AND REVIEW WORKSHOP**

From March 2-4, 2010, SMEs engaged in test-development activities for the NNAAP written or oral examination.

The meeting began with an introduction to NCSBN and continued with an item writing workshop that included specific guidelines to use when writing new items; the important statistical characteristics to apply in the review of items; a practice session in the writing and reviewing of items; a list of knowledge statements and activity statements to write new items based on an analysis of item bank needs; and an explanation of how to use the NNAAP™ Written or Oral Examination Content Outline.

SMEs discussed the guidelines necessary for reviewing active and problem items. Active items are items that are scored; problem items are approved items that are not currently on testing forms, but have been administered during a real testing situation and were found to perform poorly statistically. Statistical information is used to evaluate the usefulness of the items for testing. In preparation for the meeting, 830 approved and pretest items were analyzed by the statistician using a gap analysis, which evaluates the content areas in need of items. This evaluation determines the activity statements that items will need to be written to by the SMEs.

During the NNAAP™ Item Writing and Review Workshop, the SMEs wrote 69 new items and reviewed a total of 153 items. Of the 69 newly written items, 68 were approved and set to pretest status. Of the additional items reviewed, 61 of the 84 previously written items with a problem status were rewritten and approved for pretest. This activity resulted in the approval of 129 pretest items.

**NNAAP™ STANDARD-SETTING WORKSHOP FOR WRITTEN OR ORAL EXAMINATION**

In 2010, NCSBN used findings from the 2009 Job Analysis of Nurse Aides Employed in Nursing Homes/Long-term Care, Hospitals/Acute Care and Community/Home Health Care Settings to develop the content outline and test specifications for the 2011 NNAAP written or oral examination. There were 10 SMEs that represented all four NCSBN geographic regions with a wide variety of nursing expertise who served on the NNAAP standard-setting panel. The SMEs...
reviewed the findings from the job analysis and used their experience in teaching or working with entry-level NAs and other resources and data to determine the cutscore/passing standard for the 2011 NNAAP forms, effective Jan. 1, 2011. The raw cutscore for the 2011 NNAAP written or oral examination forms is 47 out of 60 scored items.

Across all states, the pass rates for NNAAP were 92 percent for the written or oral examinations and 79 percent for the skills demonstration. The table below provides passing rates by states for the written or oral examination, skills demonstration and overall pass for forms administered in 2009. The overall pass figure provides information on the completion of all requirements for NA certification. A candidate must pass both the written or oral examination and skills demonstration to obtain an overall pass. The number in parentheses represents the number of candidates taking the examination in 2009.

### Pass Rates by States in 2009

<table>
<thead>
<tr>
<th>State</th>
<th>Written/Oral (N*)</th>
<th>Skills (N*)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First-time Takers</td>
<td>Repeaters</td>
</tr>
<tr>
<td>Alabama</td>
<td>92%</td>
<td>81%</td>
</tr>
<tr>
<td>Alaska</td>
<td>97%</td>
<td>87%</td>
</tr>
<tr>
<td>California</td>
<td>92%</td>
<td>72%</td>
</tr>
<tr>
<td>Colorado</td>
<td>96%</td>
<td>77%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>82%</td>
<td>60%</td>
</tr>
<tr>
<td>Georgia</td>
<td>91%</td>
<td>60%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>87%</td>
<td>58%</td>
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<tr>
<td>Maryland</td>
<td>92%</td>
<td>70%</td>
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<tr>
<td>Minnesota</td>
<td>96%</td>
<td>90%</td>
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<tr>
<td>Mississippi</td>
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</tr>
<tr>
<td>New Hampshire</td>
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<td>100%</td>
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<tr>
<td>New Jersey</td>
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<td>62%</td>
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<tr>
<td>North Carolina</td>
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<td>83%</td>
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<tr>
<td>North Dakota</td>
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<td>90%</td>
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<tr>
<td>Pennsylvania</td>
<td>94%</td>
<td>80%</td>
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<td>Rhode Island</td>
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<tr>
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<td>(1730)</td>
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<td>(551)</td>
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<td>(1093)</td>
</tr>
<tr>
<td></td>
<td>(1485)</td>
<td>(374)</td>
</tr>
</tbody>
</table>
Pass Rates by States in 2009

<table>
<thead>
<tr>
<th>State</th>
<th>Written/Oral (N*)</th>
<th>Skills (N*)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First-time Takers</td>
<td>Repeaters</td>
</tr>
<tr>
<td>South Carolina</td>
<td>94%</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>(5633)</td>
<td>(878)</td>
</tr>
<tr>
<td>Texas</td>
<td>91%</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>(22041)</td>
<td>(3389)</td>
</tr>
<tr>
<td>Virgin Islands</td>
<td>82%</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>(112)</td>
<td>(9)</td>
</tr>
<tr>
<td>Virginia</td>
<td>91%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>(5959)</td>
<td>(897)</td>
</tr>
<tr>
<td>Washington</td>
<td>94%</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td>(7611)</td>
<td>(769)</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>98%</td>
<td>84%</td>
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<tr>
<td></td>
<td>(10938)</td>
<td>(589)</td>
</tr>
<tr>
<td>Wyoming</td>
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<td>91%</td>
</tr>
<tr>
<td></td>
<td>(1020)</td>
<td>(95)</td>
</tr>
<tr>
<td>Total</td>
<td>93%</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>(130435)</td>
<td>(16452)</td>
</tr>
</tbody>
</table>

*Number of candidates is in parenthesis

UNLICENSED NURSING ASSISTIVE PERSONNEL WORKSHOP
In June 2010, the department hosted its first two-day Unlicensed Nursing Assistive Personnel Workshop. Day one of the workshop was devoted to NA topics while day two was devoted to medication aide/assistant (MA) topics. NA and MA regulators, program managers, training managers, as well as long-term care/nursing home administrators, were invited to attend. The purpose of the workshop was for stakeholders to discover, learn and share insights on the evolving role of NAs and MAs in nursing care, and the regulatory implications that may impact the work performed by these direct care providers.

Future Activities

- Share with the public information about NNAAP and MACE.
- Develop new test items, test forms and maintain item pools for NNAAP and MACE.
- Perform appropriate item response and statistical analyses of items for NNAAP and MACE.
- Build paper-and-pencil test forms and computer-based test forms for written or oral examination for NNAAP.
- Update skills demonstration test forms and scoring standards for NNAAP.
- Continue to increase the bank of items for MACE and build computer-based forms to meet needs of membership.
- Review NNAAP skills demonstration content with SME panel.
- Enhance the quality of NNAAP and MACE.
- Increase the number of states that use NNAAP and MACE.

Attachment
A. 2011 NNAAP™ Written or Oral Examination Content Outline
The revised 2011 NNAAP™ Examination Content Outline is based on the findings from the 2009 job analysis of nurse aides published by NCSBN in spring 2010. The examination content outline will go into effect January 2011.

The NNAAP written examination is comprised of 70 multiple-choice items; 10 are pretest items (nonscored) on which statistical information will be collected. The NNAAP oral examination is comprised of 60 multiple-choice items and 10 reading comprehension (word recognition) items. The candidate is allowed to choose between a written and an oral examination.

<table>
<thead>
<tr>
<th>Content Domain</th>
<th>2011 Content Outline</th>
<th>2010 Content Outline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weighting of Content</td>
<td>Number of Items in Domain</td>
</tr>
<tr>
<td>I. Physical Care Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Activities of Daily Living</td>
<td>14%</td>
<td>8</td>
</tr>
<tr>
<td>1. Hygiene</td>
<td></td>
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<tr>
<td>2. Dressing and Grooming</td>
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<td>3. Nutrition and Hydration</td>
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<tr>
<td>4. Elimination</td>
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<tr>
<td>5. Rest/Sleep/Comfort</td>
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<td></td>
</tr>
<tr>
<td>B. Basic Nursing Skills</td>
<td>39%</td>
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<tr>
<td>1. Infection Control</td>
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<tr>
<td>2. Safety/Emergency</td>
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<tr>
<td>3. Therapeutic/Technical Procedures</td>
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<tr>
<td>4. Data Collection and Reporting</td>
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<td></td>
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<td>C. Restorative Skills</td>
<td>7%</td>
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</tr>
<tr>
<td>1. Prevention</td>
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<td></td>
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<tr>
<td>2. Self Care/Independence</td>
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<tr>
<td>II. Psychosocial Care Skills</td>
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<td>A. Emotional and Mental Health Needs</td>
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<td>6</td>
</tr>
<tr>
<td>B. Spiritual and Cultural Needs</td>
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<tr>
<td>III. Role of the Nurse Aide</td>
<td></td>
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<tr>
<td>A. Communication</td>
<td>8%</td>
<td>5</td>
</tr>
<tr>
<td>B. Client Rights</td>
<td>7%</td>
<td>4</td>
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<tr>
<td>C. Legal and Ethical Behavior</td>
<td>3%</td>
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</tr>
<tr>
<td>D. Member of the Health Care Team</td>
<td>9%</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>60</td>
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Report of the Nursys® Committee

**Background**
The Nursys® Committee was charged by the Board of Directors (BOD) with:

- Creating an Advanced Practice Nurse Information Model for Nursys.
- Developing a model to receive electronic disciplines from Member Boards.

**Highlights of FY10 Activities**

- Changes to Nursys policy.
- Changes to add initial licensure date to Nursys.com.
- Reviewed all Nursys-related completed projects from 2006 to 2009.
- Strategized and developed a model to collect and display advanced practice registered nurse information in Nursys.
- Strategized and developed a model to receive electronic disciplines from Member Board database to Nursys, potentially eliminating the need for manual discipline entry by Member Board staff.
- Discussed and approved business requirements for discipline auto alert.

**Future Activities**
The Nursys® Committee will reconvene and work on the charges given to them by the BOD in fiscal year 2012 (FY12).

**Attachments**
None

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**Members**
Adrian Guerrero  
Kansas, Area II, Chair
Stacie Berumen  
California, Area I
Michelle Cartee  
Missouri, Area II
DeWayne Hatcher  
Oregon, Area I
Sandra Johanson  
Kentucky, Area III
Sue Tedford  
Arkansas, Area III
Terry West  
Washington, Area I
Julio Santiago  
Illinois, Area II, Board Liaison

**Staff**
Nur Rajwany, MS  
Director, Information Technology

**Meeting Dates**
- Oct. 19-20, 2009
- Feb. 16, 2010 (Teleconference)
- March 22, 2010

**Relationship to Strategic Plan**

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

**Strategic Objective 1**
Maintain a comprehensive national nurse licensure database.
Report of the TERCAP® Committee

Background

Evaluate the Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®) protocol to improve the quality of data submitted.

The TERCAP® Committee analyzed the current TERCAP protocol and its utilization by Member Boards to determine changes needed to improve the quality of the data. In addition, the committee looked at other major patient-safety projects and the data reporting format of each.

The committee’s analysis of the TERCAP protocol revealed the following concerns that impede the completion of sound, scientifically controlled research:

1. Selection bias. The current protocol was designed to encourage Member Boards’ participation in TERCAP by making its use as easy as possible. However, due to a lack of stringent case selection and submission requirements, states were allowed to develop their own case selection criteria. As a result, some states select their most egregious cases; some send cases from specific investigators; and other states randomly select cases. The committee was in agreement that inconsistency in case selection may cause significant selection bias. Because of this, the cases are not representative of the outcomes of practice breakdowns in the general population.

2. Missing data. Not all Member Board investigators routinely collect all the data that is required by TERCAP. Although participating boards of nursing (BONs) are strongly encouraged to have investigators employ the instrument questions contemporaneous to their investigation, some Member Board representatives have reported that investigators do not find this feasible. They are already pressed for time and view the instrument use as impeding the efficiency in which they could otherwise carry out the investigation. BON investigations that are completed prior, rather than contemporary to the utilization of the instrument, perpetuate the problem with missing data.

In December 2008, the NCSBN Research department performed a power analysis to determine the number of submitted cases necessary to complete a statistical analysis to answer the original research questions. The power analysis done for this project indicates that at least 1,300 cases are needed prior to any valid statistical analysis. There are currently 624 submissions. At the current rate, in order to answer the research questions, it is anticipated to take several years before actual data analysis can ensue.

Review of data reporting formats:

The committee examined other patient-safety projects and their reporting methods. Dr. Rodney Hicks, committee consultant, gave the committee an inside look at the MedMarx System’s method of reporting. NCSBN staff provided information about other systems that included Joint Commission Sentinel Events Database, Institute for Safe Medication Practices and FDA MedWatch. All of these are national, voluntary, adverse events reporting databases that identify trends, report descriptive statistics and administer alerts. These databases are highly regarded.

The committee engaged in extensive discussion about the option of TERCAP becoming a similar reporting system for practice breakdown. The advantages of converting TERCAP to an adverse event reporting system are as follows:

- An effective reporting system is a measure of progress toward achieving a safety culture. At a minimum, reporting can help identify hazards and risks, and provide information as to where the system is breaking down. This can help target improvement efforts and system changes to reduce the likelihood of injury to future patients.

- Detailed analysis of thousands of reports makes it possible to identify hazards. Natural questions guide analysts through details of context and contributing causes to probe interrelationships among event types, risk factors and contributing causes. Statistical
analysis identifies meaningful relationships and provides analysis that can generate insights into the overall systems of care. These data are classified and fed back to BONs with benchmarking from the entire database and with their own prior experience to identify targets for improvement, and to provide monitoring of progress. The most important function that a large reporting system can perform is to use the results of investigations and data analyses to formulate and disseminate recommendations for system changes. Reports are aggregated and analyzed to understand the frequency of types of incidents, patterns, trends and underlying contributory factors.

- TERCAP data, which would be reported in frequencies as recurring and consistent trends, not inferential statistics, could be reported as soon as sometime this year. Since only descriptive statistics are used, problems with selection bias and lack of generalizability are not of concern. Alerts could be issued describing specific patterns and new trends.

- Member Boards would be provided with data which may encourage additional participation from current users and initial participation by new Member Board users.

The committee does not anticipate that reporting the data as descriptive statistics and trends will affect the data previously collected from TERCAP. The disadvantages of converting TERCAP to a national database, as described above, is that the original research questions identified for TERCAP will not be answered as a primary data analysis. A secondary analysis may be possible, but not in the near future.

As recommended by the BOD, the committee consulted Patricia Benner, PhD, RN, FAAN who conducted the primary research in development of the TERCAP instrument. In March 2010, the committee had an extensive discussion with Benner. She was in full agreement that changing TERCAP into a reporting database would be a positive move as it would allow Member Boards the opportunity to access the aggregate data much sooner than would be available under a strict research protocol.

Benner also suggested that the committee review and determine a minimum data set within the instrument and voiced her recommendations as to what elements of the instrument should be mandatory for Member Boards to complete. Benner believed this would be strategic to instrument utilization as it would shorten the instrument and possibly encourage more participation, since much of the negative feedback about the instrument centers around its length (see Attachment A).

**Develop and implement a plan to increase data collection**

In addition to the above recommendation regarding the TERCAP protocol, the committee has established an industrious plan for involving more BONs in the participation of TERCAP. This entails:

1. Personal visits to BONs to teach staff about TERCAP;
2. Identifying champions who will answer questions, share their experiences and assist BONs with implementation;
3. Developing a Web-based toolkit and new marketing materials that emphasize the advantages of using TERCAP as an investigative tool;
4. Encouraging BONs that utilize TERCAP to work with health systems, hospitals and other institutions for case submission; and
5. Increasing awareness of other advantages of TERCAP:
   a. Increases transparency. BONs can summarize their data on the types of cases being addressed.
   b. Identifies system issues.
   c. Identifies competency issues.
   d. Encourages collaboration between BONs and institutions.
Kevin Kenward, PhD, MS, director, Research, NCSBN, visited three BONs during fiscal year 2010 (FY10) for TERCAP training: Virginia, New York and Mississippi. The TERCAP database now contains more than 600 cases; 18 states are currently participating. There are four champions that have been identified to assist with the recruitment and training of BONs interested in TERCAP. The TERCAP toolkit and resource materials are being updated and streamlined.

**Highlights of FY10 Activities**

- Development of an interactive, online toolkit, and updating of resource materials and website. Videos have been selected and made ready to embed by the NCSBN Interactive Services department; training materials have been updated; testimonials and the information sheet have been reformulated; other materials have been updated and made more succinct and pleasing. It was decided that release of this toolkit should coincide with the release of TERCAP data.
- Personal training sessions with BONs.
- Addition of four participating states.
- More than 600 cases in database.

**Future Activities**

- Dissemination of TERCAP data.
- Further development of implementation plan.

**Attachment**

A. 2010 TERCAP® Data Collection Instrument
Attachment A

2010 TERCAP® Data Collection Instrument

TERCAP Case ID Number _________________________________________

1. Full Name of Reviewer ____________________________________________

2. State Board of Nursing _______________________

3. Date of incident ___________________ Unknown

4. Type of Patient Event Related to Practice Breakdown
   - Fall
   - Medication Error
   - Healthcare Associated Infection
   - Allergic/Anaphylaxis/Transfusion Reaction
   - Abuse
   - Treatment Error/Omission
   - Equipment Error
   - Other (Specify)
   - Suicide
   - Healthcare Associated Infection
   - Equipment Error

5. Patient age _______ Unknown

6. Indicate the patient's diagnosis. Check no more than TWO diagnoses, those that contributed to the reported situation
   - Alzheimer's disease and other dementias (confusion)
   - HIV / AIDS
   - Arthritis
   - Hypertension
   - Asthma
   - Infections
   - Back problems
   - Ischemic heart disease (CAD, MI)
   - Cancer
   - Nervous system disorders
   - Congestive heart failure
   - Pneumonia
   - Depression and anxiety disorders
   - Pregnancy
   - Diabetes
   - Renal / urinary system disorders
   - Emphysema
   - Skin disorders
   - Fractures
   - Stomach ulcers
   - Gall bladder disease
   - Stroke (CVA)
   - Gastrointestinal disorders
   - Other (Specify)
   - Unknown diagnosis

7. Patient Harm Select ONLY one
   - No harm - An error occurred but with no harm to the patient
   - Harm - An error occurred which caused a minor negative change in the patient's condition.
   - Significant harm - Significant harm involves serious physical or psychological injury. Serious injury specifically includes loss of function or limb.
   - Patient death - An error occurred that may have contributed to or resulted in patient death.
8. Communication Factors Check all that apply
- Communication systems equipment failure
- Computer system failure
- Interdepartmental communication breakdown / conflict
- Lack of ongoing education / training
- Lack of or inadequate orientation / training
- Medical record not accessible
- No adequate channels for resolving disagreements
- Patient identification failure
- Patient name similar / same
- Patient transfer (hand-offs)
- Preprinted orders inappropriately used (other than medications)
- Shift change (patient hand-offs)
- Other (Specify) ________________________________
- No communication factors involved
- Unknown

9. Leadership / Management Factors Check all that apply
- Assignment or placement of inexperienced personnel
- Inadequate / outdated policies / procedures
- Inadequate patient classification (acuity) system to support appropriate staff assignments
- Nurse shortage, sustained, at institution level
- Poor supervision / support by others
- Unclear scope and limits of authority / responsibility
- Other (Specify) ________________________________
- No leadership/management factors involved
- Unknown

10. Backup and Support Factors Check all that apply
- Forced choice in critical circumstances
- Ineffective system for provider coverage
- Lack of adequate provider response
- Lack of nursing expertise system for support
- Lack of adequate response by lab / x-ray / pharmacy or other department
- Other (Specify) ________________________________
- No backup and support factors involved
- Unknown

11. Environmental Factors Check all that apply
- Code situation
- Equipment failure
- Frequent interruptions / distractions
- Increased noise level
- Lack of adequate supplies / equipment
- Multiple emergency situations
- Physical hazards
- Poor lighting
- Similar / misleading labels (other than medications)
- Other (Specify) ________________________________
- No environmental factors involved
- Unknown
12. Health team members involved in the practice breakdown Check all that apply
- Floating / temporary staff
- Health profession student
- Medication assistant
- Other Health professional (e.g., PT, OT, RR)
- Other prescribing provider
- Other support staff
- Patient
- Patient's Family / friends
- Pharmacist
- Physician (may be attending, resident or other)
- Staff nurse
- Supervisory nurse / personnel
- Unlicensed Assistive Personnel (nurse aide, certified nursing assistant, CNA or other titles of non-nurses who assist in performing nursing tasks)
- Other (Specify)________________________________________
- No health team members involved
- Unknown

13. Staffing issues contributed to the practice breakdown Check all that apply
- Lack of supervisory / management support
- Lack of experienced nurses
- Lack of nursing support staff
- Lack of clerical support
- Lack of other health care team support
- Other (Specify)____________________
- No staffing issues involved
- Unknown

14. Health Care Team Check all that apply
- Breakdown of health care team communication
- Care impeded by policies or unwritten norms that restrict communication
- Illegible handwriting
- Intimidating / threatening behavior
- Intradepartmental conflict / non-supportive environment
- Lack of multidisciplinary care planning
- Lack of patient involvement in plan of care
- Lack of family / caregiver education
- Lack of patient education
- Majority of staff had not worked together previously
- Other (Specify)_______________________________
- No health care team issues involved
- Unknown

15. Nurse's gender  □ Female  □ Male  □ Unknown

16. Where nurse received nursing education
- Unknown
- US
- Non-US, please list country __________________________
17. Indicate all degrees the nurse holds and list the year of graduation and year of initial licensure, if applicable.

<table>
<thead>
<tr>
<th>Degree(s)</th>
<th>Year of Graduation(s)</th>
<th>Year of Initial Licensure(s)</th>
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</thead>
<tbody>
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</table>

18. Which license did you hold at the time of the practice breakdown?

- [ ] LPN/VN
- [ ] RN
- [ ] APRN
- [ ] Nurse Practitioner
- [ ] Clinical Nurse Specialist
- [ ] Nurse Anesthetist
- [ ] Nurse Midwife
- [ ] APRN Category unknown

19. Is English the nurse's primary language?

- [ ] Yes
- [ ] No
- [ ] Unknown

20. Length of time nurse had worked in patient care location where the practice breakdown occurred

- [ ] Less than one month
- [ ] One month - Twelve months
- [ ] One - Two years
- [ ] Three - Five years
- [ ] More than five years
- [ ] Unknown

21. Type of shift

- [ ] 8 hour
- [ ] 10 hour
- [ ] 12 hour
- [ ] On call
- [ ] Other (Specify) ____________
- [ ] Unknown

22. Was the nurse working in a temporary capacity?

- [ ] Yes
- [ ] No
- [ ] Unknown

23. How many direct care patients were assigned to the nurse at the time of the practice breakdown?

Number of Patients ____________

24. Previous discipline by a board of nursing

- [ ] Yes
- [ ] No
- [ ] Unknown

25. Previous criminal convictions

- [ ] Yes
- [ ] No
- [ ] Unknown

26. Did the reported incident involve intentional misconduct or criminal behavior? Check all that apply

- [ ] No
- [ ] Yes: Fraud (including misrepresentation)
- [ ] Yes: Patient abuse (verbal, physical, emotional or sexual)
- [ ] Yes: Criminal conviction
- [ ] Yes: Theft (including drug diversion)
- [ ] Yes: Other - please specify ________________
- [ ] Unknown
27. Did the practice breakdown involve a medication error?
   - Yes
   - No (Skip to question 30)
   - Unknown (Skip to question 30)

28. Name of drug involved in the practice breakdown (Include complete medication order or skip if no medication error involved)
   - Drug ordered __________________________  Unknown
   - Drug actually given _______________________  Unknown

29. The type of medication error identifies the form or mode of the error, or how the error was manifested. Select the type of medication error. Check all that apply
   - Abbreviations
   - Wrong dosage form
   - Drug prepared incorrectly
   - Wrong drug
   - Extra dose
   - Wrong patient
   - Improper dose / quantity
   - Wrong route
   - Mislabling
   - Wrong time
   - Omission
   - Other (Specify) __________________________
   - Wrong administration technique
   - Unknown

30. Was a documentation error the cause of the practice breakdown?
   - Yes
   - No (Skip to question 32)
   - Unknown (Skip to question 32)

31. What kind of documentation error was involved? Check all that apply
   - Charting incorrect information
   - Charting on wrong patient record
   - Incomplete or lack of charting
   - Pre-charting / untimely charting
   - Other (Specify) __________________________

32. If Attentiveness / Surveillance was a factor in the Practice Breakdown. Check all that apply
   - Patient not observed for an unsafe period of time
   - Staff performance not observed for an unsafe period of time
   - Other (Specify) __________________________
   - Attentiveness/Surveillance was not a factor

33. If Clinical Reasoning was a factor in the Practice Breakdown. Check all that apply
   - Clinical implications of patient signs, symptoms and/or responses to interventions not recognized
   - Clinical implications of patient signs, symptoms and/or interventions misinterpreted
   - Following orders, routine (rote system) without considering specific patient condition
   - Poor judgment in delegation and the supervision of other staff members
   - Inappropriate acceptance of assignment or accepting a delegated action beyond the nurse's knowledge and skills
   - Lack of knowledge
   - Other (Specify) __________________________
   - Clinical reasoning was not a factor
34. If Prevention was a factor in the Practice Breakdown. Check all that apply
- Preventive measure for patient well-being not taken
- Breach of infection precautions
- Did not conduct safety checks prior to use of equipment
- Other (Specify) ____________________________
- Prevention was not a factor

35. If Intervention was a factor in the Practice Breakdown. Check all that apply
- Did not intervene for patient
- Did not provide timely intervention
- Did not provide skillful intervention
- Intervened on wrong patient
- Other (Specify) ____________________________
- Intervention was not a factor

36. If Interpretation of Authorized Provider's Orders was a factor in the Practice Breakdown. Check all that apply
- Did not follow standard protocol/order
- Missed authorized provider's order
- Misinterpreted telephone or verbal order
- Misinterpreted authorized provider handwriting
- Unauthorized intervention (not ordered by an authorized provider)
- Undetected authorized provider error resulting in execution of an inappropriate order
- Other (Specify) ____________________________
- Interpretation of provider's orders was not a factor

37. If Professional Responsibility / Patient Advocacy was a factor in the Practice Breakdown. Check all that apply
- Breach of confidentiality
- Boundary crossings / violations
- Lack of respect for patient / family concerns and dignity
- Nurse did not recognize limits of own knowledge and experience
- Nurse attributes responsibility to others
- Nurse does not refer patient to additional services as needed
- Nurse fails to advocate for patient safety and clinical stability
- Patient abandonment
- Specific patient requests or concerns unattended
- Other (Specify) ____________________________
- Professional responsibility/patient advocacy was not a factor

38. Select which Practice Breakdown categories you selected above is most significant (Primary)
- Attentiveness/Surveillance
- Clinical Reasoning
- Prevention
- Intervention
- Interpretation of provider's orders
- Professional responsibility/patient advocacy
39. Board of Nursing Outcomes

- Dismissed, no action
- Referral to another oversight agency
- Recommendations to the health care agency involved in the practice breakdown
- Non-disciplinary action (e.g., letter of concern)
- Alternative Program – The nurse was given the opportunity to participate in a non-discipline program to address practice and / or impairment concerns
- Board of Nursing disciplinary action

Provide any additional comments and feedback regarding the TERCAP Instrument:
Report of the Transition to Practice Committee

Background
NCSBN’s Transition to Practice Committee members recategorized the Transition to Practice Modules to be more in line with the Institute of Medicine (IOM) competencies and the Quality and Safety Education in Nursing (QSEN) initiative. The modules include patient-centered care, communication and teamwork, evidence-based practice, quality improvement and informatics. Committee members developed objectives, content outlines and interactive exercises, and identified sources for the modules (Attachment A). If the Board of Directors (BOD) approves the Transition to Practice business plan, NCSBN's Interactive Services department will use this document to develop online, interactive modules for the pilot study and those employers who don't develop a transition program that meets NCSBN standards. The module outlines will also be the document employers use when they develop their own transition program to meet NCSBN standards.

Committee members provided input so NCSBN could work with Ground Floor Partners to formulate a business plan to develop the online modules and conduct a multisite pilot study of the Transition to Practice model, which was presented to the BOD. See Attachments C and D for business plan templates for boards of nursing and employers. The committee members also provided feedback to the Transition Advisory Panel, research experts hired by NCSBN to assist with the planning and conduct of the pilot study (Attachment B).

Highlights of FY10 Activities
- Recategorized NCSBN modules to be more in line with national initiatives.
- Developed objectives, content and interactive exercises, and identified sources for the following modules:
  - Patient-centered Care;
  - Communication and Teamwork;
  - Evidence-based Practice;
  - Quality Improvement;
  - Informatics; and
  - Preceptors.
- Collaborated with stakeholders to inform them about, and to gain feedback on, NCSBN’s transition model. Over the past two years, the committee members have collaborated with more than 35 stakeholders and policy makers.
- Held a conference call with Susan Boyer of the Vermont Nurse Internship Program (VNIP) for input into the design of the preceptor module.
- Sent the recategorized modules out to NCSBN's membership for information and comment.
- Presented a draft of the module outlines at NCSBN's Midyear Meeting and made revisions based on suggestions.
- Working with consultants, developed a business plan for:
  - NCSBN's module development and conduct of the multisite pilot study;
  - Business plan template for boards of nursing; and
  - Business plan template for employers.
Developed a research plan, timeline and outcome measures for the Transition Pilot Study through consultation with research experts.

Met with NCSBN's Marketing and Communications department to develop a logo for the marketing materials (see Attachment E).

**Future Activities**

The committee members completed their charges and recommend that NCSBN go forward with developing the modules and conducting the Transition to Practice pilot study.

**Attachments**

A. NCSBN’s Transition to Practice Modules  
B. Report of Transition to Practice Advisory Panel  
C. Business Plan Template for Boards of Nursing (BONs) 
D. Business Plan Template for Employers  
E. Transition to Practice Design
NCSBN’s Transition to Practice Modules

INTRODUCTION
The goal of NCSBN’s Transition to Practice Model is to promote public safety by supporting newly licensed nurses during their critical entry period and progression into practice.

Guiding Principles
- The mission of boards of nursing (BONs) is to protect public health, safety and welfare.
- Nursing regulators recognize the value of evidence-based models in their responsibility of public protection.
- Transitioning new nurses to practice is best accomplished when practice, education and regulation collaborate.
- Transition to practice programs should occur across all settings and education levels.
- Regulation criteria for transition programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection.
- Transition program outcomes are consistent with the knowledge, skills and attitudes required for safe and effective provision of nursing care.

Relevant Definitions
Competent—The ability to demonstrate an integration of the knowledge, skills and attitudes necessary to function in a specific role and work setting (Modified from American Association of Critical-Care Nurses’ Preceptor Handbook).

Deliberate practice—Focused learning with an engaged learner that involves repetitive performance of psychomotor or cognitive skills coupled with rigorous assessment, informative feedback and the opportunity for reflection.

Orientation—The process of introducing staff to the philosophy, goals, policies, procedures, role expectations and other factors needed to function in a specific work setting. Orientation occurs for new employees and when changes in nurses’ roles, responsibilities and practice settings occur (ANA’s Scope and Standards of Practice for Nursing Professional Development).

Preceptor—A competent nurse who has received formal training for the preceptorship role.

Preceptorship—A formal relationship between a qualified preceptor and a newly licensed nurse that facilitates active learning and transition into practice.

Transition to Practice—A formal program of active learning implemented across all settings, for newly licensed nurses (registered nurses [RNs] and licensed practical/vocational nurses [LPN/ VNs]) designed to support their progression from education to practice.

See NCSBN’s Transition to Practice toolkit for further information about the NCSBN model.

CONTENT OF MODULES
The following modules include the objectives, content outlines, suggested exercises and references for the five evidence-based modules that were developed for the Transition to Practice model:
- Communication and Teamwork;
- Patient-centered Care;
- Evidence-based Practice;
Quality Improvement; and
Informatics.

In addition, there is a module for preceptor training and some information about how employers can support newly licensed nurses in the last six months of the new graduate’s first year in practice. Integrated in the patient-centered care module are ideas for employers to consider for supporting the learning of specialty content. Research has suggested that transition programs are more successful when they provide experiential learning within the specialty where the newly licensed nurse is working. Safety and clinical reasoning were specifically considered when designing all the modules, and have been integrated throughout. Similarly, strategies for providing feedback and opportunities for reflection during the new nurses’ first year in practice have been identified.

It has been the vision that NCSBN’s Transition to Practice Model is flexible; that is, employing agencies can develop the transition program, incorporating the standards as spelled out in the NCSBN modules. Employers are encouraged to partner with other organizations that hire new nurses or with academic settings in order to develop their own modules. However, since this is a regulatory model that requires new nurses to complete a standardized transition program before they can renew their license after the first year of practice, the online modules will be available so that every newly licensed nurse will have the opportunity to meet this requirement. Similarly, preceptor training is required in this model and there are a number of programs available where preceptors could meet this requirement.

NCSBN’s Transition to Practice Model has been designed to promote experiential learning, rather than relearning material that should have been learned in the nursing program. Interactive exercises have been developed to promote this in the face-to-face programs. Further, the online modules will be designed to encourage experiential learning. In these interactive online modules, the new nurses will make decisions, set priorities and choose appropriate pathways using cutting-edge technologies.

The committee members have reviewed pocket-sized texts that new graduates would be able to use during this program. While no firm decisions have been made, *Clinical Coach for Nursing Excellence* by Campbell, Gilbert & Lausten (2010) seems to be general enough that it could be used across settings and education. It was designed for new graduates and has considerable emphasis on patient safety, organization and prioritization, communication and collaboration, delegation, responding to changing patient situations and ethical decision making, all of which are highlighted in NCSBN’s model.

All of this material will become part of a manual that will be made available to practice settings, beginning with the participating pilot sites during next year’s pilot study.
REFERENCES
While each module is followed by a list of resources, the following are some general sources that support NCSBN's Transition to Practice Model:


PATIENT-CENTERED CARE

Contact Hours

Development and Implementation Guidelines: This module must be tailored so it is consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Considerations for Specialty Care: The evidence supports that newly licensed nurses need experiential learning in the practice areas where they are employed. The focus will be on specific populations, practice settings and specialty competencies. This experiential learning must be provided by the employer.

Tips for agency support when incorporating specialty content: (a) consider development of partnerships between facilities, nursing programs, etc.; and (b) consider using specialty organization resources, online continuing education (CE) programs, etc.

In order to understand specialty care, it is recommended that the new nurse:

1. Interact with key individuals in specialty area;
2. Meet with the interprofessional team to include the nurse administrator and charge nurse; and
3. Review national standards, state requirements, and agency-specific policies and procedures as related to the specialty.

Learning Objectives

1. Appreciate the multiple dimensions of patient-centered care.
   a. Patient, family, community.
   b. Consider values and preferences.
   c. Consider cultural, ethnic, social and religious backgrounds.
   d. Examine how quality, safety and health care costs can be improved with involvement of patients and families.
   e. Consider ethical and legal implications of care.

2. Advocate for the patient.
   a. Put the patient first.
   b. Teach and learn principles for patient-centered care.
   c. Understand that the nurse is the patient’s last line of defense.
   d. Reflect on ways nurses advocate for patients.

3. Make sound decisions when caring for patients, based on recognition and validation of relevant patient data.
   a. Consider ways of looking at a clinical issue, utilizing:
      i. Basic natural and social sciences, including pathophysiology and psychopathology;
      ii. Ethical decision-making framework;
      iii. Reflective thinking, contemplation and deliberation; and
   b. Incorporate the following actions when making sound clinical decisions:
      i. Systematically gather, retrieve and weigh relevance of multiple types of data (e.g.,
signs and symptoms; diagnostic testing; laboratory results);

ii. Identify missing data;

iii. Distinguish relevant from irrelevant data;

iv. Organize and interpret clinical cues;

v. Define patient/client health problem(s);

vi. Recognize desired outcomes; and

vii. Identify specifics related to patient populations/settings:

- Patient teaching;
- Patient data collection and/or assessment;
- Common diagnoses;
- Common medications;
- Common procedures;
- Policies, procedures, practice standards, protocols, pathways and clinical guidelines applicable to the practice setting;
- Setting, age and cultural competencies;
- Safety and quality-improvement initiatives;
- Key members and roles of the interprofessional team;
- Evidence-based practice in specialty area;
- Continuity of care considerations;
- Emergency/code response; and
- End of life.

c. Recognize changes in patient status, including imminent threats to patient/client safety, and intervene appropriately.

i. Document and communicate/notify (substantiate decision making).


a. Use clinical data sources (technology/information systems).

b. See the unexpected; that is, recognize that not all cases look the same.

c. Detect signs that a particular patient is not like most people and thus, may not be helped or may even be harmed by following standard protocols.

d. Ask “Why?” and “Why not?”

e. Identify patterns, trends and red flags specific to patient populations and settings.

f. Understand and anticipate risks.

g. Recognize complications of treatments and procedures and intervene appropriately.

h. Know when and how to call the patient’s health care provider.

i. Phone orders

ii. Rapid response teams, when available
5. Prioritize patient care.
   a. Review the levels of priority ranking for patient needs:
      i. First order priority need—immediate threat to health, safety or survival;
      ii. Second order priority need—actual problem for which immediate help has been requested by the client or family;
      iii. Third order priority need—actual or potential issue that the client or family is not aware of; and
      iv. Fourth order priority need—actual or potential issue that is anticipated in the future and for which help will be needed.
   b. Recognize and discuss the “priority-setting traps” (Vaccaro, 2001):
      i. “Path of least resistance”;
      ii. “Squeaky wheel”;
      iii. “Whatever hits first”; and
      iv. “Default.”
   c. Demonstrate sound clinical reasoning when deciding what activities should take priority depending upon client situations, based on safety, quality and systems considerations:
      i. Understand one’s own power, accountability and responsibility in the process of prioritizing/organizing nursing care;
      ii. Determine the short- and long-term goals for the patient/client;
      iii. Ask “Is the task/activity important?” and “Does the activity/task need to be done right now?”;
      iv. Assess one’s own skill level;
      v. Assess the availability of resources, including assistance from other more experienced staff;
      vi. Recognize the need to delegate tasks to others appropriately;
      vii. Assess patient’s/client’s needs and preferences at the time of decision making;
      viii. Recognize the need to evaluate and potentially change the priority/order in which tasks are to be done;
      ix. Keep track of multiple responsibilities; and
      x. Consider patient and system costs, and analyze ways to decrease them.
   d. Manage self with respect to time, while at the same time incorporating patient safety standards:
      i. Understand the importance of safety, while attempting to achieve efficiency in prioritizing/organizing client care;
      ii. Allow time for planning care including establishing priorities;
      iii. Eliminate time wasters; i.e., group activities together that are in the same location, gather all needed supplies before beginning an activity, etc.;
      iv. Eliminate interruptions, if at all possible;
      v. Delegate appropriately; and
vi. Assess/personally reflect on organizational skills (e.g., how and why time is wasted, what is the best time of day to work, considering safety standards, etc.) and seek feedback on how to improve.

   a. Utilize strategies for prioritizing and analyzing data.
   b. Be mindful when caring for patients.
   c. Seek and use constructive feedback.
   d. Consider factors affecting clinical reasoning and patient safety (e.g., anxiety, stress, fatigue, environmental distractions, personal factors, ethical dilemmas).

   e. Analyze strategies to enhance efficiency of the system:
      i. Demonstrate knowledge of the nursing service delivery patterns and systems in the facility or organization;
      ii. Recognize that nursing is one part of a larger environment;
      iii. Understand the types of nursing care delivery methods (e.g., team nursing, primary nursing, case management, etc.) that are utilized at the facility; and
      iv. Know how the facility uses information and technology in client care.

7. Maintain professional boundaries with patients and key parties (see NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules, Article XI). Understand the following:
   a. Principles of professional boundaries;
   b. Professional boundary crossings;
   c. Professional boundary violations; and
   d. Cautions with disseminating patient information via Internet/cell phone cameras.

Interactive Exercises

1. Journal to focus your thinking and reflect on what you did (or did not do), why you did it and what you could do differently in daily patient/client care situations.

2. Think aloud with preceptor(s) and/or experienced staff to develop questioning skills at higher cognitive levels of analysis (e.g., compare, discriminate, examine), synthesis (e.g., perform, propose, organize) and evaluation (e.g., prioritize, rank) to increase knowledge and understanding of complex patient/client situations commonly found on unit.

3. Think aloud with preceptor(s) and/or experienced unit nursing staff using each of the steps of the nursing process to work through a complex patient/client situation.

4. Think aloud with preceptor(s) and/or experienced unit nursing staff to examine actions that result in adverse events or undesirable patient/client outcomes.

5. Think about and discuss with preceptor: “What evidence do you have or need to collect to determine the effectiveness of your intervention?”

6. Using case studies corresponding to the clinical focus of the unit, develop written responses addressing pathophysiology related to the case; selection of rapid baseline assessment priorities; clinical judgments with validation and potential alternatives; and nursing interventions. Prioritize and provide rationales to substantiate decisions.

7. Using the case study, critique strength and relevance of how available evidence influences choice of interventions.
8. Simulate learning activities: administer medications to 10 or more patients; provide direct care to more that two patients; rehearse with preceptor(s) how and when to call physician with change in patient/client status; high acuity, less frequent vignettes (Beyea et al., 2007).

9. Reflect upon a near-miss situation that you were involved in and think about what you might have done differently. Seek feedback from your preceptor on the situation and consider alternative ways you might have responded. Consider how patient safety might have been adversely affected if you only had considered your efficiency.

10. Use a priority grid to help prioritize activities. Ask whether the activity is important and urgent, and place it on the grid in the appropriate space. Practice with activities such as giving a shift report ordering a routine medication from the pharmacy for a client, talking to a client’s family who has a complaint about a nurse, etc.

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11. Make a list of time wasters that you experience during a shift. Include both internal (procrastination, poor planning, etc.) and external (e.g., phone calls, paperwork, socializing, etc.)

12. Make a to-do list at the beginning of your shift, estimating the time that specific tasks/activities will take. Reevaluate it at the end of the shift to determine your effectiveness and efficiency of prioritizing and organizing. What could you have done differently?

13. Reflect upon a day when you felt disorganized or overwhelmed and think about what you might have done differently. Seek feedback from your preceptor on the situation and consider alternative ways you might have responded. Consider how patient safety might have been adversely affected if you only had considered your efficiency.

14. Examine relationships that you have built and reflect on how they have helped you in safely managing care in difficult situations.

15. Develop a teaching plan for your patient with feedback from your preceptor.

16. View NCSBN’s “Crossing the Line” videos and reflect, with your preceptor, on boundary crossings/violations that could occur where you work. Particularly talk about the implications of today’s society of information disclosure (i.e., via cell phone cameras, social networking, blogging, Internet forum postings, etc.) related to patient boundaries and confidentiality.

**Suggested References**


COMMUNICATION AND TEAMWORK MODULE

__ Contact Hours

Development and Implementation Guidelines: This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Learning Objectives

Upon completion of the Communication Module, the licensed nurse will be able to:

1. Determine strategies for socializing to the organization.
   a. Recognize that the NCSBN's Transition to Practice Model occurs during the first year of practice and assumes a separate orientation; understand that orientation is the process of introducing staff to the philosophy, goals, policies, procedures, role expectations and other factors needed in a specific work setting. Orientation occurs for new employees and when changes in nurses’ roles, responsibilities and practice settings occur; therefore, as nurses progress in their professions, they may have many orientations.
   b. Make the transition from student to licensed, accountable nurse.
   c. Understand a healthy work environment, where there is mutual respect and collaboration and where each team member is valued and has a voice in patient-centered care.
   d. Know the role of newly licensed nurses and how they fit into the organization.
   e. Know manager/supervisor expectations.
   f. Understand interpersonal dynamics and expectations of immediate co-workers and colleagues in other work areas. Identify and seek out resources/social support systems in institutions.
   g. Recognize and respond to negative behaviors that impact clinical practice.
   h. Expect the culture to be that nurses should ask for assistance whenever questions arise.
   i. Evaluate the importance of role socialization as a key strategy for supporting high standards of nursing practice.
   j. Participate in shared (team) decision making, evidence-based practice and quality improvement group dynamics of the work environment.
   k. Clarify roles and perceptions of health care team members.
l. Develop communication techniques for approaching experienced co-workers and other essential members of the health care team.

2. Evaluate personal effectiveness when communicating with co-workers, preceptors, supervisors and members of the interprofessional team.
   a. Self-reflection.
   b. Know thyself (strengths/limitations).
   c. Know own biases and stereotypes.
   d. Know nonverbal cues.
   e. Examine the ability to give and receive constructive feedback regarding performance expectations.
   f. Understand the perception of feedback.
   g. Foster assertiveness.
   h. Understand factors affecting clinical reasoning and patient safety (e.g., anxiety, stress, fatigue, environmental distractions, personal factors, ethical dilemmas)

3. Demonstrate the ability to clearly communicate and collaborate with the interprofessional team to ensure quality care and patient safety.
   a. Hand-offs (transfer of care).
   b. Use SBAR (Situation, Background, Assessment and Recommendation) for reports.
   c. Use of other TeamSTEPPS (Team Strategies and Tool to Enhance Performance and Patient Safety) strategies:
      i. Two-challenge rule (voice concerns at least twice to assure being heard);
      ii. CUS (I am concerned; I am uncomfortable; this is a safety issue!);
      iii. Call-out (e.g., “Airway status?”); and
      iv. Check-back (double check messages received).
   d. Understand the diverse perspectives of the health care team (Garman, Leach & Spector, 2006).
   e. Learn team-building concepts.
   f. Understand group dynamics.
   g. Know documentation procedures.

4. Use clear and concise communication in the delegation process.
   a. Utilize the delegation decision-making process safely and effectively.
      i. Recognize that there is both individual and organizational accountability for delegation:
         ■ Nursing employers need to recognize that a newly licensed nurse is a novice who is still acquiring foundational knowledge and skills. In addition, many nurses lack the knowledge, skill and confidence to delegate effectively, so ongoing opportunities to enforce the theory and apply the principles of delegation are an essential part of employment orientation and staff development, as well as topics for continuing education offerings, mentoring opportunities and other continued competence strategies (NCSBN, 2005).
         ■ Appropriately assign care
      b. Know key concepts and steps of the delegation decision-making process.
c. Definitions:
   i. Assignment—Describes the distribution of work that each staff member is to accomplish on a given shift or work period (NCSBN, 2005).
   ii. Delegation—Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation (NCSBN, 2005).
   iii. Supervision—Provision of guidance or direction, oversight, evaluation and follow-up by the licensed nurse for the accomplishment of a nursing task delegated to nursing assistive personnel.
      ■ Direct supervision involves the presence of the licensed nurse who is working with other nurses and/or nursing assistive personnel to observe and direct the assistant’s activities. The proximity of this supervision is such that immediate intervention is possible if problems occur.
      ■ Indirect supervision occurs when the licensed nurse is not present and supervision is provided by other-than-direct observation of the nurses and/or nursing assistive personnel. The absence of proximity of the licensed nurse requires processes being in place for the direction, guidance, support and monitoring of the LPN or nursing assistive personnel activities (NCSBN, 2005).
   iv. Surveillance and monitoring—The process of observing and staying attuned to client status and staff performance (NCSBN, 2005).
   v. Unlicensed assistive personnel—Any unlicensed personnel, regardless of title, to whom nursing tasks are delegated (NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules).

d. Understand the steps of delegation (NCSBN, 2005):
   i. Assess and plan;
   ii. Communication;
   iii. Surveillance and supervision; and
   iv. Evaluation and feedback.

e. Learn the delegation decision tree:
   i. Practice pervasive functions of assessment, planning, evaluation and nursing judgment, which cannot be delegated;
   ii. Consider the patient’s needs/status/acuity;
   iii. When competencies have been established, tasks can be delegated; and
   iv. Refer to NCSBN’s delegation decision tree.

5. Differentiate between the RN and LPN/VN scope of practice related to delegation, according to your state/jurisdiction.
   a. Know the nurse practice act, and rules and regulations:
      i. Accountability;
      ii. Assignment;
      iii. Delegation;
      iv. Supervision;
      v. What can and cannot be delegated according to the nurse practice act and rules and regulations (some states/jurisdictions delineate areas where RNs and LPNs/VNs cannot delegate);
vi. Review and understand the scope of practice of RNs versus LPN/VNs; and
vii. Review the state/jurisdiction definition of unlicensed personnel, where available.

b. Review policies and procedures (institutional level).

6. Discuss situations in which the nurse should not delegate.
   a. Does not have the authority to intervene and take corrective action if needed.
   b. Has never performed the activity to be performed.
   c. Does not have the opportunity to provide effective monitoring.
   d. Staffing adequacy for supervision.
   e. Would not be able to intervene if there were a problem.
   f. Accepting assignment to supervise the unlicensed assistive personnel (NCSBN, 2005).

7. Examine strategies to improve team functioning within the system.
   a. Understand team functioning and how it affects safety and quality.
   b. Reflectively think, contemplate and deliberate when working with the team.
   c. Utilize effective communication techniques in challenging situations.
   d. Develop action plans to address performance deficiencies and rectify problematic situations.
   e. Learn conflict resolution techniques.
   f. Learn problem-solving skills.
   g. Develop decision-making skills.
   h. Appreciate differences in communication styles.
   i. Know how to respond assertively when feedback is perceived to be negative or inaccurate.
   j. Understand high-risk behavior.
   k. Examine end-of-life situations.

8. Discuss professional development opportunities within the work setting, as well as outside nursing organizations:
   a. Agency staff development offerings;
   b. In-house offerings, such as Clinical Ladder;
   c. CE offerings;
   d. State and national professional organizational offerings/opportunities;
   e. Specialty organizations;
   f. Other consultation and resources; and
   g. BON open session meetings.

**Interactive Exercises**

1. Communicating with preceptors:
   a. Make an appointment with your preceptor(s) to openly and honestly discuss your clinical performance.
   b. Devise a way to address and correct deficiencies that were identified in this discussion with your preceptor(s).
c. How would you handle the preceptor’s critical appraisal of your performance if you believe the unfavorable criticism is not accurate?

d. What steps would you take if you believe your professional development needs are not being met/adequately addressed by your preceptor?

e. How would you propose a change of preceptors?

2. Communicating with your supervisor:
   a. Schedule an appointment (10-15 minutes) to meet with your nursing supervisor who is responsible for reviewing your performance.
   b. Clarify with your supervisor how your performance will be evaluated, by whom and how often.
   c. Request a copy of the performance evaluation tool that will be used to appraise your performance. Seek clarification so performance expectations are clearly understood prior to the actual evaluation.
   d. Rehearse how you would begin discussion of your clinical performance to date, including examination of areas in which you feel confident/competent as well as areas in which skill development/performance improvement is needed.
   e. Develop written goals. Design a plan with your supervisor to facilitate your continued skill development and monitor your performance.

3. Interprofessional communication:
   a. Introduce yourself to key team members, such as physicians, occupational therapists, physical therapists, respiratory therapists and laboratory personnel. Find out what led each person to enter their chosen profession and what they enjoy the most about their professional work.
   b. Contact a physician to report your focused assessment findings that reflect a change of patient condition. Reflect on the effectiveness of your communication and patient care/advocacy outcomes.
   c. Problem solve how to handle a situation involving a physician who is not responding to an emergent patient situation that you have assessed as needing an immediate response (e.g., physician refuses to come in to do a face-to-face assessment of patient; physician not willing to make a referral to a specialist).
   d. Describe a challenging person/department in your workplace. What are some of the problems you have encountered when working with this person/department? What factors would you change if you could? Can you identify a possible solution to this situation? What resources are available to help you handle this situation? What, if anything, have you tried to do to handle this situation? Devise a plan of action to try to resolve this situation.

4. Communicating effectively when assigning and delegating patient care:
   a. What information would you give to an unlicensed assistive staff member who has floated to your unit where she will be assigned to provide one-on-one monitoring of a suicidal patient?
   b. Rehearse giving directions to this unlicensed staff member regarding:
      i. Environmental considerations (i.e., no sharp items, no belts, no metal silverware, etc.) to ensure patient safety; and
      ii. Physical proximity requirements (i.e., no more than an arm’s length away from the patient) when providing one-on-one monitoring of a patient who is on suicide precautions.
c. What information do you expect this unlicensed staff member to report to you immediately?

d. What information do you need from this staff member prior to the change of shift?

e. What support do you anticipate this unlicensed staff member will need to safely and effectively carry out the one-on-one patient care assignment?

f. What are the supervisory expectations of you, as a charge nurse, in this situation?

g. How would you respond if you found the suicidal patient unattended, taking a shower with a razor and shaving cream left in the bathroom, while the unlicensed staff member was reading the newspaper in the staff break room?

5. Analyze a patient safety vignette. Go through a root cause analysis and describe what went wrong and why. How could it have been prevented? What is the accountability of the new nurse?

6. Use the TeamSTEPPS strategies with your preceptor’s feedback.

7. Give report using SBAR.

8. Interactive exercises related to delegation:
   a. View NCSBN video clips.
   b. Discuss a scenario where the organization does not have adequate staffing for the new nurse to delegate. This will incorporate safety, systems and assertiveness (communication) issues.
   c. Delegation exercise: Complete the following, indicating which scenarios can be delegated to an LPN/VN or unlicensed assistive personnel. The computer will alert the new graduate to variances across states/jurisdictions or clinical situations.

9. Interactive exercises related to socialization to the role:

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<tr>
<th>Procedure</th>
<th>Personnel to whom it can be delegated</th>
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<td>Stocking of supplies</td>
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<td>Feeding a patient with a recent cerebral vascular accident (CVA)</td>
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<td>Suctioning a tracheostomy</td>
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<td>Providing transportation to an eye clinic</td>
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<td>Providing transport to ICU for status change</td>
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<td>Administering a Fleet enema</td>
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<td>Teaching a diabetic patient about diet and exercise</td>
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<td>Assisting physician with a central line insertion</td>
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<td>Ambulating a first-day postoperative patient</td>
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<td>Taking routine postoperative vital signs</td>
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<td>Clarifying physician orders</td>
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<td>Preoperative teaching</td>
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<tr>
<td>Administering tube feedings</td>
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<tr>
<td>Bathing a patient with dyspnea</td>
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</table>
a. Socialization is best facilitated when the new nurse feels a part of the group. Based on your entry into practice, reflect on the differences of being a licensed, accountable nurse versus a student nurse. Identify quality-improvement teams and how you might participate.
b. Identify evidence-based practice initiatives and how you might participate.
c. Identify who you might contact for questions that might arise.
d. Identify your team members and strategies on how to become an effective team member.
e. All work environments have unwritten rules of expectations for performance. A new nurse may feel isolated if he/she doesn't know them and may experience failure for not recognizing the need to gradually be acclimated to the work setting. As that new nurse, what kinds of questions could you ask to find out these unwritten expectations?
f. How would you handle these situations?
   i. Some physicians want nurses to round with them and plan for specific times to have that done. What steps could you take to make sure this is communicated and incorporated during the plan of care?
   ii. Assignments may seem strange. For instance, if Jane Doe is a seasoned nurse on a 15-bed unit and she is just rehabilitating from knee surgery, how would you respond to the situation when other nurses gripe unnecessarily that Jane's assignment has all of the patients in the front hall?
g. Describe how you would handle the following scenario and with whom would you discuss the problem:
   Your preceptor, Julie, continues to hover when you administer medication. She believes you are slow. What can you do to improve and meet her expectations for patient safety? What are the institutional policies related to timely medication administration? Write a plan for improvement, identifying some personal and/or other barriers.

h. Plan a meeting with your manager/supervisor and review the job description, competency checklists and the agency's organizational chart.
i. Describe and discuss with your preceptor the adjustment you have had with your personal and professional role balance. Would you relate any of it to “reality shock”?
j. Attend a staff development offering, complete a continuing education session or participate in a professional development opportunity.

Suggested References


The Lancet, 363, 312-319.


Goodman, G. R. (2004). How can nurses help patients to work more effectively with nurses to improve the safety of patient care? Nursing Economics, 22(2), 100-102, 70.


**EVIDENCE-BASED PRACTICE MODULE**

___ Contact hours

**Development and Implementation Guidelines:** This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

**Learning Objectives**

1. Define evidence-based practice.
   a. Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.
      i. Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values (Sackett, Straus, Richardson, Rosenberg & Haynes, 2000).

2. Utilize various databases to locate relevant evidence to support practice (RNs only; LPNs participate in using evidence-based protocols under supervision of RNs):
   a. CDSR (Cochrane Database of Systematic Reviews);
   b. CINAHL;
c. ERIC (Education Resources Information Center);
d. Google Scholar has free search strategies;
e. MEDLINE;
f. NGC (National Guidelines Clearinghouse);
g. OVID;
h. PsycINFO; and
i. PubMed.

3. Participate in critiquing research, noting the strength of the evidence presented (RNs only; LPN/VNs participate by utilizing practice guidelines).
   a. With assistance and existing standards, critically appraise original research reports and practice guidelines (RNs only).
   b. Consider the strength of evidence (e.g., the hierarchy of evidence: meta-analysis of randomized clinical trials, one well-designed randomized trial, well-designed clinical trials without randomization, well-conducted systematic review, well-conducted non-experimental studies) (RNs only).
   c. Lower levels of evidence by scrutinizing closely (e.g., poorly controlled or uncontrolled studies; conflicting evidence, consensus reports or published practice guidelines; qualitative studies, including meta-analysis of qualitative data; opinions from experts in the field; and clinical expertise, intuition and anecdote practice guideline evaluation criteria) (RNs only).

4. Evaluate practice changes that are needed or have occurred within the institution based on the evidence. For LPNs/VNs, identify practice gaps and share with preceptors or nurse manager.
   a. Compare actual practice with evidence-based recommendations.
   b. What needs to change or has changed since being hired?
   c. If a change needs to be made, consider who needs to make the change.
   d. What are/were the intended outcomes of the proposed change/or the change that has occurred?
   e. Participate in identifying relevant resources that support practice changes, such as:
      i. Systematic reviews;
      ii. Meta-analyses; and
      iii. Practice guidelines.

5. Identify evidence-based implementation models (RNs only):
   a. Disciplined Clinical Inquiry (DCI) Model offers a pathway to integrate evidence-based practice into organizational and individual performance (Sanares et al., 2009);
   b. Iowa Model of Evidence-Based Practice and Research Utilization (Titler, 2006, 2008);
   c. Academic Center for Evidence-Based Practice (ACE) Model bridges research into practice with the ultimate goal of improving care, patient outcomes and patient safety (http://www.acestar.uthscsa.edu/learn_model.htm);
   d. Melnyk's five steps: (1) ask burning question in PICO (population, intervention,
comparison, outcome) format; (2) collect relevant best evidence; (3) critical appraisal; (4) integrate evidence with clinical expertise and patient values; and (5) evaluate the change (Melnyk & Fineout-Overholt, 2005); and

e. Johns Hopkins Nursing Evidence-Based Practice (EBP) Model and Guidelines’ goal is to promote effective nursing interventions, efficient care and improved outcomes for patients, and provide the best available evidence for clinical, administrative and educational decision making (Newhouse et al., 2007).

6. Work with the team to utilize evidence-based strategies to implement evidence-based health care improvements.

a. Examples of strategies include:

i. Conferences—Participation of health care providers in conferences, lectures, workshops or traineeships.

ii. Local consensus process—Inclusion of participating providers in discussion to ensure that they agree that the chosen clinical problem is important and the approach to managing the problem (i.e., the clinical practice guideline or definition of adequate care) is appropriate. The consensus process might also address the design of an intervention to improve performance.

iii. Educational outreach visits—Use of a trained person who meets with providers in their practice settings to provide information with the intent of changing the provider’s performance. The information given may include feedback on the provider’s performance.

iv. Local opinion leaders—Use of providers nominated by their colleagues as educationally influential. The investigators must explicitly state that the opinion leaders were identified by their colleagues.

v. Patient-mediated interventions—Any intervention aimed at changing the performance of health care providers where specific information was sought from or given to patients, e.g., direct mailings to patients; patient counseling delivered by someone other than the targeted providers; clinical information collected from patients by others and given to the provider; educational materials given to patients or placed in waiting rooms.

vi. Audit and feedback—Any summary of clinical performance over a specified period of time. Summarized information may include the average number of diagnostic tests ordered, the average cost per test or per patient, the average number of prescriptions written, the proportion of times a desired clinical action was taken, etc. The summary may also include recommendations for clinical care. The information may be given in a written or verbal format.

vii. Reminders (manual or computerized)—Any intervention that prompts the health care provider to perform a specific clinical action.

viii. Marketing—Use of personal interviewing, group discussion (focus groups), or a survey of targeted providers to identify barriers to change and the subsequent design of an intervention that addresses these barriers.

ix. Multifaceted interventions—Any intervention that includes two or more of the above.

b. Strategies that are generally effective include educational outreach (for prescribing
behavior) and reminders.

c. Multifaceted interventions based on assessment of potential barriers to change are more likely to be effective than single interventions.

Interactive Exercises

1. Review textbooks on evidence-based practice (see reference list). Complete online tutorial on EBP at http://www.biomed.lib.umn.edu/learn/ebp. Topics include key steps of EBP, hierarchy of evidence, finding the evidence, critiquing evidence, summarizing evidence, applying evidence and communicating evidence.

2. Determine a topic of interest to you and choose something you need more knowledge about. Go onto a computer (the library, on the unit, etc.) where databases are accessible. Search your topic and print at least one related article.
   b. Classify the article using a recognized evidence hierarchy tool.
   c. Access a variety of models, such as the Johns Hopkins Nursing EBP Model and Guidelines; the ACE Star Model of EBP; the DCI model; the Iowa Model of Evidence-based Practice and Research Utilization; or Melnyk's Five Steps of Evidence-based Practice.
   d. Summarize findings.

3. Discuss with colleagues actual practice changes within your institution based on the evidence.
   Example: Discontinuing the use of heparin in IV reservoirs/locks and changing to saline, which improved patient safety and lowered costs
   Example: Evidence driven Magnet Status for health care organizations.

4. Work in a group, depending on your setting, and determine a clinical problem/situation that you feel could be improved. Research the literature on the topic, formulate a synthesis/summary of findings, design an EBP protocol and implementation plan, and communicate findings to nursing management (See Heye & Stevens, 2009, for an excellent example).
   Suggested topics could include: smoking cessation; pain; prevention of gastric irritation during chemotherapy; patient education after various procedures like colonoscopy, pacemaker insertion or gastric bypass; fall prevention; restraint use; high-risk medication administration; etc.

5. Identify an actual clinical problem and suggest a practice change based on the gap between actual practice and evidence-based practice (for RNs or LPNs/VNs).
   a. Consider what really bothers you or what changes are needed.
   b. Consider who needs to work with you on this project:
      i. Review communications and teamwork module on problem solving/decision making; and
      ii. Reflect on the differences between the participation of the LPN/VN versus RN.

Suggested References


**Online Tutorials**

“Welcome to Evidence-Based Practice: An Interprofessional Tutorial” at http://www.biomed.lib.umn.edu/learn/ebp


**Online References**

Healthlinks/University of Washington at http://healthlinks.washington.edu/ebp

Cochrane Collaboration Reviews: http://www.cochrane.org/reviews

QUALITY IMPROVEMENT MODULE

___ Contact hours

Development and Implementation Guidelines: This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Learning Objectives

Upon completion of the Quality Improvement Module, the licensed nurse will be able to:

1. Use available data to identify and prioritize health care improvement or practice gap opportunities. Such data may include, but are not limited to:
   a. Prevention guidelines or process-outcome measures;
   b. Condition-management guidelines or process-outcome measures;
   c. Sentinel event root-cause analyses;
   d. Reason's Swiss Cheese Model (http://patientsafetyed.duhs.duke.edu/module_e/swiss_cheese.html);
   e. Utilization data;
   f. Readmission/transfer to higher level of care data;
   g. Morbidity/mortality data;
   h. Admission/discharge data;
   i. Length of stay data;
   j. Incident/risk management reports;
   k. Nursing-sensitive care performance measures;
   l. Medication error data;
   m. Infection control data;
   n. National patient safety goals across settings (http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals); and
      i. Prioritize identified practice gaps based on:
         ■ Population impact—decrease in morbidity/mortality;
         ■ Cost;
         ■ Leadership interests; and
         ■ Ease of implementation.

2. Identify the best method to address improvement/practice gap opportunities at the point of care and within the system:
   a. Policy and procedure;
   b. Practice guidelines;
   c. Quality improvement systems:
i. Six Sigma uses a systematic methodology that utilizes information and statistical analysis to measure and improve systems.; and

ii. Lean is a principle of continuous improvement and respect for people.

d. Case management;
e. Discharge/transition planning;
f. Patient self-management education;
g. Community-based initiative;
h. Legislation; and
i. Reliability of the health care delivery system.

3. Evaluate barriers to implementing improvements through the support of:
   a. Leadership;
   b. Physician and other health care provider stakeholders;
   c. Patient;
   d. Resource availability:
      i. Money;
      ii. Personnel;
      iii. Equipment;
      iv. Supplies; and
      v. Time.
   e. Burden of health care improvement initiative.

4. Utilize evidence-based implementation strategies to facilitate improvement (Grimshaw, Shirran, Thomas, Mowatt, Fraser, Bero, et al., 2001):
   a. Develop mindfulness and vigilance.
   b. Understand systems thinking; e.g., analyzing why people decided to work around safety systems.

5. Develop an implementation plan for quality improvement, considering the following:
   a. Identify outcome measures to determine the success of an improvement;
   b. Pilot the implementation plan on a small scale using Plan Do Study Act (PDSA) methodology until the identified outcomes are achieved on a small scale (http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowtoImprove/testingchanges.htm);
   c. Implement the improvement full scale using the revised implementation plan;
   d. Measure the success of the full-scale implementation of the improvement using the established outcome measures;
   e. Revise the improvement implementation plan as needed to achieve the targeted improvement outcome; and
   f. Continue measurement and measurement feedback until maintenance of the change is achieved as demonstrated by outcome measure attainment.

Interactive Exercises
1. Complete one or more of the following Institute for Healthcare Improvement Open
School quality improvement training opportunities:

a. Institute for Healthcare Improvement Open School training:
   i. Quality Improvement: http://ihi.org/lms/onlinelearning.aspx; and


3. Identify the organizational structures and/or personnel in your organization that participate in quality-improvement activities.

4. Identify current and future improvement initiatives for your patient population from among the following national improvement initiatives:

   d. Nursing Quality Indicators: https://www.nursingquality.org/
   f. Institute for Health Care Improvement 5 Million Lives Campaign and other initiatives:
      i. 5 Million Lives: http://www.ihi.org/IHI/Programs/Campaign
      ii. Other: http://www.ihi.org/IHI/Programs/StrategicInitiatives
   g. Institute for Safe Medication Practice initiatives and alerts:
   h. Food and Drug Administration medication and device safety alerts:
      i. Alerts: http://www.fda.gov/Safety/Recalls/default.htm
   l. Condition management process outcome measures: http://www.qualitymeasures.ahrq.gov
   m. Patient safety initiatives:
      iii. The Joint Commission: http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals
5. Identify future improvement initiatives from setting-specific data, as appropriate:
   a. Risk-management data:
      i. Sentinel event root-cause analyses;
      ii. Failure to rescue and cardiac arrest data;
      iii. Readmission/transfer to a higher level of care data;
      iv. Mortality/morbidity data;
      v. Incident/risk-management reports;
      vi. Medication error data; and
      vii. Infection control data.
   b. Utilization data:
      i. Admission/discharge data; and
      ii. Length of stay data.
   c. Customer/patient satisfaction data.
   d. Employee satisfaction data.
   e. Financial data.

6. Participate in a health care improvement initiative at your facility.

7. Participate in a root-cause analysis in your facility.

8. Support new and ongoing improvement initiatives in your setting through active participation, provision of feedback and compliance.

Suggested References


**Supplemental Resources**

*Agency for Healthcare Research and Quality (AHRQ)*

Evidence-based Practice Centers

http://www.ahcpr.gov/clinic/epcindex.htm
National Guideline Clearinghouse  
http://www.guideline.gov

Prevention Guidelines/USPSTF  
http://www.ahrq.gov/clinic/uspstfix.htm

Guide to Clinical Preventive Services, 2009  
Recommendations of the U.S. Preventive Services Task Force  
http://www.ahrq.gov/clinic/pocketgd.htm

AHRQ Health Care Innovations Exchange  
http://www.innovations.ahrq.gov

National Healthcare Quality & Disparities Reports  
http://www.ahrq.gov/qual/measurix.htm#quality

Outcomes and Effectiveness  
http://www.ahrq.gov/clinic/outcomix.htm

Putting Prevention Into Practice  
http://www.ahrq.gov/clinic/ppipix.htm

Quality and Patient Safety  
http://www.ahrq.gov/qual

Technology Assessments  
http://www.ahrq.gov/clinic/techix.htm

Research Findings  
http://www.ahrq.gov/research

AHRQ E-mail Updates  
https://subscriptions.ahrq.gov/service/subscribe.html?code=USAHRQ_102

Quality Indicators  
http://www.qualityindicators.ahrq.gov

Understanding Quality Measurement  
http://www.ahrq.gov/chttoolbox/understn.htm

Advances in Patient Safety: From Research to Implementation  
http://www.ahrq.gov/qual/advances

Medical Errors & Patient Safety  
http://www.ahrq.gov/qual/errorsi.htm

Health Care 411  
http://healthcare411.ahrq.gov

Online Web M&M  
http://www.webmm.ahrq.gov

Patient Safety Network  
http://psnet.ahrq.gov

Patient Safety Fact Sheets

- Provider: (Example) 30 Safe Practices for Better Health Care  
  http://www.ahrq.gov/qual/30safe.htm

- Patient: (Example) 20 Tips to Help Prevent Medical Errors  
  http://www.ahrq.gov/consumer/20tips.htm
Supplemental Resources: Veteran Health Association/Department of Defense—VHA/DoD

National Center for Patient Safety
http://www.patientsafety.gov

Falls Toolkit
http://www.patientsafety.gov/SafetyTopics/fallstoolkit/index.html

VHA Hand Hygiene Information and Tools
http://www.patientsafety.gov/SafetyTopics/HandHygiene/index.html

Supplemental Resources: Other Federal Government Agencies

CDC
Guide to Community Preventive Services
http://www.thecommunityguide.org

Institute for Clinical Systems Improvement
http://www.icsi.org/knowledge

Institute for Healthcare Improvement
http://www.ihi.org/ihi

Institute for Healthcare Improvement Improvement Map
http://www.ihi.org/IHI/Programs/ImprovementMap

Institute for Healthcare Improvement 5 Million Lives Campaign
http://www.ihi.org/IHI/Programs/Campaign

Centers for Medicare & Medicaid Services

Medicare/Medicaid
http://www.cms.hhs.gov/HospitalQualityInits/11_HospitalCompare.asp

Hospital Compare
http://www.hospitalcompare.hhs.gov/

Home Health Compare
http://www.medicare.gov/HHCompare

Nursing Home Compare
http://www.medicare.gov/NHCompare

American Nurses Association

National Database of Nursing Quality Indicators
https://www.nursingquality.org

National Quality Forum
http://www.qualityforum.org

The Joint Commission
http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement

FDA

Educational Resources
http://www.fda.gov/Safety/MedWatch/ucm133050.htm

Medwatch
http://www.fda.gov/Safety/MedWatch/HowToReport/default.htm

Patient Safety Alerts
http://www.fda.gov/cdrh/safety.html
Supplemental Resources: Other International Governmental
Registered Nurses Association of Ontario
- Clinical Practice Guidelines
- Guideline Implementation Tool Kit
  http://www.rnao.org/Storage/12/668_BPG_Toolkit.pdf

United Kingdom National Health Service National Patient Safety Agency
http://www.npsa.nhs.uk/

Supplemental Resources: Other Private Organizational
Institute for Healthcare Improvement (IHI)
- 5 Million Lives Campaign
  http://www.ihi.org/IHI/Programs/Campaign
- Patient Safety
  http://www.ihi.org/IHI/Topics/PatientSafety

Institute for Safe Medication Practices (ISMP)
http://www.ismp.org

ISMP Medication Safety Tools and Resources
http://www.ismp.org/Tools/default.asp

Supplemental Resources: The Joint Commission
General
http://www.jointcommission.org

National Patient Safety Goals
http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals

Patient Safety Speak Up Initiatives
http://www.jointcommission.org/PatientSafety/SpeakUp

Supplemental Resources: National Patient Safety Foundation (NPSF)
http://www.npsf.org

Supplemental Resources: Safe Care Campaign
http://www.safecarecampaign.org

Agency for Healthcare Research and Quality Evidence Reports
http://www.ahrq.gov/clinic/epcindex.htm

Institute for Safe Medication Practices List of High-Alert Medications
(http://www.ismp.org/Tools/highalertmedications.pdf)

Class/Category of Medications:
- Adrenergic agonists, IV (e.g., epinephrine, phenylephrine, norepinephrine)
- Adrenergic antagonists, IV (e.g., propranolol, metoprolol, labetalol)
- Anesthetic agents, general, inhaled and IV (e.g., propofol, ketamine)
- Antiarrhythmics, IV (e.g., lidocaine, amiodarone)
- Antithrombotic agents (anticoagulants), including warfarin, low-molecular-weight
- Heparin, IV unfractionated heparin, Factor Xa inhibitors (fondaparinux), direct
Thrombin inhibitors (e.g., argatroban, lepirudin, bivalirudin), thrombolytics (e.g., alteplase, reteplase, tenecteplase) and glycoprotein IIb/IIIa inhibitors (e.g., eptifibatide)

- Cardioplectic solutions
- Chemotherapeutic agents, parenteral and oral
- Dextrose, hypertonic, 20 percent or greater
- Dialysis solutions, peritoneal and hemodialysis
- Epidural or intrathecal medications
- Hypoglycemics, oral
- Inotropic medications, IV (e.g., digoxin, milrinone)
- Liposomal forms of drugs (e.g., liposomal amphotericin B)
- Moderate sedation agents, IV (e.g., midazolam)
- Moderate sedation agents, oral, for children (e.g., chloral hydrate)
- Narcotics/opiates, IV, transdermal and oral (including liquid concentrates, immediate and sustained-release formulations)
- Neuromuscular blocking agents (e.g., succinylcholine, rocuronium, vecuronium)
- Radiocontrast agents, IV
- Total parenteral nutrition solutions

National Guideline Clearinghouse (NGC) Features (AHRQ, 2009)
- Structured abstracts (summaries) about the guideline and its development.
- Links to full-text guidelines, where available, and/or ordering information for print copies.
- Smartphone downloads of the complete NGC summary for all guidelines represented in the database.
- A guideline comparison utility that gives users the ability to generate side-by-side comparisons for any combination of two or more guidelines.
- Using guideline comparisons called Guideline Syntheses, prepared by NGC staff, compare guidelines covering similar topics, highlighting areas of similarity and difference. NGC Guideline Syntheses often provide a comparison of guidelines developed in different countries, providing insight into commonalities and differences in international health practices.
- An electronic forum, NGC-L for exchanging information on clinical practice guidelines, their development, implementation and use.
- An annotated bibliography database where users can search for citations for publications and resources about guidelines, including guideline development and methodology, structure, evaluation and implementation.
- An expert commentary feature written/reviewed by the NGC/National Quality Measures Clearinghouse (NQMC) Editorial Board.
ELEMENTS OF INFORMATICS MODULE

___ Contact hours

Development and Implementation Guidelines: This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

Learning Objectives
Upon completion of the Informatics Module, the licensed nurse will be able to effectively utilize information at the point of care to support quality patient care by being able to:

1. Identify all electronic and/or print information data available at the point of care, as available in the agency:
   a. Patient history and physical;
   b. Patient diagnosis(es);
   c. Patient orders/treatment plan;
   d. Progress notes;
   e. Laboratory data;
   f. Medication information;
   g. Reference materials;
   h. Policies and procedures;
   i. Adverse event reporting systems;
   j. Consultation reports/referral information;
   k. Community resources; and
   l. Health information resources for patients and family members.

2. Determine the information needed at the point of care.

3. Access the needed information effectively, efficiently and in accordance with agency security requirements.

4. Recognize the various tools and technologies available to improve the quality of care, including electronic health records (EHRs), bar code medication administration (BCMA), computerized provider order (CPO), CPO entry with decision support systems (DSS), data capture, care planning tools, clinical decision support systems (CDSSs) and telehealth.

5. Identify the challenges of integrating health care information technology into practice.

6. Ensure confidentiality of all patient health information (PHI), whether print or electronic, relative to the Health Insurance Portability and Accountability Act (HIPAA), and other applicable laws and institution-specific policies.

7. Demonstrate compliance with laws, regulations, institutional policies and etiquette related to the access and use of information resources.

Interactive Exercises
1. Systems-related activities:
   a. Locate the policies and procedures at your work setting (e.g., How long did it take you? Were you able to find what you were looking for?).
   b. Review a policy/procedure for a common activity/situation, comparing what is written with the standard of current practice observed in your work setting.
   c. Propose a plan for developing a new policy/procedure or revising an existing policy/procedure if revision is needed to reflect current practice standards. Who would you
approach regarding the need for policy development/revision? Where would you go to access references or resources to support your claim that a new policy/procedure is needed (i.e., online literature searches, CINAHL, WebMD, Medline, standards of care)?

2. Access the Technology Informatics Guiding Educational Reform (TIGER) Informatics Competencies Collaborative (TICC) Final Report at http://tigercompetencies.pbworks.com/f/TICC_Final.pdf. See the list of competencies at the end and decide which competencies you have now and which ones you need to develop in the future. How might you work to develop the competencies?

3. Think about a patient with whom you have recently worked. How did you use informatics to locate the information you needed? Were you able to find everything you needed? If not, consult with your preceptor.

4. Choose one of the systems outlined in the objectives above (HER, BCMA, CPOE with DSS, data capture tools, care-planning tools, telehealth). What are the challenges of the system you chose?

Suggested References


**Additional References**


**ELEMENTS OF TRANSITION TO PRACTICE PRECEPTOR TRAINING MODULE**

**Contact Hours**

Development and Implementation Guidelines: This module must be tailored to be consistent with RN and LPN/VN scopes of practice in each state or jurisdiction.

**Learning Objectives**

1. Describe the role and responsibilities of the preceptor.
   a. Role socialization.
   b. Differentiate between staff nurse and preceptor.
   c. Understand delegation and accountability.
   d. Develop work-life balance (self-care).
   e. Role modeling.
   f. Describe how to establish an ongoing preceptor-nurse relationship.
g. Foster the development of clinical reasoning in the novice nurse.

h. Assist novice nurse to gather information about practice gaps and identify potential interventions.

i. Emphasize the importance of reflective practice.

j. Develop trusting relationship/confidentiality.

k. Identify support systems:
   i. Staff development;
   ii. Manager;
   iii. Peer; and
   iv. Board of Nursing.

l. Team preceptorship as an option.

m. Recognize and celebrate the novice nurse’s success.

2. Examine the principles of teaching-learning.
   a. Adult learning principles.
   b. Benner’s Novice to Expert Model emphasizes that newly licensed nurses are functioning at advanced beginner stage; goal of the Transition to Practice program is to reach the competency stage.
   c. Diversity in learning styles (e.g., auditory, visual, tactile, etc.).
   d. Generational and cultural differences in learning.
   e. Learning domains:
      i. Cognitive;
      ii. Affective; and
      iii. Psychomotor.
   f. Providing a positive learning environment.

3. Demonstrate effective communication.
   a. Understand systems.
   b. Understand teamwork and collaboration across disciplines.
   c. Learn group dynamics.
   d. Know feedback, reflection and evaluation process:
      i. Ways to deliver—techniques and timing;
      ii. Summative and formative evaluation;
      iii. Written/verbal;
      iv. Importance of providing feedback and evaluation;
      v. Positive and negative/corrective;
      vi. Perception of feedback;
      vii. Critical self-reflection; and
      viii. Formal documentation.
e. Utilize different strategies, such as SBAR and TeamSTEPPS.
f. Learn about conflict management.

4. Incorporate elements of NCSBN's Transition to Practice Model when precepting.
a. Orientation to unit/agency is entirely separate.
b. Review manual and essential elements of the Transition to Practice modules; review handbook newly licensed nurses use.
c. Integrate principles of safety and how to accept accountability for actions:
   i. Regulatory model: Mission of BONs is to protect the public;
   ii. Nurse practice act, scope of practice, rules and regulations;
   iii. Legal/ethical;
   iv. Policy and procedures;
   v. Standards of practice;
   vi. Evidence-based practice;
   vii. Competence development;
   viii. Root-cause analysis;
   ix. Incident reports;
   x. Protection of new nurse from making errors that might threaten patients, self and/or others;
   xi. Requirements when assigning or delegating to others, according to the state's nurse practice act;
   xii. Importance of stressing professional boundaries to newly licensed nurses; and
   xiii. Fostering a reliable health care system (e.g., avoiding work-arounds, etc.).

d. Integrate clinical reasoning, which is defined by Benner, Sutphen, Leonard & Day (2010) as “The ability to reason as a clinical situation changes, taking into account the context and concerns of the patient and family.”
e. Threading reflection and feedback throughout while building confidence.
f. After preceptorship, six more months of support; development of long-term mentor.

Interactive Exercises
1. Complete the Index of Learning Styles questionnaire (http://www.engr.ncsu.edu/learningstyles/ilsweb.html).
2. Take Myers-Briggs and analyze results.
3. Examine the INSIGHT tool (AONE suggested; insightinstitute.com).
4. Discuss conflict situations, such as:
   a. New protégé who is not meeting performance expectations;
   b. Resources when the preceptor is not a good fit; and
   c. Physicians/other nurses/patients/other health care personnel who only want to work with a “seasoned” nurse.
5. Review concepts of TeamSTEPPS scenario and SBAR (see Communication and Teamwork module), and develop a scenario where they can assist new nurses to use these principles.
Suggested References


**INSTITUTIONAL SUPPORT FOR TRANSITION TO PRACTICE**

NCSBN’s Transition to Practice Model requires a six-month preceptor program, followed by six months of institutional support. These are some tips for those last six months of support.

The following are some resources that the employer should plan for:

- Planning, preparation and oversight time for educators/managers;
- Preceptor education and support/mentoring time;
- Approval of and support for preceptor and new nurse transition activities (staffing, patient/client assignments, preceptor support and mentoring, etc.);
- Implementation of policies, competencies and evaluation tools related to preceptor and new nurse transition activities;
- Organizational leadership preparation for implementation of transition to practice activities;
- Implementation of evaluation strategies that identify best practices and measure the impact of implementing best practice transition activities; and
- Provision and maintenance of equipment, software and space needs to implement transition to practice activities.

**Organizational Implementation Steps**

The organization will:

1. Educate organizational leadership, nursing management and nursing personnel on the goals and components of the nurse residency program.
2. Enlist nursing management, human resource, quality improvement and other organization personnel in the development of organization-specific components and implementation of the transition to practice program:
   - a. Policies;
   - b. Procedures;
   - c. Logistical support (personnel, equipment, space);
   - d. Preceptor education;
   - e. Preceptor support;
   - f. Nurse orientation program;
   - g. Transition to practice program; and
   - h. Evaluation tools (resident, preceptor, program).
3. Identify the individual(s) within the organization who will be responsible for:
   - a. Preceptor education;
   - b. Preceptor coordination and support; and
   - c. Nurse resident coordination and support.
4. Ensure integration of all components of the nurse residency into all relevant organizational processes:
   - a. Human resources;
   - b. Performance/quality improvement;
   - c. Risk management;
d. Nursing management;

e. Support services (pharmacy, respiratory therapy, physical therapy, occupational therapy); and

f. Service lines.

5. Provide opportunities for:
   a. Feedback and reflection of practice (e.g., “What would I have done differently?” What lessons were learned?);
   b. Committee work (e.g., quality improvement, implementing safety measures) or participation in grand rounds to encourage engagement in the agency;
   c. Evaluation of program/participant/preceptor/nurse manager;
   d. Peer support; sharing their stories;
   e. Post sentinel event/near-miss discussion of root-cause analysis (see Nursing Pathways for Patient Safety, 2009). Be sure all new nurses have gone through this;
   f. Feedback to share professional development goals for the next year/strengths/weaknesses; understanding what a performance appraisal is; and
   g. Celebrating the end of the program.

Resources

1. Overall support:
   a. NCSBN will provide online modules and support for those agencies that cannot develop the resources and don’t have partnership opportunities.
      i. Website address (when available)
         ii. Transition to practice toolkit: https://www.ncsbn.org/1603.htm

2. See preceptor training modules.

3. Support for competency development:
   a. Transition to practice modules
   b. Quality and Safety Education for Nurses: http://www.qsen.org

4. Commission on Collegiate Nursing Education (CCNE) accreditation information:
   http://www.aacn.nche.edu/accreditation/pdf/resstandards08.pdf

Suggested References


Attachment B

Report of Transition to Practice Advisory Panel

TRANSITION TO PRACTICE ADVISORY PANEL MEMBERS

- Jane Barnsteiner, PhD, RN, FAAN, professor, University of Pennsylvania. Areas of expertise: safety and quality research; QSEN Advisory Board.
- Mary Blegen, PhD, RN, FAAN, professor, University of California, San Francisco. Areas of expertise: safety and quality research.
- Mary Lynn, PhD, RN, professor, University of North Carolina, Chapel Hill. Areas of expertise: measuring graduate competencies; has analyzed Health Resources and Service Administration (HRSA) transition data and University HealthSystem Consortium (UHC/AACN) residency program data.
- Elizabeth Ulrich, EdD, RN, FACHE, FAAN, senior vice president, Business Analytics & Research, Versant. Areas of expertise: workforce research and analysis of new graduate transition data.

DATE OF MEETING

All four consultants met at NCSBN’s offices March 25-26, 2010, with Nancy Spector, PhD, RN, director, Regulatory Innovations, NCSBN, and Kevin Kenward, PhD, MA, director, Research, NCSBN.

CONSULTATION AGREEMENT

The consultants have agreed to assist NCSBN with planning the Transition to Practice Pilot Study and provide ongoing advice throughout the conduct of the pilot. Most meetings will be via conference call and each meeting will have specific objectives. The objectives for the March 2010 meeting were:

- Provide recommendations for conducting a multisite, pilot study of NCSBN’s transition model; and
- Develop outcomes for NCSBN’s pilot study, with an emphasis on quality and safety measures.

For each day of consultation (in-person or via conference call), NCSBN will pay the consultants $200. NCSBN will also pay for travel expenses for in-person meetings.

SUMMARY OF MARCH 2010 MEETING

The Transition Advisory Panel described NCSBN’s model as revolutionizing how nurses are brought into the profession. Because of this, it is important to conduct a sophisticated pilot study that will provide evidence upon which to make decisions. The outcomes will be important for transition policy decisions, but the study will also provide implementation best practices.

NCSBN’s Transition Pilot Study will be conducted in two phases:

<table>
<thead>
<tr>
<th>Phase I</th>
<th>Phase I will establish internal validity of NCSBN’s transition model and therefore should be conducted under more controlled conditions. It will be conducted with registered nurses (RNs) in hospital settings since 85 percent of newly graduated RNs work in the hospital setting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase II</td>
<td>Phase II will establish external validity to see if the program can be generalized across settings and levels of licensure. During this phase, outcomes of the model will be measured on licensed practical/vocational nurses (LPN/VNs) in long-term settings and other settings, and with RNs in settings other than hospitals, such as school nursing, visiting nursing, correctional facilities, office nursing, etc.</td>
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</tbody>
</table>
**Sample:**

Three states will be selected for the study to provide some geographic diversity. State selection will also be made based on board of nursing (BON) willingness and interest by various nursing stakeholders within the state to mount this pilot study, as well as an adequate number of new graduates. It was feared that the study would become too unwieldy and costly for NCSBN to manage were more states and sites involved. Each state will have a state coordinator who will make sure the data from all sites are consistently and accurately being put into the computer program. These three roles will be crucial to the study and therefore must be paid adequately.

- Each state will have 25 sites: 10 experimental and 15 control. Sites within states will be chosen by:
  - Permission to use a centralized Institutional Review Boards (IRBs) or willingness to shepherd through the institution's IRB on NCSBN's timeline.
  - Minimum number of new graduates from April through July;
  - Administration commitment;
  - No standardized programs in place (the only two standardized programs are Versant's and UHC/AACN's);
  - Willingness to pay site coordinators to work with the study, though each site will receive a $2,000 bonus at the end of the study to be used for education purposes within the institution;
  - Staff has access to computers;
  - Willingness to share their data related to safety and quality; and
  - Collect nurse sensitive quality indicator (NSQI) data.

- If possible, data from the experimental and control sites will be compared to data from two national standardized programs: Versant and UHC/AACN. Ulrich with Versant and Lynn with UHC/AACN have worked with those programs and will look into it for the panel. It was agreed that comparing NCSBN's model to other standardized program outcomes, as well as control outcomes, would be valuable.

**Outcomes:**

Since many institutions already collect a number of statistics, including patient safety measures, NSQI data and patient satisfaction, it would be efficient to use the data they collect, whenever possible. Data will be collected on a quarterly basis, when available:

- New graduate data
  - Demographics
  - New graduate perception tool (revise NCSBN's tool)
  - Preceptor perception tool (revise NCSBN's tool)
  - Commitment
  - Horizontal violence
Institutional data
- Agency for Healthcare Research and Quality (AHRQ) safety indicators
- Centers for Medicare & Medicaid Services (CMS) core indicators
- NSQI data
- Retention at one year
- Patient satisfaction
- Nurse satisfaction
- Incident reports (such as falls data)
- Physician and other health care provider satisfaction
- Length of stay
- Staffing

Control variables
- Case mix (CMS)
- Technology
- Size
- Type (profit/nonprofit; private/public; academic; federal)
- Teaching intensity
- Cost of hiring new graduates
- Magnet
- Rural/urban
- Nurse supply in state
- Unemployment rate in state

Budget: Cost of conducting this multisite, 30-month study was discussed and shared with the business plan consultants who incorporated the costs into their plan. The consultants emphasized the importance of committed state coordinators because there will be a large amount of data to monitor over the two phases of the study.

Timeline: If the NCSBN Board of Directors (BOD) approve the business plan for the pilot study at the July 2010 BOD meeting:

Phase I
May 6–Sept. 30, 2010
- NCSBN’s Interactive Services department will begin to develop the modules, though much of that development will take place after Oct. 1, 2010, when the NCSBN’s fiscal year begins.
- NCSBN’s Regulatory Innovations department will develop a plan for meetings with the Transition Advisory Panel, and begin to search for a project manager and assistant.
- Tools will be identified.
- States that are interested will be contacted and specific sites will be looked at. Selection of pilot states will be made by October 2010.
- Online modules will be completed and pretested.
- States and sites will be identified.
- Three state coordinators will be named.
- Site coordinators will be identified.

April 1, 2011–Sept. 30, 2012 (Phase II starts July 1, 2012)
- Collection of data on a quarterly basis.
- Preparation for Phase II of study.
- Phase II will begin July 1, 2012.
- Phase I will end Oct. 1, 2012.
- Ongoing data analysis.

- Phase II data collection continues.
- Ongoing data analysis.

- Final analysis and dissemination of results.
- Assist interested states/jurisdictions with implementation of the model.
- Present results to May BOD for possible vote at 2014 Delegate Assembly.
Attachment C

Business Plan Template for Boards of Nursing (BONs)

The model that NCSBN plans to develop for its Transition to Practice initiative will need to be embraced by BONs in order to enact legislation. As in any profession, newly graduated hires do not possess the same level of knowledge or skills in comparison to others with multiple years of experience. Nurses are no different. Yet, because nurses work on a daily basis with vital health care outcomes, the lack of readiness has potentially greater consequences. Research indicates that newly licensed nurses are susceptible to:

- Increased stress;
- A greater likelihood of committing medical errors;
- Increased level of committing near misses;
- Decreased levels of patient safety and positive health care outcomes; and
- Higher rates of job turnover, which has a negative impact on patient safety.

The NCSBN Transition to Practice Model is designed to support new nurses, promote public safety and achieve greater worker retention in health care settings. It is NCSBN’s hope that all new nurse graduates will participate in some form of a transition program. NCSBN would simply like to provide a flexible baseline requirement that new nurses can fulfill upon their entrance into a professional health care practice setting.

While many BONs have shared their enthusiasm about the prospect of a transition program for newly licensed nurses, other BONs have expressed skepticism about their ability to handle the perceived increased workload that would come with the implementation of a transition to practice program within their state, particularly within this economic climate. Although several states have made investments and witnessed progress on the implementation of their own nurse transition or residency programs, only Kentucky has successfully enacted a transition program through legislation. The Kentucky Board of Nursing (KY BON) provides an example of how helpful a transition program can be for new nurses and how relatively easy it is to successfully run, monitor and license these new nurses during and after the participation in their entry into practice program.

CASE STUDY: KENTUCKY

In the mid 1990s, the KY BON was receiving troublesome correspondence from both new graduates and their employers. The new graduates were worried that they were being pushed into practice-setting situations that they were simply unprepared to handle. This lack of confidence in their own level of practice competence caused high levels of stress among many newly licensed nurses. Meanwhile, employers were contacting the KY BON to complain about the readiness and preparedness of these new nurse hires.

As a result, the KY BON Education Committee decided to form a Competency Task Force in 1995 to deal with the issues being raised by new nurses and practice. The task force, which was represented by a diverse group of nurses from both education and practice, came to the conclusion that a capstone experience prior to graduation and an integrated internship after graduation and before licensure would be the best solution. In 2004, the KY BON submitted their required nurse internship plan to the state legislature. Negotiations prior to submission meant that the KY BON had to compromise the postgraduation internship down to 120 required hours over a three-week period, rather than a longer-term engagement for the new nurse.

Effective Jan. 1, 2006, the legislation stated that new nurse graduates would be required to undertake a clinical internship before they received full licensure from the KY BON. The legislation (KY BON, 2008) states, “The key elements of the clinical internship include: direct patient care, supervision by a licensed nurse, 120 hours in duration, and a six-month provisional license time frame.” Upon graduation from an accredited school of nursing, new nurses are
awarded a provisional license and allowed to register for the NCLEX® examination. During this provisional period, new nurses are referred to under the title RNA (registered nurse applicant) or LPNA (licensed practical nurse applicant). By the end of this six-month period, if the applicant has not successfully passed the NCLEX and completed the 120-hour clinical internship, he/she will not receive full licensure to work in the state of Kentucky. Even if the new nurse graduate passes the NCLEX, permanent licensure will not be granted without successful completion of a clinical internship.

While some BONs have expressed worry about the costs and time commitment to implement and manage a transition program, the reality in Kentucky indicates that these should not be major concerns. In 2007, the KY BON counted 64,932 registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) in the state. This figure included 3,544 new RNs and 1,030 new LPN/VNs (NCSBN, 2009). Among the costs and time commitment to manage its approximately 4,500 new nurses were:

- Minimal programming costs to update the KY BON nurse license database;
- Fielding calls from new nurse graduates about internship program details;
- Website redesign to explain the internship program;
- Public relations expenditures related to program introduction; and
- Internship preceptors who are not monetarily compensated, but rather, are awarded a full number of mandated yearly continuing education credits.

The Entry to Practice Initiative in Kentucky did NOT require the KY BON to hire any additional staff. Paperwork associated with the clinical internship was mailed to the newly graduated nurse in the same packet as the instructions for the NCLEX examination, which meant that the number of required mailings remained at the same level. The KY BON does not need to spend valuable staff hours continuously monitoring new nurses during the internship because if the new nurse fails to receive sign-off and mail in his/her Verification of Completion of Clinical Internship Form by the end of the six-month trial period, the provisional license is voided by the KY BON and the individual can no longer work in the capacity of a licensed professional within the state.

While the program is still relatively in its infancy, the feedback the KY BON has received from various stakeholder groups has been overwhelmingly positive. Thus, the KY BON has concluded that their Entry into Practice Internship Model has been a demonstrated success within the state.

Nurses are considered to be the heart and soul of health care settings—the frontline caregivers to clients. Supporting nurses through their critical entry into the profession is not only good for the development of the nurse and the employer, but also for good of the patient. Regulation implies the government intervention to accomplish an end beneficial to its citizens. Through the implementation of administrative regulations, KY BON has taken these two steps to assist new graduates in developing entry-level clinical competence under the guidance of an experienced professional (KY BON, 2008).

While Kentucky’s clinical internship program is the only model enacted through regulation, other states, such as Mississippi, North Carolina and Vermont, have already begun some form of a transition program. Given the identified need to assist new nurse graduates as they enter their professional careers, it is in the general public's best interest that all states attempt to adopt some form of transition initiative to help provide greater assistance to the nurses who serve within their state.

**WHAT DO STATES NEED TO DO?**

NCSBN would work with each and every BON to help make the introduction and implementation of a transition model as easy and seamless as possible. If it is decided to develop the online Transition to Practice Modules, they will be available to all new nurses, although NCSBN encourages practice to use whatever transition program they feel best suits their specific needs. For BONs, NCSBN plans to make the implementation of transition programs with each state
as hassle-free as possible. The NCSBN Marketing & Communications department will work to create marketing materials that can be utilized at the state level to persuade various stakeholder groups to support legislation. As NCSBN stays abreast of all the latest research data, they will look to share with states all key findings that can further make the case for transition model adoption. The core goal for NCSBN and BONs should be to work with employers and educators to promote and legislate for some kind of transition model for new nurses.

If BONs decide to implement the model, the following strategies are recommended:

- Identify and approach state legislators who are proponents of continuing education, health care reform and/or better patient safety outcomes.
- If nurse license renewal occurs once every two years, rewrite state guidelines so that new nurses must be evaluated again after one year in practice and demonstrate they took part in a Transition to Practice Program that meets NCSBN’s standards. NCSBN provided model statutes and administrative rule language for the BONs in 2009, which is available in the NCSBN Transition to Practice Toolkit at www.ncsbn.org/1603.htm.
- Collect evidence from each new nurse’s designated preceptor that the individual successfully completed the modules and has demonstrated competency and understanding of the subject matter. An official form can be sent out to new nurses in a manner similar to Kentucky’s strategy.
- Budget approximately $2 per new nurse for the mailing of forms and correspondence. However, given the heightened Internet usage among these and future generations of nurses, BONs should attempt to use electronic communications whenever possible, since this would reduce costs.
- Budget a modest amount ($5,000-$10,000) for public relations upon introduction of Transition to Practice to get all stakeholders on board.¹
- Budget about $5,000-$7,000 for website design and content upgrades related to Transition to Practice.

Should larger states feel apprehensive about their ability to afford the additional cost and employee time commitment toward enacting legislation and launching Transition to Practice within their state or jurisdiction, there are alternative methods of financing the program. First, nurse license application and renewal fees could be increased by $2 to $10 to offset any predicted additional costs. Grant funding is possible from a host of sources, including the Health Resources and Services Administration (HRSA), Robert Wood Johnson Foundation, the Carnegie Foundation, Centers for Medicare & Medicaid Services (CMS), Medicaid Transformation Grants, or the State Survey and Certification of Health Care Providers and Suppliers. In addition, if NCSBN develops online modules, NCSBN will pay for and provide most of the operational capacity for the modules, as these might be used in rural settings or those settings without valid preceptors (e.g., schools or long-term care facilities). At this point, BONs simply need to commit to the Transition to Practice initiative and work to induce discussion on the subject within their respective state legislatures.

CONCLUSION

Research suggests that new nurses are more prone to errors, near misses and poorer patient outcomes than more seasoned nurses. The inability to become properly acclimated to practice environments creates higher levels of stress, which further exacerbates the likelihood of performance errors and can lead to increased employee turnover. NCSBN has worked over several years to design an evidence-based transition program that can provide new nurses with proper guidance as they enter their profession.

¹ NCSBN plans to provide a portfolio of marketing communications materials that will help make the case for a legislated transition program within a state. In recent years, with the Internet becoming an extremely cost-effective communication channel, costs to announce and promote new initiatives has become far easier and cheaper. Nevertheless, BONs should budget some funds for specific print placements and travel.
REFERENCES
Attachment D

Business Plan Template for Employers

PART I: USING NCSBN’S MODULES

1. Calculate your organization’s turnover rate:
   How many new nursing graduates left your organization within the past year? (A): _____
   How many new nursing graduates did your organization hire within the past year?
   (B): _____
   The new nursing turnover rate at your organization: (Z): A/B = __________

2. Calculate your organization’s potential loss of first-year nurses with Transition to Practice:
   A PriceWaterhouseCoopers study estimated that median first-year nurse turnover in the
   U.S. stands at 27.1%.\(^1\) Under NCSBN’s Transition to Practice Program, first-year nursing
   turnover was X% for the X,000 RNs that took part in the pilot study.
   (Y): B x X% = __________

3. Calculate the estimated turnover cost per nurse at your facility:
   Studies indicate that new-nurse turnover replacement costs may be $46,000 or greater.\(^2\)
   For your specific health care practice setting, turnover replacement cost typically amounts
   to 1.3 times the nurse’s salary.\(^3\) Median base salary of staff RN is $41,642.
   Enter your practice’s average first-year nurse’s annual salary (S): ________
   The estimated turnover cost per nurse at your facility is then given by (D): 1.3 x S = ________

4. Calculate your organization’s potential cost savings from reduced turnover from the
   NCSBN Transition to Practice Model:
   (G): (Z x B – Y) x D = __________
   G is the estimated benefit of implementing Transition to Practice at your health care facility.
   Note that this does NOT include potential savings from reductions in medication errors,
   nurse-specific poor patient outcome errors and benefits accruing from increased patient
   satisfaction.

5. Calculate the Transition to Practice program costs for your organization:
   (C1): $100 x B = ________
   Median new nurse salary in the U.S. is $39,000 for an RN and $33,500 for an LPN/VN.\(^4\) This
   amounts to an hourly wage of $19.50 for a new RN and $16.75 for a new LPN.
   New nurse resident salary for modules taken during work hours (C2):
   60 x (S/12) x B = ________
   Preceptors should be registered nurses with more than three years of experience. The
   median salary for nurses with more than three years of experience in the U.S. is $47,110 for
   an RN, or $23.55 an hour.\(^5\)
   Enter your facility’s average preceptor hourly rate (P): ________

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\(^5\) Ibid.
Preceptor nurse resident salary for mentorship and preceptor module taken during work hours (C3): \(60 \times P \times B\) = _____

Add the three cost factors to find the total Program Cost (C): \(C1 + C2 + C3 = \) __________

6. Calculate the potential ROI for your health care facility:
   
   \((\text{ROI}) = \frac{(G – C)}{C} = \) __________

PART II: HOW PRACTICE CAN DEVELOP THEIR OWN TRANSITION PROGRAM

Many practice settings may choose to develop a specific transition program that aligns with the unique practice environment at their facility. While any practice setting is welcome to use the online modules designed and developed by NCSBN, organizations may want to provide a more specific transition experience for their new nurse hires. Major topics include:

- Patient-Centered Care;
- Communication and Teamwork;
- Quality Improvement;
- Informatics; and
- Evidence-Based Practice.

Safety and clinical reasoning are to be integrated throughout the topics, and feedback and reflection are to be embedded throughout that first year. Standards for the topics, including objectives, content outline, suggested interactive exercises and sources will be available on the Transition to Practice website. The topics should be presented during the first six months of practice, and during this time new nurses should be assigned to clinical preceptors who have been trained for the role. NCSBN believes that newly licensed nurses will become more effectively transitioned into practice with the help of preceptors. These should be fairly experienced nurses who are trained for the role and can help provide advice to the novice nurses within the organization. During the second six months of practice, ongoing employer support of the newly licensed nurse is an expectation. Tips for providing this support are available in NCSBN's Transition to Practice Modules Standards document.

NCSBN encourages practice settings to collaborate with each other and/or with colleges/universities in order to develop a transition program that meets the NCSBN standards. This might particularly be beneficial to smaller community agencies or long-term care settings.

The Impact

The impetus behind this flexible and robust model (includes all levels of licensure and all settings) is to promote public safety. The NCSBN Transition to Practice initiative provides a regulatory model for new nursing hires designed to promote public safety through:

- Decreased number of medical errors;
- Decreased number of medication errors;
- Better identification of life-threatening complications;
- Enhanced patient health care outcomes;
- Superior response times; and
- Decreased turnover rates among newly hired nurses.

While all of the above points are important from a caregiver-patient relationship standpoint, turnover is a measurable cost to practice organizations. PriceWaterhouseCoopers has estimated that every one percent increase in nursing turnover correlates to $300,000 in additional budget 6 This estimates the time preceptors spend helping new nurses in the transition program while on duty and receiving wages + the number of hours for Preceptor Module (~5-6) x hourly rate of an experienced nurse x number of new nurses in the program (assuming a new nurse:preceptor ratio of 1:1).
expenses for a large health care organization. The Transition to Practice Model provides a robust, evidence-based platform to create better patient outcomes and ensure greater worker satisfaction. Adoption of the Transition to Practice program within an organization will help with cost savings and greater patient satisfaction. The cost factors associated with replacing nurses are quite substantial, and include:

- Advertising and recruitment;
- Vacancy costs (e.g., paying for agency nurses, overtime, closed beds, hospital diversions, etc.);
- Interviews and hiring decisions;
- Orientation and training;
- Decreased worker productivity at initiation of work;
- Termination/unemployment benefits;
- Added potential for errors, compromised quality of care;
- Loss of organizational knowledge; and
- Poor existing employee morale leads to additional turnover (Jones & Gates, 2007).

Implementation of a transition program at a facility can save management from the costs and hassles that occur in instances of frequent staff turnover. Several other practice settings have adopted transition programs and the results have been quite positive.

**UHC/AACN NURSE RESIDENCY PROGRAM**

At the multistate, national level in the U.S., the University HealthSystem Consortium and American Association of Colleges of Nursing (UHC/AACN) have introduced their own Nurse Residency Program. The standardized model is currently being offered in 61 university health care sites in 27 U.S. states. The program is implemented in addition to the typical orientation process at these health care facilities.

The core curriculum includes course modules on leadership, research-based practice, professional development, communication, critical thinking, patient safety and nurse skills, all of which are complemented with clinical guidance from a preceptor. This residency program meets the standards of NCSBN's Transition to Practice Model.

Preliminary results indicate that health care facilities where the Nurse Residency Program was adopted realized a reduction in first-year nurse turnover to 12 percent compared to prior studies that indicated turnover ranged from 36 percent to 55 percent for new nurse graduates.

**CHILDREN’S MEMORIAL HOSPITAL, CHICAGO**

Diane Halfer published a case study on the introduction of an RN internship program to nurture new nurse graduates as they entered their pediatric careers. In 2002, Children’s Memorial Hospital in Chicago calculated that the new graduate nurse turnover in the first year had reached 29.5 percent. Because the cost per new graduate hire stood at $41,624, management at the hospital understood action needed to be taken.

The nurse internship program began in 2003, thanks in part to three Health Resources and Services Administration (HRSA) grants that totaled $639,000. The program called for classroom time for new graduate nurses that included 80 hours of general content and 32 to 72 hours of specialty-specific content related to the nurse’s intended health care focus. Interns also have the flexibility of completing the pediatric courses through an online educational Web-based subscription service. The program also implemented group discussions with facilitators to help others express worries, feelings and personal instances where they could receive constructive group feedback.
The internship program not only helped the hospital retain more first-year nursing graduates (Children's Memorial has averaged 12.3 percent turnover per class since 2003), but saw “multiple applications for every one intern hired, allowing nursing directors to select the most highly qualified candidates who completed the NCLEX® exam, best fit the medical center’s culture, and often came with relevant experience.” (Halfer, 2007) This has directly led to a 28 percent increase in recruitment at the hospital. Moreover, since the inception of the graduate nurse internship program, there have been an average of 17 more nurses staying at the medical center each year, yielding a calculated cost savings of $707,608 annually.

Methodist Hospital of Houston

Rosemary Pine and Kathryn Tart wrote about return-on-investment (ROI) opportunities for health care facilities that adopted the nurse residency program from UHC/AACN. At Methodist Hospital in Houston, retention rates for first-year nurses reached an all-time low of 50 percent in 2003. Administrators knew they needed to do something to turn this phenomenon around.

The University Health Consortium (UHC) Baccalaureate Nurse Residency Program was introduced in 2004. The one-year program is based on Patricia Benner’s theoretical framework on transition to professional nursing called From Novice to Expert: Excellence and Power in Clinical Nursing Practice (Benner, 1984).

The UHC program received buy-in from senior executive leadership, including the chief nurse executive. There were 48 first-year resident nurses enrolled in the UHC program at a total cost of $93,100 to the hospital. As a result of the residency program, turnover was reduced to 13 percent in 2005, thus realizing ~$1,098,000 in cost savings and a net program benefit of ~$824,000 and ROI of 884.7 percent (Pine, Tart, 2007). The research study indicates that investment in a residency transition program leads directly to increased first-year nurse retention and substantial cost savings for the hospital, which in turn leads to better health outcomes for patients.

Considerations for Practice

Many practice settings will want to consider the design and use of their own transition program. The administrative management at the practice setting will need to work with the chief nursing officer (CNO), unit leaders and other experienced nurses within the organization to develop what the practice-specific program should entail, while at the same time, meeting the standards of NCSBN’s Transition to Practice Model. Subject matter experts may need to be hired to develop content and teaching strategies for the various subjects that will be covered in the transition program. Activities incorporated within the program might include roundtable discussions, classroom lectures, simulation games, guest speakers for certain subjects, written or oral presentations given by new nurses, and other options that provide a dynamic and interactive transition experience for new nurses.

The decision to develop and conduct a comprehensive residency program included recognition of the required investment of the significant human and financial resources that are necessary to support these new graduate nurses in their successful role transition. The costs of the program can be grouped into expenses that directly support the program and indirect costs associated with resident time spent away from the clinical setting. Analysis of the ROI must also include evaluation of the expected cost avoidance associated with decreased turnover and the benefits of hiring employees who are anticipated to have long tenures in the organization. These benefits also include the anticipated future returns of the clinical practice of these nurses in the context of improved outcomes of care, patient safety, clinical productivity, and patient and staff satisfaction. (Keller, Meekins & Summers, 2006)

Direct program costs will likely include tuition for online modules, text and journal subscriptions, photocopy and office supplies, speaker and consultant fees, refreshments and administrative management. The transition program implemented at the University of Texas Medical Center found that the direct costs came to approximately $1,000 per new nurse while the program has witnessed nurse retention rise to 89.2 percent.
CONCLUSION
NCSBN plans to work with states/jurisdictions to legislate for new nurse transition programs. While NCSBN will make its six online modules for new nurses and preceptors available for any practice organization that needs them, employers are encouraged to use whatever transition model fits best with their organization. The end goal is for everyone involved to provide greater patient care that enhances public safety. New nurses who experience a transition program become acclimated more effectively and show increased clinical competence. This in turn will lead to less stress and, as research indicates, greater retention rates and better practice outcomes. NCSBN and employers should come together to provide these positive outcomes for the next generation of new nurses.

REFERENCES


Attachment E

Transition to Practice Design

Transition to Practice

ENGAGING · EXPERIENCING · EMPOWERING
Report of Uniform Licensure Requirements and Portability Committee

Background
In 1999, NCSBN undertook a major initiative to develop minimal licensure requirements for adherence by every Member Board. Upon recommendation by an appointed committee, a set of uniform core licensure requirements (UCLRs) were adopted by the Delegate Assembly. Adoption by individual boards of nursing (BONs), however, varied to wide degrees. As defined by the 1999 committee, the UCLRs were minimal requirements for BONs. This gave BONs the flexibility to adopt the requirements in many ways, often adding further requirements if their state chose to do so. As a result, while many of the BONs adopted the requirements, many variances emerged and licensure requirements were no longer uniform throughout the jurisdictions.

During the 10 years that followed, both intrinsic and extrinsic environmental factors have affected the nursing profession. Workforce shortages, a technological boon that rapidly advanced the capabilities of telehealth and globalization, among other factors, have impacted health care delivery and have stakeholders requesting uniformity among state nursing laws and regulations in regards to licensure. During the 2008 Delegate Assembly, a resolution was made and passed requesting that the UCLRs be reviewed and updated. In response, the current Uniform Licensure Requirements and Portability Committee was established.

The Committee is made up of 10 members: five from compact states and five from noncompact states. All four areas of the U.S. are represented on the committee. The committee consists of four members from umbrella BONs and six members from independent BONs.

The 2009-2010 committee used a variety of resources in its deliberations. They consulted legal counsel, thoroughly examined each state’s requirements, as well as variances, and considered all comments made at the 2008 UCLR conference, in which two members of every BON were invited and sponsored by NCSBN to attend. In addition, the following resources were used by the committee:

a. The 1999 UCLRs;
b. The 2008 UCLR Survey to Member Boards;
c. The comments, feedback and concerns that emerged from the 2008 UCLR Conference small-group breakout sessions;
d. Positions of the NCSBN Delegate Assembly and the Board of Directors (BOD) that relate to licensure;
e. State information on criminal background checks and fingerprint systems, including the Rap-Back System;
f. The Americans with Disabilities Act (ADA);
g. NCSBN Member Board Profiles; and
h. The report from the NCSBN and Nurse Licensure Compact Administrators (NLCA) action plan that emerged from the 2008 focus groups.

The following is a comprehensive summary of the committee’s charges:

- Review and recommend revisions to the 1999 Delegate Assembly UCLRs. Include initial, renewal, endorsement and international requirements.
- Review and recommend actions regarding variances to core requirements.

The committee spent a great deal of time in thoughtful deliberation reviewing the licensure requirements (initial, renewal, endorsement and international) of all 60 NCSBN Member Boards. In addition, every variance was noted and discussed by the committee.
The committee’s first set of draft requirements was distributed during fall 2009 to executive officers and Member Board presidents in all jurisdictions. All feedback was carefully reviewed and discussed. Modifications were made based on the Member Board’s feedback; a revised draft was constructed and presented to the BOD in February 2010. A second draft of the ULRs was presented and discussed at the 2010 NCSBN Midyear Meeting. All comments and suggestions were carefully examined and discussed. Based on this feedback, further modifications were made.

When the completed document was submitted to the BOD at the May 2010 meeting, the BOD felt as though there was not enough consensus by the membership on two issues: (1) whether graduation from a nursing program should be required for licensure; and (2) whether permanent bars to licensure should be required by certain states. The BOD requested the committee reconvene to find further evidence to support the recommendations related to these issues. In addition, they requested further evidence for removing the ULR related to functional abilities. For that reason, the ULRs will not be voted on by this year’s Delegate Assembly. See Attachment A for the most recent draft.

- Develop a strategic plan for assisting Member Boards to implement the ULRs.

The committee has developed a comprehensive strategic plan that contains strategies for enactment of the ULRs through statute or rule/regulation through the process of implementation. During fall 2009, when the first draft of the ULRs was distributed, Member Boards were asked to comment on potential barriers to implementation in their state and how NCSBN can assist in implementation. The information received was incorporated into a comprehensive strategic plan.

The plan is currently on hold until the ULRs are completed and adopted by the Delegate Assembly.

- Recommend solutions for issues identified regarding the interface between the two licensure models (Attachment B).

**Highlights of FY10 Activities**

- Development of 2010 ULRs.
- Development of a strategic plan for implementation.
- Recommended solutions for issues identified regarding the interface between the two licensure models.

**Future Activities**

- Develop a common licensure application.

Obtain further evidence for final draft of ULRs.

**Attachments**

A. Uniform Licensure Requirements (ULRs) Draft (May 2010)

B. Recommended Solutions for Issues Regarding the Interface Between the Two Licensure Models
Attachment A

Uniform Licensure Requirements (ULRs) Draft (May 2010)

ULRs are the essential prerequisites for initial, endorsement, renewal and reinstatement licensure needed in every NCSBN jurisdiction to ensure the safe and competent practice of nursing.

ULRs protect the public by setting consistent standards and promoting a health care system that is fluid and accessible by removing barriers to care and maximizing portability for nurses. They also assure the consumer that a nurse in one state has met the requirements to practice nursing in every other state. ULRs support the fact that the expectations for the education and responsibilities of a nurse are the same throughout every NCSBN Member Board jurisdiction in the U.S.

It is recommended that Member Boards unite in a common goal of adopting the ULRs into their state practice act/regulations by 2016.

<table>
<thead>
<tr>
<th>1999 UCLR Education Requirement: RN</th>
<th>1.A Nursing Education Requirements: RN</th>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduation from or verification of completion and eligibility for graduation from state-approved registered nurse (RN) program.</td>
<td>As of 2016: Graduation from a Member Board approved* professional nursing education program.</td>
<td>As of 2016: Verification of graduation from a Member Board approved* professional nursing education program. Grandfather students licensed or enrolled in a nursing program prior to 2016.</td>
<td>1. Language changed to “Member Board,” as defined in the ULR definitions, to include all jurisdictions. 2. This requirement applies to full members of NCSBN only, not associate members, as defined by NCSBN. 3. Graduation has been added as a defined exit point and assures the public that all requirements are met. 4. New language will require that generic master's programs confer a degree to their students once they have completed the RN requirements of the program in order for the students to be eligible for licensure prior to completing their master's degree.</td>
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<tr>
<td>Applicant Responsibility</td>
<td>Board Duty</td>
<td>Rationale for Change</td>
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<td>5. This ULR is also meant to protect students. There is nothing that provides assurance that students in a generic master’s program will complete all program requirements and receive a degree if they are allowed to take the NCLEX® examination prior to graduation. Not having a degree in nursing may place them in a compromised position at some point during their career.</td>
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<td>6. The recommended year for compliance is 2016. This will allow time for nursing programs to adjust their requirements and accommodate this change in curriculum should they need to do so.</td>
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<td>7. No other health care profession allows licensure without graduation.</td>
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<td>8. Allowing licensure without graduation adds another method of becoming a nurse and further confuses the public and other professions as to the true requirements for becoming a nurse.</td>
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<td>9. The grandfathering clause has been inserted as not to penalize nurses enrolled in a generic master’s program prior to 2016.</td>
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<tr>
<td>1999 UCLR Education Requirement: LPN/VN</td>
<td>2.A Nursing Education Requirements: LPN/VN</td>
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<tr>
<td>Graduation from or verification of completion and eligibility for graduation from state-approved licensed practical/vocational nurse (LPN/VN) program.</td>
<td><strong>Applicant Responsibility</strong></td>
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<tr>
<td></td>
<td>As of 2016: Graduation from a Member Board approved* practical nursing education program. Includes:</td>
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<td>• Graduation from a Member Board approved military LPN/VN program.</td>
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<td></td>
<td>• Graduates from RN programs who have successfully completed a Member Board approved LPN/VN role delineation course.</td>
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<td><strong>Board Duty</strong></td>
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<tr>
<td></td>
<td>As of 2016: Verification of graduation from a Member Board approved* practical nursing education program. Includes:</td>
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<tr>
<td></td>
<td>• Graduation from a Member Board approved military LPN/VN program.</td>
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<tr>
<td></td>
<td>• Graduates from RN programs who have successfully completed a Member Board approved LPN/VN role delineation course.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rationale for Change</strong></td>
<td>1. New language is inclusive of applicants from two-step or ladder programs; however, it will require that these programs confer a degree to their students once they have completed the LPN/VN requirements of the program in order for the students to be eligible for licensure.</td>
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<td></td>
<td>2. This eliminates the requirement that an RN-prepared applicant would have to first fail the NCLEX-RN® Examination prior to sitting for the NCLEX-PN® Examination.</td>
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<td></td>
<td>3. RN and LPN/VN roles are distinct. Individuals taking the NCLEX-PN® Examination must have complete understanding of the PN role. This keeps educated individuals in the workforce. There is no evidence that supports or reflects an increase in discipline or practice issues when RNs are allowed to work as LPN/VNs.</td>
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<td>4. Military Corpsman programs are NOT equivalent to LPN/VN programs and graduates from these programs should not be considered eligible for PN licensure.</td>
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</table>
### 1999 UCLR
#### Education Requirement for Foreign-Educated Candidates: RN

Graduation from nursing programs comparable to U.S. state-approved RN nursing programs as verified by credentials review agency.

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduation from a nursing program substantially equivalent to a Member Board approved RN program.</td>
<td>Verification by a credentials review of graduation from a nursing program substantially equivalent to a Member Board approved RN program.</td>
<td>Revision requires graduation from a nursing program. In foreign nursing programs, “program completion” may have different meanings. Graduation is a defined exit point and universally understood. This change will help ensure that nursing education of foreign graduates is consistent across jurisdictions, will make verification easier and may decrease the number of fraudulent applicants.</td>
</tr>
</tbody>
</table>

#### Education Requirement for Foreign Educated Candidates: LPN/VN

Graduation from nursing program comparable to U.S. state-approved LPN/VN nursing programs as verified by credentials review agency.

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduation from a nursing program substantially equivalent to a Member Board approved LPN/VN program.</td>
<td>Verification by a credentials review of graduation from a nursing program substantially equivalent to a Member Board approved LPN/VN program.</td>
<td>Same as 3.A.</td>
</tr>
</tbody>
</table>

#### NCLEX® Requirements

- U.S. Candidates-RN: NCLEX-RN, unlimited attempts.
- U.S. Candidates-LPN/VN: NCLEX-PN, unlimited attempts.
- Foreign-educated Candidates-RN: NCLEX-RN, unlimited attempts.
- Foreign-educated Candidates-LPN/VN: NCLEX-PN, unlimited attempts.

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passage of NCLEX-RN or NCLEX-PN exam.</td>
<td>Verification of NCLEX-RN or NCLEX-PN exam.</td>
<td>This ULR applies to both U.S. and internationally educated graduates. Individual Member Boards may determine the timeframe required for NCLEX passage, as this does not affect mobility.</td>
</tr>
</tbody>
</table>
### 1999 UCLR  
**Additional Requirements for Foreign-educated Nurses**

1. **Foreign-educated RN Candidates:**  
   - Commission on Graduates of Foreign Nursing Schools (CGFNS) certificate or equivalent credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English.

2. **Foreign educated LPN/VN Candidates:**  
   - Credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English.

### 6.A Additional Requirements for Foreign-educated Candidates

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-disclosure of nursing licensure status in country of origin, if applicable.</td>
<td>Verification of nursing licensure status in country of origin, if applicable.</td>
<td>1. Licensure in the country of education is not required; however, if the nurse has been licensed in the country of origin, the board of nursing (BON) should determine whether the license has ever been disciplined.</td>
</tr>
<tr>
<td>Successful passage of an English proficiency exam that includes the components of reading, speaking, writing and listening, except for applicants from countries where English is the native language, and the nursing program where the applicant attended was taught in English and used English textbooks.</td>
<td>Verification of successful passage of an English proficiency exam that includes the components of reading, speaking, writing and listening, except for applicants from countries where English is the native language, and the nursing program where the applicant attended was taught in English and used English textbooks.</td>
<td>2. The English proficiency requirement was changed to include four English language testing components. This provides for additional public protection and makes the requirements consistent with the government's minimal eligibility requirements for an occupational visa.</td>
</tr>
<tr>
<td>Verification of successful passage of an English proficiency exam that includes the components of reading, speaking, writing and listening, except for applicants from countries where English is the native language, and the nursing program where the applicant attended was taught in English and used English textbooks.</td>
<td></td>
<td>3. Credentials review has been placed under 3.A and 4.A: Nursing Education Requirements of International Candidates: RN and LPN/VN.</td>
</tr>
</tbody>
</table>
### 1999 UCLR
#### Criminal Background Check Requirements: RN and LPN/VN

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-report regarding all felony convictions and all plea agreements and misdemeanor convictions of lesser-included offenses arising from felony arrests. Local/state and federal background checks using current technology (i.e., fingerprinting) to validate self-reports.</td>
<td>Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld).</td>
<td>Identification of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure. State and federal fingerprint checks. Deny license for any felony conviction, pursuant to NCSBN Model Act Article 6 § 3.</td>
</tr>
</tbody>
</table>

### 1999 UCLR
#### Chemical Dependency and Functional Abilities Requirements: RN and LPN/VN

- **Chemical Dependency**: Self-report regarding any drug-related behavior that affects the candidate's ability to provide safe and effective nursing care.
- **Functional Abilities**: Self-report regarding any functional ability deficit that would require accommodation to perform essential nursing functions.

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-disclosure of any abusive or excessive use of drugs, including alcohol, narcotics or chemicals, that resulted in physical or psychological dependence within the last five years.</td>
<td>Review of any applicant for renewal or reinstatement of licensure who may have a current drug or alcohol problem that could affect the ability to practice nursing safely.</td>
<td>1. Elimination of functional abilities question: Assessment of functional ability for licensure (according to American Disabilities Act [ADA] standards) would require BONs to have a professional evaluation done on candidates reporting physical/mental disabilities. Interpretation is time-consuming and complex, and should be the responsibility of employers who know the accommodations their institutions can provide. 2. According to the ADA, asking about drug and alcohol use is time-limited. Legal counsel recommends BONs inquire about drug or alcohol use that is limited to the last five years.</td>
</tr>
</tbody>
</table>
### 9.A Additional Public Protection Requirements:
*Other Licenses, Certifications and Registrations*

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification.</td>
<td>Review of any actions taken or initiated against a professional or occupational license, registration or certification and consideration of the individual's ability to practice nursing safely.</td>
<td>This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.</td>
</tr>
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</table>

### B. Renewal/Reinstatement Requirements

#### 1.B Criminal Background Check (CBC)

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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</table>
| Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld) not previously reported to the BON. | • Identification of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld) not previously reported to the BON for determination of eligibility for renewal or reinstatement of licensure.  
• State and federal fingerprint checks using automatic criminal background feedback system (such as Rap-Back).  
• Deny license for any felony conviction, pursuant to NCSBN Model Practice Act Article 6 § 3. | Recommendation adds state and federal fingerprint checks for renewal. This recommendation takes into account future technology of fingerprint and CBC systems that will allow for automatic feedback to BONs when a licensee is convicted of a crime at any point in their career, i.e., Rap-Back system. This will give real-time data to make accurate licensure decisions on behalf of public protection. It is anticipated that the cost will decrease with development and adoption by BONs. This requirement would move the current CBC check system forward. Fingerprints would be taken at application for initial, renewal or reinstatement of licensure and stored. If a nurse has a criminal violation, the BON would be automatically notified. See NCSBN Model Practice Act Article. 6 § 3. |
### 2.B Substance Abuse

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-disclosure of any abusive or excessive use of drugs, including alcohol, narcotics or chemicals, that resulted in physical or psychological dependence.</td>
<td>Review of any applicant for renewal or reinstatement of licensure who may have a current drug or alcohol problem that could affect his/her ability to practice nursing safely.</td>
<td>According to the ADA, asking about drug and alcohol use is time-limited. Legal counsel recommends boards inquire about drug or alcohol use that is limited to the last five years.</td>
</tr>
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</table>

### 3.B Nursing Disciplinary Actions

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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</thead>
<tbody>
<tr>
<td>Self-disclosure of any action taken on a nursing license, privilege to practice, or current/pending investigation by a Member Board.</td>
<td>Identification/review of any action taken on a nursing license, privilege to practice or current/pending investigation by a Member Board.</td>
<td>This requirement has been added to ensure that any nursing disciplinary action will be identified and considered prior to renewal/reinstatement of licensure.</td>
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</table>

### 4.B Other Licenses, Certifications and Registrations

<table>
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<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification not previously reported to the BON.</td>
<td>Review of any actions taken or initiated against a professional or occupational license, registration or certification not previously reported to the BON and consideration of the individual's ability to practice nursing safely.</td>
<td>This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.</td>
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</table>

### C. Endorsement Requirements

#### 1.C Education, Exam and Licensure Verification

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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<tbody>
<tr>
<td>▪ Graduation from a Member Board approved professional nursing or practical nursing education program.</td>
<td>▪ Verification of education.</td>
<td>Verification of nursing licensure has been added to determine whether a license from any state has an encumbrance, discipline or pending investigation.</td>
</tr>
<tr>
<td>▪ Successful passage of the NCLEX/State Board Test Pool Exam.</td>
<td>▪ Verification of successful passage of the NCLEX/State Board Test Pool Exam.</td>
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<tr>
<td>▪ Self-disclosure of status of all nursing licenses (includes any board actions taken, or any current or pending investigations by a Member Board)</td>
<td>▪ Verification of all nursing licenses.</td>
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<td></td>
<td>▪ Identification/review of any action taken against a nursing license or privilege to practice, including any pending investigation.</td>
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</table>
### 2.C Criminal Background Check

<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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</table>
| Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld). | • Identification of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure.  
• State and federal fingerprint checks.  
• Deny license for any felony conviction, pursuant to NCSBN Model Practice Act Article 6 § 3. | See NCSBN Model Practice Act Article. 6 § 3. Recommendation is that licensure be denied for the following felonies: murder, felonious assault, kidnapping, rape, aggravated robbery, sexual crimes involving children or vulnerable adults, criminal mistreatment of children or vulnerable adults and exploitation of a vulnerable individual (e.g., financial exploitation in an entrusted role). |

### 3.C Substance Abuse

<table>
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<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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</thead>
<tbody>
<tr>
<td>Self-disclosure of any abusive or excessive use of drugs, including alcohol, narcotics or chemicals that resulted in physical or psychological dependence within the last five years.</td>
<td>Review of any applicant for renewal or reinstatement of licensure who may have a current drug or alcohol problem that could affect his/her ability to practice nursing safely.</td>
<td>According to the ADA, asking about drug and alcohol use is time-limited. Legal counsel recommends boards inquire about drug or alcohol use that is limited to the last five years.</td>
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### 4.C Other Licenses, Certifications, Registrations

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<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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<tbody>
<tr>
<td>Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification not previously reported to the BON.</td>
<td>Review of any actions taken or initiated against a professional or occupational license, registration or certification and consideration of the individual's ability to practice nursing safely.</td>
<td>This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.</td>
</tr>
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</table>

*Member Board approved also applies to states in which the nursing program approval is done through another state agency such as the Commission on Higher Learning.*

Administrative code regulations such as child support, payment of taxes, school loans, etc., are not included in these licensure requirements as those are state specific and do not solely apply to the BON.
Attachment B

Recommended Solutions for Issues Regarding the Interface Between the Two Licensure Models

Uniform licensure requirements (ULRs) assure consistent standards across all jurisdictions in the U.S. and its territories. In doing so, they afford public protection and promote mobility. These alone, however, are not sufficient to allow for fluidity in the licensure process. The licensure process requires an environment of open communication and collaboration that engages regulators across state lines.

Since the 2000 the U.S. and its territories have supported two main licensure models for nursing: the Nurse Licensure Compact (NLC) and the single state model. The NLC requires nurses to be licensed in their home state while authorizing them to work in another state without obtaining a new license. The single-state model requires every nurse working in a state to be issued a license from that jurisdiction's state board of nursing (BON) and allows them to work only in that state. NLC states use the single-state model for specific circumstances, such as for individuals residing in a noncompact state working in compact states.

The Uniform Licensure Requirements and Portability Committee was given the charge to recommend solutions for issues identified regarding the interface between the two licensure models. The group ascertained the issues regarding the interface between the two licensure models and has made recommendations. This is the first step in building a stronger and more cohesive organization of nurse regulators.

The committee acknowledges the overall positive relationships between Member Boards. The intention of this document is to further strengthen those relationships and resolve pending differences between two equally effective licensure models. The following is a summary of the issues and solutions identified by the Uniform Licensure Requirements and Portability Committee.

LICENSURE-RELATED ISSUES

For the remainder of this report, compact will be used to refer to all states that are currently members of the NLC and noncompact will refer to all states that are not members of the NLC.

Every decision put into legislation or policy may inadvertently impact another state. A state adopts new legislation or a licensing BON issues a new regulation and other states experience sequelae from the other state's action.

Recommended Solution: In order to provide a forum for discussion where both noncompact and compact states can discuss issues of concern, the Uniform Licensure Requirements and Portability Committee recommends the development of a group, such as a Commission on Licensure, a working group that is part of NCSBN, designated to address issues involving both licensure models. It is suggested that this group consists of 10 representatives from compact and noncompact states; five representatives from compact states would be selected by the Nurse Licensure Compact Administrators (NLCA) and five representatives from noncompact states would be selected by NCSBN members who are not currently a part of the NLC. The group would meet periodically to discuss licensure issues. In addition, the commission would problem solve, exchange ideas, and discuss changes in state laws and/or regulations and licensure problems experienced by all members, including the implementation of ULRs. The

1 Minnesota has its own model and for the purposes of this document shall be considered a noncompact state.

2 The name of the group, Commission on Licensure, is suggested solely for the purpose of providing a creative title that would distinguish this group from a typical NCSBN committee in which the NCSBN Board of Directors determines membership and charges. It does not, in any way, imply any type of authority or have any legal implications. The definition of the word "commission" in this title is defined simply as "a group with a task."

3 In response to the need to address licensure issues from the interface between licensure models, the NCSBN Board of Directors, at their May 2010 meeting, per the NCSBN Bylaws and consistent with organizational practice, appointed a new committee for fiscal year 2011 with equal members representing single states and compact states. The new Nurse Licensure Models Committee was given the following charges: (1) Identify and recommend solutions to address current and emerging licensure issues that impact patient safety in all jurisdictions; and (2) Develop communications processes for regular sharing of information and promotion of dialogue to enhance the interface among all licensure models.
commission would choose a representative from a noncompact or compact state to speak on one of the licensure models on behalf of NCSBN. It is recommended that the commission would have an outside facilitator and provide reports to the Member Boards about the discussions and decisions made. The objective of this recommendation is to eliminate misunderstanding and educate both compact and noncompact states about contrasting licensure perspectives.

Every BON has a mission to protect the public. A benefit afforded to compact states is the access to significant investigative information of other compact states. When a licensee in a compact state is under investigation, the compact states are notified through an alert on Nursys®. This alert is only seen by compact states as noncompact states do not have access to information in Nursys about a licensee until a board action is taken. The interval from investigation to board action may allow the licensee time to move to a noncompact state and potentially become licensed.

Recommended Solution: In the interest of public protection, the committee recommends that all states should have the authority to share significant investigative information and have access to significant investigative information. The committee recommends that the following be considered for operationalizing this recommendation:

- The alert in Nursys, indicating a licensee is under investigation (currently seen only by members of compact states) is visible to all NCSBN Member Boards (this process is required by compact law). Compact states will continue to have access to details about the investigation.
- Compact states that are not currently restricted by statute or rule from sharing the details of their significant investigative information with noncompact states allow that information to be accessible on Nursys to all Member Boards.
- Noncompact states currently allowed to share investigative information with other states allow that information to be accessible on Nursys to all Member Boards.
- All states that are not currently allowed to share significant investigative information with all Member Boards initiate statutory and/or rule changes to allow all Member Boards access to their significant investigative information.

The goal of this recommendation is that all Member Boards will share and have access to significant investigative information from all jurisdictions in an effort to protect the public.

OTHER ISSUES REGARDING THE INTERFACE OF THE TWO MODELS

The Uniform Licensure Requirements and Portability Committee was focused on licensure issues. In the course of their discussion, other issues and recommendations emerged regarding compact and noncompact states. The committee felt this additional feedback might be useful to BONs and is therefore included in this report.

- The BON should give consideration to separate licensure models when choosing committee members and ensure that compact and noncompact states are represented on the committee.
- Per Policy 1.10 of the NLCA Policies and Procedure Manual, the Uniform Licensure Requirements and Portability Committee believes that notification should be provided to the executive officer of any noncompact state in which a compact administrator is invited to speak. The committee recommends the executive officer be directly contacted as soon as possible, prior to the visit.

- There is a lack of knowledge about the NLC. The committee recommends:
  - Promoting education about the NLC to the membership at large.
Noncompact states participating in the NLCA meetings/phone calls that are currently open to the entire membership in order to learn more about the compact and bring forth questions.

NCSBN explaining financial assistance given to the NLCA during the Finance Committee's report at Annual Meeting.

It is the hope of the Uniform Licensure Requirements and Portability Committee that these recommendations will assist in unifying all Member Boards and help them work together to compliment one another, build a stronger organization and provide the highest level of public protection for all consumers of health care.