

Practical Nurse Scope of Practice White Paper

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Nancy Spector, DNSc, RN
Director of Education, NCSBN

Executive Summary

The Practical Nurse Scope of Practice White Paper was written as a recommendation from the April 2004 PN Focus Group that was held at the NCSBN offices in Chicago. This national Focus Group comprised people with a broad range of experience and knowledge in nursing related disciplines from across the U.S. The NCSBN Board of Directors convened this Focus Group after discussions about the 2003 LPN/VN Practice Analysis, which prompted the NCSBN Board of Directors to consider whether regulatory boards should re-evaluate the practical nurse (PN) scope of practice.

This white paper incorporates findings from the PN Focus Group, findings from a survey sent to boards of nursing about the PN scope of practice, and findings from external research projects on LPN/VN scope of practice. Data from various sources validated that the boards of nursing vary widely with regard to the LPN/VN scope of practice. NCSBN found that this variation particularly exists with allowing LPNs/VNs to administer IV medications and blood transfusions, make decisions on comparing data to the normal, and independently plan and provide education to patients and their families. Yet, NCSBN's data showed that there was general agreement that LPNs/VNs in most states don't:

- Independently develop the plan of care
- Make changes in the plan of care
- Perform telephone triage

Seago et al. (2004) comprehensively studied LPNs/VNs and made 11 evidenced-based recommendations, based on their findings. Their report found contention around the words "assessment," "delegation," "supervision," "decision making," and "critical thinking."

A strong recommendation in this white paper is that dialogue with nursing practice, regulation and education must take place, addressing:

- Developing initiatives to enhance the mobility of practical nurses by establishing statewide articulations programs.
- Establishing a national practical nurse curriculum.
- Decreasing the wide disparity that is present in the Nurse Practice Acts regarding the practical nurse scope of practice.
- Developing a national clearinghouse for practical nurse data.
- Providing education to all health care workers about the LPN/VN scope of practice.
- Conducting more research on the practical nurse scope of practice.

Background

At the December 2–4, 2003, NCSBN Board of Directors meeting, one key action of the Board was stated as, "Based on the 2003 LPN/VN Practice Analysis findings, the Board discussed the expanding role of PNs, questioned whether PNs receive adequate preparation for practice and if regulatory boards need to reevaluate the PN scope of practice. The Board approved a focus group to be convened to identify PN practice and education issues and provide the board with options for next steps." Therefore, a practical nurse (PN) focus group was convened in Chicago to discuss the findings of the 2003 LPN/VN Practice Analysis (Smith & Crawford, 2003) and to make recommendations to the NCSBN Board of Directors.

One of the recommendations of the PN focus group was to write a White Paper about the focus group discussion of the scope of PN practice and highlighting any PN data that has either been collected here at NCSBN or by external groups. By distributing

this White Paper widely to all the stakeholders, the focus group anticipated that it would stimulate an important dialogue about the PN scope of practice. One of the issues that the focus group would like to be addressed is the wide disparity in the PN scope of practice in the nurse practice acts and the nursing administrative rules. The focus group also hoped there would be discussion of developing a national PN curriculum and of educating practice about the role of the PN.

April 29, 2004, PN focus group

SCHEDULE OF THE MEETING

An experienced focus group facilitator helped to plan the focus group, presided over the group that day and assisted with the various reports from the group. The facilitator, Richard English, from Surrey, England, was chosen because of his expertise in facilitation and his objectivity. He is not a nurse, nor does he live in the United States, so it was anticipated that his fresh perspective would stimulate rich discussions that otherwise might not occur.

To ensure the broadest possible range of experience and knowledge, participants were selected from a range of nursing-related disciplines across the United States. The full list of participants is in Appendix I to this Report. There was representation from the boards of nursing, the National League of Nursing Accrediting Commission (NLNAC), the National Association of Practical Nurse Education and Service (NAPNES), NCSBN, NCSBN's Exam Committee, NCSBN's Practice, Regulation and Education (PR&E) Committee, Joint Commission's Longterm Care Accreditation, Institute for the Future of Aging Services, National Federation of Licensed Practical Nurses (NFLPN) and the American Organization of Nurse Executives (AONE).

The group members were aware of the background of this meeting. All members were supplied with a copy of the 2003 PN Practice Analysis and a detailed discussion guide was prepared that gave direction to the group discussion. The event was specifically designed to allow for the maximum participation of delegates and thus a large amount of time was spent on small group work. Dr. Spector, director of education at NCSBN, and Mr. Richard English, the facilitator, worked closely in planning the meeting, and they devised an algorithm (Appendix II) for preparing for the discussion. To allow for return travel, the day was scheduled to finish early — by 4:30 pm — and this necessitated an early start with a working breakfast. This worked very well and, in spite of the volume of work to be undertaken, the day finished slightly ahead of time and most participants were able to stay until the close of the meeting.

To help delegates to understand the background of the study and of the relationship to the NCLEX® test plan, presentations were given by June Smith, PhD, RN, former NCSBN associate director of research services, and Casey Marks, PhD, NCSBN associate executive director of operations.

GROUP SESSIONS

Considering that many of the delegates had never met prior to this event, the group bonded quickly, with all the breakout sessions generating many good ideas. The various groups were asked to look at the four main questions posed in the discussion guide, and the findings of each session are summarized here. Throughout all group discussions the ideas of listening to the consumers in this debate and putting patient safety first, were implicit in all decisions that are made.

Discussions by the PN focus group members included:

1. What do the findings of the 2003 LPN/VN Practice Analysis mean, considering the scope of practice of LPN/VNs?

Group 1 — Yellow Group

- Is there a difference between the reports from LPN/VNs about their practice, versus what is actually happening? There was considerable discussion about this, and some thought the employers' surveys and the panel of experts validated the findings of the LPN/VN survey.
- Are LPN/VN roles expanding? Are LPN/VNs being educated adequately for practice in the long-term care settings or the acute care settings? Some thought there was a gap between practice and education.
- Some boards of nursing have looked at RNs placing LPN/VNs in bad positions by asking them to practice outside their scope of practice. The group asked whether boards of nursing are seeing more discipline cases with LPN/VNs, regarding scope of practice. Some boards of nursing are, while others are not.
- The bottom line is that safety of the patient must be considered; this is a regulatory question.
- Consider the difference between the "care plan" and the "service plan." What is nursing? What is not nursing? Who decides which is which?

- The question of adequate supervision was raised. Oftentimes an LPN/VN may be supervised by someone who doesn't understand the legal scope of practice.

Group 2 — Blue Group

- What precisely is meant by “scope?” It is a legal term and refers to the body of knowledge in a profession and it is mandated by legislation.
- “Scope” encompasses the nurse’s judgment and is affected by the setting, staff mix, etc.
- When legislating “scope,” one must think towards the future, at least five years in advance.
- “Knowledge” can’t be delegated, though technical tasks, etc. can be. Delegation is an important part of this discussion of “scope of practice.”
- Consider the patient. Our responsibility is to protect the patient.

Group 3 — Red Group

- What do these findings mean? It is hard to generalize because it varies from jurisdiction to jurisdiction and facility to facility. Do these facilities make their decisions based on the practice act and rules and regulations in that state?
- There is a variance between education and practice of the LPN/VN. Practice evolves over time. A third of LPN/VNs need more education to practice in entry-level jobs.
- RNs don’t have an understanding of the LPN/VN scope of practice.
- What are the differences between LPN/VN practice? Does the RN think more critically? The intangible differences (i.e., synthesis, application, critical thinking) are harder to measure.
- Supply and demand issues often drive using the LPN/VN in a more expanded role, sometimes outside their legal scope of practice.
- Safety is the most important consideration in all of this discussion.

Summary of Group Discussion: The delegates concluded that the practice of LPN/VNs is evolving and they questioned whether there is a gap between education and practice. Further, all three groups mentioned safety and protection of the patient as the most important consideration in these discussions. One group asserted that RNs and facilities don’t always understand “scope of practice issues,” and many of the delegates lamented that often employers and RNs don’t understand the responsibilities associated with delegation and supervision. The groups made the point that the survey represented the perceptions of LPN/VNs, and some questioned whether this was necessarily an accurate vision of what is happening in practice. One group thought the discussion of scope of practice would be clearer were we able to specifically spell out the differences between LPN/VNs, yet the delegates realized that there are hard-to-measure intangibles.

2. What are the implications of the *2003 LPN/VN Practice Analysis*, related to the LPN/VN scope of practice, to NCSBN?

Group 1 — Yellow Group

- Why is the core curriculum of the LPN/VN so inconsistent?
- Why are the LPN/VN scopes of practice in different states so inconsistent?
- Is there a better regulatory model?
- Are practice acts too restrictive?
- What are the drivers of change?
- More clarity with delegation is needed.
- More information on transition from education to practice is needed.

Group 2 — Blue Group

- Revisit the model practice act and rules to differentiate basic differences of the RN/LPN. Don’t leave the nursing assistants out of the loop.
- A white paper on LPN/VN and RN differences would be helpful.

- Raise the level of discussion between the boards of nursing so as to address the inconsistency with practice acts and rules and regulations.
- NCSBN should create dialogue between the consumers, education, regulation and practice to address this scope of practice issue. Patient rights were specifically addressed, referencing the American Nurses' Association "Social Policy Statement."
- NCSBN should be a clearinghouse for LPN/VN data, including NCSBN data (from the Taxonomy of Error, Root Cause Analysis and Practice Responsibility or TERCAP project, Profiles of Member Boards and Research Services), as well as other organizations that might collect such data.
- Collaboration with other groups and organizations was stressed.
- Drivers of society were discussed, such as the economy and technology.

Group 3 — Red

- We need to tap the resources of other groups — be a resource of data.
- Is the Member Board Profiles publication collecting enough data on LPN/VNs?
- First and foremost, the concern of NCSBN should be safety. Can NCSBN encourage states to collect and analyze data regarding practice issues/complaints?
- The LPN/VNs stated that they were best prepared for direct patient care, documentation, care planning and medications. They stated they were least prepared to interact about the patients and to supervise the care of others. These are important aspects for nursing education/regulation/practice to address.
- Delegation should be addressed by NCSBN.
- Labor Unions may be an issue.
- We can't look at LPN/VNs in isolation.

Summary of group discussion: NCSBN needs to revisit the model rules regarding scope of practice of the LPN/VN versus that of the RN. NCSBN should summarize their own data regarding PN practice, as well as look at the findings of studies of other groups. NCSBN should create a dialogue about LPN/VN scope of practice between the boards of nursing, consumers, educators and practice. Again, clarifying delegation came across strongly, as well as NCSBN's goal being to address patient safety. Two of the groups also mentioned the importance of not just looking at the LPN/VN practice issues in isolation, but with other health care providers, such as nursing assistants and RNs.

3. What are the implications of the *2003 LPN/VN Practice Analysis*, related to the scope of practice, for education and practice?

Group 1 — Yellow

- Increased collaboration and communication.
- Support mentoring.
- Drivers
 - Practice: third party payers, special interests, consumer, society, quality outcomes and safety.
 - Education: best practices, model curriculums.

Group 2 — Blue

- Developed excellent models of current practice, evolving practice and future visions.
- Is regulation futuristic enough to be a driver?
- See Appendix III: The Desired Evolution of Regulation (p. 121)

Group 3 — Red

- Regulation
 - Too restrictive.
 - Boards of Nursing need to be active in order to drive health care decisions.

- Mutual recognition is a means of evolving.
- Education
 - Need more uniform LPN/VN curriculums.
 - Competencies should be spelled out.
 - How time is counted should be uniform across programs.
- Practice
 - Need to deliver safer care
 - Do their job descriptions fit the state's scope of practice?
 - Are expectations of new graduates too high?
 - Yet, need to utilize LPN/VNs to their capacity.

Summary of group discussion: There should be stronger links and more collaboration between education, regulation and practice because of the disconnect between practice and education. Perhaps there is the need for a national model LPN/VN curriculum and/or best practices. Likewise, regulation needs to be more proactive in promoting health care decisions. The mutual recognition model is one way for regulation to continue to evolve. The utilization of the LPN/VN should be discussed in the practice arenas, especially regarding safe practice. Two of the groups identified the drivers of health care, including the consumer and quality care, economics, special interests, education, practice and regulation.

4. What are possible strategies of attaining greater universality regarding the scope of practice of LPN/VNs, across jurisdictions?

Group 1 — Yellow

- Develop white paper of these discussions and share with stakeholders to open a discussion.
- Develop model scope of practice and base national curriculum on it.
- Develop PN education best practices/standards.
- Research PN outcomes.

Group 2 — Blue

- Practical nurses need to be at the table when these education/regulation/practice decisions are being made (e.g., ANA, JACHO, etc.). This seldom occurs.
- Model curriculum — will it work?
- Identify regulatory barriers that inhibit the scope of practice.
- Educate RNs about the LPN/VN scope of practice in that state.
- Likewise, the employer must understand the state's scope of practice in order to decide upon the correct qualifications for the job.

Group 3 — Red

- There needs to be better communication of LPN/VN needs with organizations; encourage more LPN/VN representation on panels, committees, etc., that address health care issues.
- The data at the federal level should clearly differentiate LPN/VN data from RN data.
- There should be more online offerings geared toward the LPN/VN.
- We should establish a forum where educational, practice and regulatory consistency are discussed in order to increase consistency across the states, increase competency and ultimately to increase safety.

Summary of the discussion: The overwhelming finding here was that there should be greater cooperation and communication between all parties and that there is a clear need for a forum (e.g., a white paper was brought up several times) to facilitate this. PN involvement in panels, committees, etc., was also felt to be very important. Again, the idea of a model curriculum, or even a

model scope of practice, was discussed. Collecting LPN/VN data and researching the LPN/VN role was also discussed by two of the groups.

Recommendations to the NCSBN Board of Directors

Based on the discussions that were held that day, the following recommendations were presented, by motion, to the NCSBN Board of Directors at the July 2004 Board of Directors meeting. The Board unanimously approved the recommendations:

1. **White Paper:** There was strong consensus, both during small group sessions and in the large group, that the most important recommendation was for NCSBN to write a white paper capturing the discussion of the day. As much data should be included in this Paper as possible from the various research projects at NCSBN, thus making it evidence-based.

This White Paper can be used as a vehicle to develop partnerships and begin dialogue about the scope of practice of LPN/VNs with employers, associations, boards of nursing, nurse executives and educators. These partnerships can begin to promote mobility of the LPN through articulation programs, such as those that exist in Texas, Washington, Colorado and Kentucky.

This White Paper might begin dialogue to create a model LPN curriculum. It was thought that this would decrease some of the regulatory barriers that exist today. Collaboration and input from various stakeholders would be important when designing this model curriculum. Some of the groups to include would be practice, education, boards of nursing and consumers. Consumer suggestions included AARP, CAC and groups working with Alzheimer's disease.

It was this recommendation that stimulated the writing of this White Paper. It will be disseminated to practice, education and regulatory groups in order to create discussion about the LPN/VN scope of practice. Other steps taken to make nurses aware of this discussion have been:

- Articles summarizing the focus group were published in a regulatory journal and in a publication to all nursing educators from and boards of nursing (Spector, 2004; Spector, 2005).
- PN Focus Group summary on NCSBN Web site (http://www.ncsbn.org/regulation/nursingeducation_D0E4EEEC95DA434CB223B4CEEAD8B193.htm).

2. **Model Rules:** While the group realized that the Model Rules were going to be voted on in 2004 Delegate Assembly, they emphasized that this should be a dynamic document that should change as LPN/VN practice changes. Specific LPN/VN-related questions will be addressed annually at the Practice, Regulation and Education (PR&E) meetings and appropriate recommendations will be made to the NCSBN Board of Directors.
3. **NCSBN as a Central Clearing House for LPN/VN Data:** It was recognized that there are a lot of LPN data available, but those data haven't been shared with various groups. Groups that collect data on LPN/VNs should collaborate and share their data and NCSBN should make available all of the shared data. Some groups currently that are collecting data on LPN/VNs include NCSBN (practice analyses, Profiles of Member Boards, employer surveys, etc.), NLNAC, NAPNES, workforce data, AACC (American Association of Community Colleges) and discipline data from boards of nursing discipline. As to the latter source of data, the group recommended that NCSBN encourage the use of the use of the Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP) instrument by all boards of nursing. One board of nursing has statewide initiatives where they are investigating the LPN/VN scope of practice. The results of all individual studies, from boards of nursing taken together, will help us to identify best practices.

The LPN/VN data should be held in one central place. NCSBN should summarize the available in a readable form and distribute it to all stakeholders. It was emphasized that stakeholders would benefit by a two- or three-page document summarizing these results, rather a longer one that is full of raw data and graphs.

Organizations and boards of nursing were contacted, and the following sources of data were identified and will be included in this Paper:

- June Smith, PhD, RN, former NCSBN associate director of research, collected the recent NCSBN research that has addressed the LPN/VN role and scope of practice and summarized it for this Paper.
- NLN, NLNAC, NAPNES and NFLPN were contacted for research data that they might have.
 - Dr. Lin Jacobson, director of research at NLN, stated that they are conducting a survey of LPN/VNs, but that it is not yet ready to cite in this White Paper.
 - NAPNES and NFLPN cited the work done by Seago, Spetz, Chapman, Dyer, Grumbach (2004) and that study was retrieved.

- Dr. Seago provided NCSBN with the first national sample survey of LPN/VNs, from 1984 (Bentley, Campbell, Cohen, McNeill, & Paul, 1984)

- Minnesota Board of Nursing study (McEvoy, 2005).

4. NCSBN's Committee Format Should Support LPN/VNs: While there are subcommittees at NCSBN that support other groups of nurses (e.g., the APRN Subcommittee), there is not a committee that just addresses LPN/VNs. Concern was expressed that not all LPN/VN issues are discussed in NCSBN committees. There wasn't consensus, however, on whether to have a separate LPN/VN subcommittee of PR&E. While some thought it a good idea, others worried it would further separate RNs from LPN/VNs. However, there was consensus that the committees should specifically address LPN/VN issues and the Board should consider LPN/VNs when committee charges are written and when the committee members are selected. Consequently, when the NCSBN Board of Directors met in July to name committee members and to approve committee charges, care was taken to consider LPN/VN members for committees and to consider their issues with committee charges.

In summary, as can be seen, more questions than answers arose from the PN Focus Group, though that was to be expected. This was the first time a national group of people with varied LPN/VN experiences and talents met to discuss the scope of practice of LPN/VNs. The group proposed, using this White Paper as their forum, to create a dialogue and future discussions, especially related to developing a national curriculum, advocating for more LPN/VN regulatory consistency across the states, and educating practicing RNs about the LPN role.

Some of the problems the groups pointed to are already being addressed at NCSBN. For example, for two years a subcommittee studied delegation and working with others. They have written an in-depth Paper, entitled, "Working with Others: a Concept Paper" and they have developed a proposed article for the NCSBN *Model Nursing Practice Act* and a proposed chapter in the *NCSBN Model Administrative Rules*. When these are reviewed and approved by NCSBN Board of Directors and Member Boards, they will be available to guide LPN/VNs, boards of nursing, education and practice at: www.ncsbn.org. Similarly, the Practice, Regulation and Education (PR&E) Committee at NCSBN has been studying transition of education and practice for two years. They have developed a model for transition programs (available at www.ncsbn.org on the Education page) that addresses:

- The importance of the same mentor for new LPN/VNs.
- The pros and cons of specific versus general knowledge in the structure of transition programs.
- The ideal placement of transition programs (that is, are the programs best when offered before or after graduation?).
- The advantages of mandatory versus voluntary transition programs.

Further, the PR&E Committee is continuing to study transition of new LPN/VNs by investigating the outcomes of specific transition programs.

Available LPN/VN Data

NCSBN LPN/VN DATA FROM RESEARCH BRIEFS

In an unpublished Paper summarizing NCSBN's research with LPN/VNs, Smith (2004) reports that all U.S. states and territories identify a scope of practice for either LPNs or LVNs. However, Smith (2004) asserts, the practices allowed by those scopes vary widely. While most LPN/VN scopes of practice stipulate a directed role under the supervision of a registered nurse (RN), many differ in the areas of care planning, assessment, intravenous (IV) therapy, teaching and delegation. For example, some states hold the LPN/VN accountable for performing assessments, while others only allow the LPN/VN to contribute to the assessment by 'collecting data.' Similarly, some states restrict the LPN/VN role in patient education to following a previously developed teaching plan, while others do not restrict this role. The area with the most disagreement among state scopes, however, is IV therapy. Some states expect LPN/VN education programs to provide training in IV therapy and allow LPN/VNs a liberal range of IV tasks in their practice settings, while other states strictly forbid IV therapy activities and still others allow the performance of various limited IV therapy tasks after the LPN/VN has completed additional coursework.

Several recent NCSBN research studies have demonstrated a wide variety of LPN/VN practice patterns throughout the nation. While some of the variation in practice may be attributable to different state scopes of practice, it is possible that some nursing employers are requiring LPN/VNs to perform many tasks that exceed their state-mandated scopes of practice.

The *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2003) found that 43% of LPN/VNs spent various proportions of their time performing administrative roles such as coordinator, team leader or area manager, with 31% working as charge nurses. Respondents to that study reported spending equal amounts of time providing routine care and managing client care.

A total of 163 activity statements were included in the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2004). The activity statements were developed by a panel of experts to cover the full range of possible LPN/VN practice topics. Survey respondents indicated whether or not the activities applied to their specific work setting and if they did apply, they recorded the frequency with which they personally performed the activities on their last day of work. Some activities (such as those relating to care planning, assessment and teaching) were included on the survey in two ways, one indicating independent performance of the activity and the other describing a more directed role.

Of those newly licensed LPN/VNs responding to the *2003 LPN/VN Practice Analysis*, 48% reported that they independently developed clients' plans of care and 83% reported that they contributed to the development of clients' plans of care. In the area of education, 91% reported that they assisted in or reenforced education to clients/families about safety precautions and 78% reported that they independently planned and provided education to clients and families on the same topic. When asked about components of assessment, 84% reported collecting data for initial or admission health histories and 72% reported comparing the data collected for the health history to expected norms for decision-making or care planning.

Ten activity items on the *2003 LPN/VN practice analysis* addressed various aspects of IV therapy. Respondents reported involvement in those activities in the following proportions:

- 58% gave IV fluids or IV piggyback medications through peripheral IV lines.
- 32% provided medications through peripheral IV lines by IV push.
- 38% gave IV fluid, IV piggyback or IV push medications though central venous catheters.
- 53% gave total parenteral nutrition (TPN).
- 55% started initial peripheral IV lines on adult clients.
- 47% restarted IV lines on adult clients.
- 19% started or restarted IV lines on pediatric clients (age 16 years or younger).
- 28% administered blood products.
- 40% monitored the transfusion of blood products.
- 74% assessed clients' IV sites and flow rates.

An Employers Survey (Smith & Crawford, 2004a) and a Practice and Professional Issues Survey (Smith & Crawford, 2004b) were performed during the fall and winter of 2003. These surveys were designed to collect the same types of information from nurses in their first six to 18 months of practice and from nurse employers. Respondents to each of these studies were asked to comment on the working relationships of RNs and LPN/VNs in their settings. Of those respondents writing comments about RN and LPN/VN working roles, 39% of employers, 52% of LPN/VNs and 62% of RNs wrote that RNs and LPN/VNs in their settings held the same role and performed the same work or that their roles were the same except for specific activities that the RN performed for the clients of the LPN/VNs, such as admitting assessments or IV medications.

This brief overview of NCSBN research findings illustrates that LPN/VNs are being utilized to perform tasks that may or may not be included in their state's scope of practice. These findings have a number of implications for boards of nursing, nursing education programs and nurse employers.

NCSBN LPN/VN DATA FROM PROFILES OF MEMBER BOARDS

The *2002 Profiles of Member Boards* (Crawford & White, 2003) is a triennial publication that provides an overview of the regulatory environment of the 60 boards of nursing. These 60 boards of nursing comprise the Membership of (NCSBN. This rich publication includes LPN/VN data about the various requirements of the 60 boards of nursing. Relevant LPN/VN data includes:

- Approval/Accreditation data by boards of nursing.
- Minimum credit hours required for theory courses.
- Minimum number of clinical experience hours required.
- Minimum educational requirements of program administrators.
- Minimum educational requirements of program faculty.
- Mandatory and voluntary articulation programs.

- Student/Faculty ratios.
- Boards requiring clinical education facilities to be approved by the board of nursing or boards that mandate on-site visits be made to clinical facilities.
- State requirements for clinical teaching assistants in LPN/VN programs and LPN/VN student-preceptor ratios.
- Regulation of students in clinical settings.
- Guidelines for clinical experiences in non-traditional settings.
- Curriculum guidelines in LPN/VN nursing programs.
- Distance learning guidelines.
- LPN/VN criteria by for licensure by examination, including equivalency programs, such as the military programs.
- Eligibility to sit for the NCLEX-PN® examination, including those from military programs, limitations on number of times a candidate can sit for the exam and limitations on the number of times a candidate can attempt to pass the NCLEX-PN® exam without further study.
- LPN/VN qualifications for licensure by endorsement.
- Eligibility for LPN/VN licensure by endorsement.
- Temporary or Interim Permits.
- Verification of licensure.
- Required course work.
- American Disabilities Act guidelines.
- Licensure data, such as number of years license is valid, fees and licensure questions.
- Continuing education requirements.
- Periodic refresher courses.
- Competency requirements.
- Criminal background checks.
- Mandatory reporting of violations of the nurse practice act required in state.
- Investigation of complaints.
- Standard of proof.
- Alternative disciplinary approaches.
- Formal disciplinary processes.
- Disciplinary remedies.
- Characteristics of probation and fees.
- Telenursing information.

Information in the *2002 Profiles of Member Boards* (Crawford & White, 2003) that is particularly important to the LPN/VN scope of practice is the question about whether delegation appears in the nurse practice act or rules and regulations for LPN/VNs. Please see Table 1 for that information.

Table 1 — Delegation is Addressed for LPN/VNs (Crawford & White, 2003)	
Delegation in the Rules, Practice Act or Other References	Delegation is Inferred

Alabama	<p>Arizona — Questions referred to scope of practice committee — review and recommend to board.</p> <p>California-VN — In basic nursing program within supervision content area.</p> <p>Florida — Listed in statute, board rule.</p> <p>Louisiana-PN — Board memo, newsletter, Web site.</p> <p>Missouri — Specific board opinions/decisions, MSBN newsletter, board position statements, MSBN Web site, etc.</p> <p>Pennsylvania — Licensees may not delegate.</p> <p>Virgin Islands — Planning workshop for nurses and employers.</p> <p>West Virginia-PN — Published “guidelines on scope and delegation” approved by RN and LPN boards, mailed to all RNs and LPNs and used to answer all practice questions.</p> <p>West Virginia-RN — Special joint publication between RN and LPN boards which includes a scope of practice model and a delegation model.</p>
Alaska	
Arkansas	
District of Columbia	
Idaho	
Iowa	
Kansas	
Kentucky	
Maine	
Maryland	
Massachusetts	
Montana	
New Hampshire	
New Jersey	
New Mexico	
New York	
North Carolina	
North Dakota	
Ohio	
Oklahoma	
Oregon	
Rhode Island	
South Carolina	
South Dakota	
Tennessee	
Utah	
Vermont	
Washington	
Wisconsin	
Wyoming	

NCSBN SCOPE OF PRACTICE SURVEY RESULTS

In preparation for writing this White Paper the Practice, Regulation and Education (PR&E) Committee at NCSBN recommended that we conduct an electronic survey of the boards of nursing and the two LPN/VN organizations to answer some important questions on the LPN/VN scope of practice. The survey to the two organizations was slightly adapted from the survey to the boards of nursing. The specific questions on LPN/VN tasks that were addressed (e.g., IV therapy, administering blood transfusions, etc.) all were questions asked in the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2003). Since the PN Focus Group was convened to discuss the results of that survey, it made sense to use those specific task questions in this survey of the boards of nursing and LPN/VN organizations. The PR&E Committee reviewed the final draft of the survey and it was sent out electronically in February of 2005. Of the 60 boards of nursing, 48 completed the survey. The results and individual comments can be reviewed on the Education page of our Web site, which is www.ncsbn.org. Each question will be summarized here.

Question 1 — Do LPN/VNs independently develop the client’s plan of care?

A large majority of the boards (46 to 2) responded “no” to this question. A large number of respondents (14) commented that the LPN/VN should contribute to the plan of care, but that the RN or physician must approve it. One board of nursing said that this might be allowed with further education of the LPN/VN.

Question 2 — Can the LPN/VN make changes to the client’s plan of care?

Again, a large majority of the respondents replied “no” (41) to this question, with five saying yes. Again the preponderance of comments was that the RN must approve changes in the plan of care. One board of nursing said that LPN/VNs may be allowed to make changes with further education and another said that it depended on the nature of the change.

Question 3 — Can the LPN/VN decide on the level or type of care needed from a phone conversation with the client, that is can the LPN/VN perform telephone triage?

Thirty-one boards of nursing answered “no” to this question, while eight replied yes. Four of the boards said that it was allowed only when protocols or standing orders were in place. Another said that all abnormal findings must be reported to the physician or RN, while two boards of nursing said that this may be allowed with further education.

Question 4 and 8 — Can the LPN/VN independently plan and provide education to clients/families about safety precautions or on ways to manage clients with behavioral disorders?

A majority of the boards of nursing said that LPN/VNs couldn’t provide education about safety precautions (29), though 11 said yes. Five respondents said that the LPN/VN could provide education to the clients, but they also said that the total plan of care is the responsibility of the RN. Two boards of nursing said that the LPN/VN provides routine health information and instruction recognizing individual differences. One board said that the RN could assign this activity to the LPN/VN after the RN has determined that the LPN/VN is competent to provide such teaching.

The response for providing education on ways to manage clients with behavioral disorders was even more skewed; 39 said no, while four said yes. Here, four boards said that the LPN/VN needs to follow the educational plan developed by the RN supervisor. Some of these can be semantic issues; for example, one board said, “the regulation states ‘participate in health teaching.’” That means the LPN/VN and his or her supervisor has to discriminate between “participating” and “independently planning.”

Questions 5, 6, 7 and 20 — Comparing data collected for health history, psychological status, potential for violence and the client’s nutritional or hydration status to expected norms for decision making or care planning?

Table 2 — Boards of Nursing LPN/VN Requirements for Decision Making		
Decision-Making or Care Planning	Yes	No
Compare health history data to norms for decision-making or care planning?	25	17
Compare psychological data to norms for decision-making or care planning?	21	18
Compare potential for violence data to norms for decision-making or care planning?	21	19
Compare nutritional or hydration status data to norms for decision-making or care planning?	29	12

See Table 2 for a summary of how the boards differ regarding comparing data to the normal values and then making decisions or care plans based on that interpretation. The following discussion summarizes the comments for those questions.

Thirteen of the boards of nursing commented that LPN/VNs could compare the data collected for the health history to the norms and make decisions or revise the care plan when they collaborate with the RN or physician. Another said that they could do this if there were prepared guidelines and another said it could be done if it were a part of the plan.

When asked about comparing psychological status data to norms for decision-making and care planning, 10 boards said that LPN/VNs could do this in collaboration with the RN or physician. Another said that the LPN/VN would need further education to do this and yet another said the LPN/VN would have to be evaluated to see if he or she had this ability.

Similarly, when comparing the data on potential for violence to norms, for decision-making and care planning, eight boards indicated that the LPN/VN would need to collaborate with an RN or physician in order to do this. As in the above question, boards indicated that further education or evaluation would be needed before LPN/VNs could carry out these functions.

When comparing nutritional or hydration data to the norms and making decisions about the care plan, 10 boards commented that LPN/VNs could do this, but that they would need to report to the RN or physician. Another board included the distinction that the RN develops the care plan, while the LPN/VN contributes to it.

Questions 9 and 10 — Can LPN/VNs monitor and administer transfusions of blood products?

Thirty-six boards of nursing allow LPN/VNs to monitor blood transfusions, though five do not. However, only 18 boards of nursing allow LPN/VNs to administer blood products, while 22 do not. One board commented that its law is silent on both issues. Five boards said that LPN/VNs aren't taught to monitor blood transfusions in their basic programs so they must document further training in this area before they are allowed this responsibility. Another three boards say that LPN/VNs can administer blood transfusions when they provide evidence that they have had further training.

Questions 11, 12, 13, 14, 15, 16 and 18 all address intravenous (IV) responsibilities: Can LPN/VNs assess client's IV site and flow rate? Give a medication through a peripheral IV line by intravenous piggyback (IVPB) or IV? Provide medications by intravenous push (IVP)? Give IV fluid or IVPB/IVP medication through a central venous catheter? Give total parenteral nutrition (TPN)? Start or restart an IV line on a client 16 years or younger? Restart an IV line on a client 16 years or older?

IV Activity	Yes	No
Assess IV site and flow rate?	40	3
Give medications through a peripheral line (IV or IVPB)?	39	2
Medications given IVP through a peripheral line?	22	18
Medication given IVPB or IVP through a central line?	23	19
Give TPN?	27	16
Start or restart an IV on a client 16 years old or younger?	29	13
Start or restart an IV on a client older than 16 years?	34	7

As can be seen from Table 3, there is much variation with IV requirements for LPN/VNs in the boards of nursing, as has been stated (Smith, 2004). Assessing the site and monitoring the flow rate, along with starting or restarting IVs on adults seem to be the most universal of the IV responsibilities. Giving medications IVP has the most divergence across the 60 boards of nursing. Some of the comments with IVs addressed the necessity of the LPN/VN needing further education, or becoming certified, in order to carry out these functions. One board of nursing stated that its rules were silent on this issue. Another board of nursing gave a very detailed list of specific drugs that could be given by LPN/VNs; with these details the RN or pharmacist must mix the medication and the first dose of all medications must be given by the RN. Other boards also said that the LPN/VN could administer medications by the IV route as long as they were premixed and pre-labeled and other boards indicated that there were certain medications that LPN/VNs are allowed to administer by the IV route. Another board of nursing stated that only the LPN/VN who works in chronic dialysis could give specific IVP medications. Still another board of nursing said that LPN/VNs could only administer heparin or saline by the IVP route. Another board wrote in detail about IV responsibilities being a delegated function; that means then that the RN must make the decision that the LPN/VN has been adequately trained to carry out these responsibilities. A few boards of nursing leave the decision to the agencies where the LPN/VNs work.

With TPN, again, three boards commented that the LPN/VN would need to be certified before they could administer TPN. Another board of nursing said that the RN would have to initiate TPN, but the LPN/VN could then administer TPN.

On the question referring to starting or restarting IV lines on clients 16 years or younger, six boards of nursing commented that the LPN/VNs could do so with additional training. Some boards of nursing had different age requirements: one board said an LPN/VN cannot start or restart an IV on a client 12 years of age or younger or under 80 pounds; another board just said under 12 years old. Another board has age two as the cutoff, another has age four and yet another has age 18. Two boards mention that RNs can delegate this responsibility, but they must verify the training and competence of the LPN/VN before doing so. Another board specified that the IV could be started or restarted using a peripheral access device that is three inches or less in length.

Question 17 — Can LPN/VNs lead group discussions?

Twenty boards of nursing allow LPN/VNs to lead group discussions, while 14 do not. Four boards of nursing said that it depends on the discussion and three more say that it is allowed only if the LPN/VN has had further education. Three boards of nursing

say that the law is silent on that issue. One board of nursing said that this would be considered “counseling” and that is considered outside the scope of an LPN/VN. Another said that the RN could delegate this responsibility, though he or she would have to verify the competency of the LPN/VN.

Questions 26 a-f — Definitions for independent LPN/VN practice, LPN/VN decision making, assessment by LPN/VN, focused assessment by LPN/VN, delegation and assignment.

Table 4 — Board of Nursing Definitions		
Written Definitions?	Yes	No
Independent practice	10	33
Decision-making	9	34
Assessment	18	27
Focused assessment	9	34
Delegation	27	17
Assignment	11	32

Table 4 lists the number of states that do have written definitions of these terms. The states that have definitions were asked to provide them, but those comments were too detailed for the purposes of this Paper; however, the results can be found at www.ncsbn.org, on the Education page. The following are some highlights of that discussion:

- Independent practice
 - While one state comments that the LPN/VN practices under the guidance of an RN on a selected basis, within safe limits, the role of the LPN/VN may be expanded.
 - Little or no supervision.
- LPN/VN decision making
 - Makes decisions about care.
 - Depends on the level.
 - Linked to the process of delegation.
 - One state has a decision-making model.
- Focused assessment
 - Assessment with recurrent health problems.
 - Collection of “additional data.”
 - Initial and ongoing data collection.
 - Decisions that are focused within the LPN/VN scope of practice.
- Delegation
 - Transfer of authority.
 - Delegator retains accountability.
 - Must delegate to those who are qualified, competent and legally able to perform those duties.
 - One board defined it as “assigning.”
- Assignment
 - Giving others duties to perform.
 - Person receiving assignment must be authorized to perform that care.
 - Job description for a particular day.

Questions 29 & 30 — Do you allow your LPN/VNs to delegate or assign?

While 28 boards of nursing allowed their LPN/VNs to delegate, 33 allowed them to assign. Twelve boards of nursing responded that they do not allow delegation, while seven do not allow LPN/VNs to assign. Generally, the comments addressed to whom the LPN/VNs can delegate or assign, including LPN/VNs or assistive personnel (e.g., certified nurse assistants). One board said that they are requiring the LPN/VN programs to teach delegation information, with a focus on long-term care.

Questions 27 & 28 — Does your state have provisions for certification of LPN/VNs (i.e., LPN licensure designation)? If so, is that scope of practice different?

Only six boards of nursing have certification provisions, whereas 36 replied that they did not. Of those six who do have certification provisions, four allow a broader scope of practice. The specific certification addressed in the comments was IV certification.

Table 5 — Other LPN/VN Responsibilities Allowed by Boards of Nursing		
Activity	Yes	No
Change/reinsert gastrointestinal tube (g-tube)	30	10
Laser removal of unwanted hair	8	30
Perform a microderm abrasion procedure	6	30
Assist in the removal of body wastes by peritoneal dialysis	31	6
Assist in the removal of body wastes by hemodialysis	30	5
Monitor a client recovering from conscious sedation	25	16

Table 5 lists whether the boards of nursing allow six very specific functions that also were addressed in the *2003 LPN/VN Practice Analysis* (Smith & Crawford, 2003). In the comments section of the survey, some boards of nursing made some very specific comments, such as, when referring to the g-tube insertion, “Yes, if the tract is well-healed with no complications such as infection, etc.” Other boards, for many of these functions, said that they would be allowed if the LPN/VN had further education. Some boards spelled out their policy on delegation in the comments section. Other boards commented that they did not have regulations that addressed these tasks. One board, regarding conscious sedation, said, “We have not addressed this, but I imagine it is happening.”

Question 31 — Does your state have a statewide LPN/VN articulation program?

Nineteen boards of nursing stated that they have a statewide articulation program, while 20 said that they don’t.

In summary, this survey to the boards of nursing and the LPN/VN organizations documents the wide variance in the practice acts and the administrative rules regarding LPN/VN practice. This variation particularly seems to exist with allowing LPN/VNs to administer IV medications and blood transfusions, make decisions based on comparing data to the normal and independently plan and provide education to clients and their families. The boards of nursing had some agreement in that they generally didn’t allow the LPN/VN to independently develop the plan of care, make changes in the plan of care and perform telephone triage.

SEAGO ET AL., 2004, “SURVEY, DEMAND AND USE OF LICENSED PRACTICAL NURSES”

Seago et al., 2004, wrote an excellent, comprehensive document on LPN/VNs that included demographics, scope of practice and practice acts, education, factors affecting supply and demand and perspectives of the employers, educations and state boards of nursing. They collected data from primary and secondary sources and they selected four states where they conducted in-depth qualitative research, using focus groups and interviews with LPN/VN employers, educators and state boards of nursing. The complete document can be accessed at http://bhpr.hrsa.gov/healthworkforce/reports/lpn/LPN1_5.htm. This White Paper will focus on Chapter 3 of that document, which addresses the scope of practice and practice acts.

The Report states that points of contention surround the words “assessment,” “delegation,” “supervision,” “decision making” and “critical thinking.” NCSBN found that a majority of the boards responding to this question (28 out of 40 that answered that question) allow “delegation” in their states, though there was wide variance with “decision-making.” As Seago et al. (2004) assert, it is difficult to distinguish between collection of data and assessment.

Seago et al. also collected data from the boards of nursing that regulate LPN/VNs and they found substantial variation in the restrictiveness in the scopes of practice, as was found in the NCSBN survey. Further, after reviewing the board of nursing practice acts, they found some to be highly specific, while some were quite vague. Seago et al. (2004, p. 31) defined "restrictiveness" as "limiting the level of autonomy, flexibility or independence in the practice of LPNs." These authors then rated each board of nursing on restrictiveness in Appendix C of their publication, with 4 being the most restrictive and 1 being the least restrictive. They also, in the same appendix, rated each board of nursing as to specificity (4 most specific; 1 least specific), which they defined as "explicating defined parameters of practice of LPNs" (Seago et al., 2004, p. 31). Three principal investigators of the study categorized the practice acts of the boards of nursing and they had established criteria to denote agreement. On the restrictiveness scale, 15 boards of nursing were rated as 1 (least), 24 as 2, 11 as 3 and 2 as 4 (most). On the specificity scale, 14 boards were listed as 1 (least), 20 as 2, 6 as 3 and 12 as 4 (most). Their focus group data from Louisiana, Massachusetts, California and Iowa indicated that the employers restrict LPN/VN practice even more than the regulations require.

This publication has some very specific information about board of nursing requirements of LPN/VNs, such as the results of a board of nursing survey regarding IV medications, as well as an excellent table showing each state's specific scope of practice with certain functions (such as IVs, dressings and care planning), along with requirements of supervisors (such as cosigning documentation).

Again, these data point to wide variations across the country with LPN/VN regulations for scope of practice. Interestingly, in their conclusion, Seago et al. (2004) wonder if the expanded scope of practice of an LPN/VN leads to increased salary in the workplace. In their recommendations, they suggest that:

- States with the most restrictive scopes of practice should reduce those restrictions, unless it is clear that a restriction would negatively impact patient care.
- Workplaces create teams of LPN/VNs that share the workload.
- The RN and the LPN/VN should have a better understanding of the scope of practice and that the difference between the workplace scope of practice and the state board of nursing scope of practice should be clarified.
- Educational work toward standardization of LPN/VN educational preparation.
- States create articulation pathways between the LPN/VN and RN.
- While LPN/VNs cannot substitute for RNs, many tasks traditionally carried out by RNs can be carried out by the LPN/VN.
- While the LPN/VN could be used to augment the workforce during the current nursing shortage, this will depend on the ability of states to create a more flexible LPN/VN scope of practice.
- It is unlikely that the LPN/VN will substantially ease the RN shortage because LPN/VNs fall into the same worker pool.
- Employers should consider increasing wages when LPN/VNs receive additional training or education.
- Consider using the LPN/VN predominantly in long-term care, and not in acute care.
- Educate the public about the LPN/VN, both to give them recognition and to encourage people to pursue a career in practical nursing.

"FIRST NATIONAL SAMPLE SURVEY OF LICENSED PRACTICAL AND VOCATIONAL NURSES, 1983"

Bentley et al. (1984) conducted the first national survey of LPN/VN data. A survey was sent to 22,004 LPN/VNs between November 16–23, 1983. Of those sent out, they received 8,240 completed questionnaires back. The sampling design was a two-stage, multiple-frame alphabetic cluster design, with the population being all licensed LPN/VNs. The lists of LPN/VNs were obtained by the state boards of nursing in all 50 states and the District of Columbia. There are a number of tables in this document, though beyond a very brief explanation of the study design and a summary of the results, there was no analysis of this study, nor were there any conclusions or recommendations.

The categories of data collected in this survey were:

- Number of LPN/VNs
- Sex and race
- Age
- Marital status and children

- Employment status
- Spouse education
- LPN/VN license data
- Educational background
- Continuing education
- Employment settings
- Employment titles
- Hours and earnings
- Temporary employment services
- Status of those not employed
- Geographic mobility
- Change in employment status

“SCOPE OF LPN PRACTICE STUDY TO IDENTIFY CONGRUENCIES AND INCONGRUENCIES AMONG LPN REGULATIONS, EDUCATION AND PRACTICE, JANUARY 2005” MINNESOTA BOARD OF NURSING AND MINNESOTA COLLEAGUES IN CARING

McEvoy’s (2005) Report to the Minnesota Board of Nursing outlined the purpose of the LPN Task Force, which was to:

- Identify congruencies and incongruencies among LPN regulations, education and practice.
- Make recommendations based on identification of incongruencies.

This group collected documents that reflect the education, practice and regulation of LPN/VNs in the state of Minnesota. The group was concerned that the practice of LPN/VNs in that state wasn’t congruent with their education and the state regulations. Therefore, a random sample of LPNs in Minnesota according to practice area and geographic area were surveyed. They had a 64.3% response rate with this survey. Their significant findings included:

- Confusion with the terms “observation” and “assessment;” these terms lacked congruency across education, practice and regulation. Therefore, they recommended that the nature of observation and assessment needs to be clarified and differentiated from assessment and observation in RN practice.
- Confusion with the terms “delegation” and “supervision” in LPN/VN practice because of incongruence among regulations, education and practice. They recommended that ongoing education on the use of supervisory positions is needed, with clear examples of how to communicate the role differentiation between the LPN/VN and RN.
- No consistent statewide trends with urban or rural settings and long-term care and acute care. Therefore, the Committee recommended that scope of practice be state specific, not geographic or practice specific. Further study of practical nursing practice in long-term care and rural acute care is warranted.

Conclusions

Based on the results of the PN Focus Group, the survey to the boards of nursing, and internal and external research results on LPN scope of practice, it is clear that the states are quite varied with regard to the LPN/VN scope of practice. A strong recommendation in this white paper is that dialogue with nursing practice, regulation and education must take place, addressing:

- Developing initiatives to enhance the mobility of practical nurses by establishing statewide articulations programs.
- Establishing a national practical nurse curriculum.
- Decreasing the wide disparity that is present in the Nurse Practice Acts regarding the practical nurse scope of practice.
- Developing a national clearinghouse for practical nurse data.
- Providing education to all health care workers about the LPN/VN scope of practice.
- Conducting more research on the practical nurse scope of practice.

Appendices

- I. PN Focus Group Members
- II. Algorithm for Discussion
- III. The Desired Evolution of Regulation

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Appendix I

PN Focus Group Members

Marcia Hobbs, DSN, RN
NCSBN Board Member Vice President (until August 2004), Kentucky Board of Nursing

Anita Ristau, MS, RN
Executive Director, Vermont Board of Nursing

Marjesta Jones, LPN
NCSBN Board Member Director-at-Large (until August 2004), Alabama Board of Nursing

Claire Glaviano, MN, RN
Executive Director, Louisiana State Board of Practical Nurse Examiners

Mariann Williams, BSN, MPH, MSN, RN
Washington Board of Nursing

Marianna Kern Gracheck
Executive Director, Joint Commission's Long Term Care Accreditation

Marilyn Smidt, MSN, RN
Director of Nursing Programs, National League of Nursing Accrediting Council (NLNAC)

Donna M. Herrin, NSN, RN, CNA, CHE
Senior Vice President and Chief Nurse Executive, Methodist Healthcare

Casey Marks, PhD
NCSBN Associate Executive Director — Business Operations

Gregory Tyrone Howard, LPN
President, National Federation of Licensed Practical Nurses (NFLPN)

Patricia Shutt, LPN
President, Nevada State Board of Nursing

Susan C. Reinhard, RN, PhD
Rutgers, The State University of New Jersey

Richard R. Kerr, LPN
President, National Association for Practical Nurse Education and Service (NAPNES)

Mr. Richard English, LCGI
Group facilitator

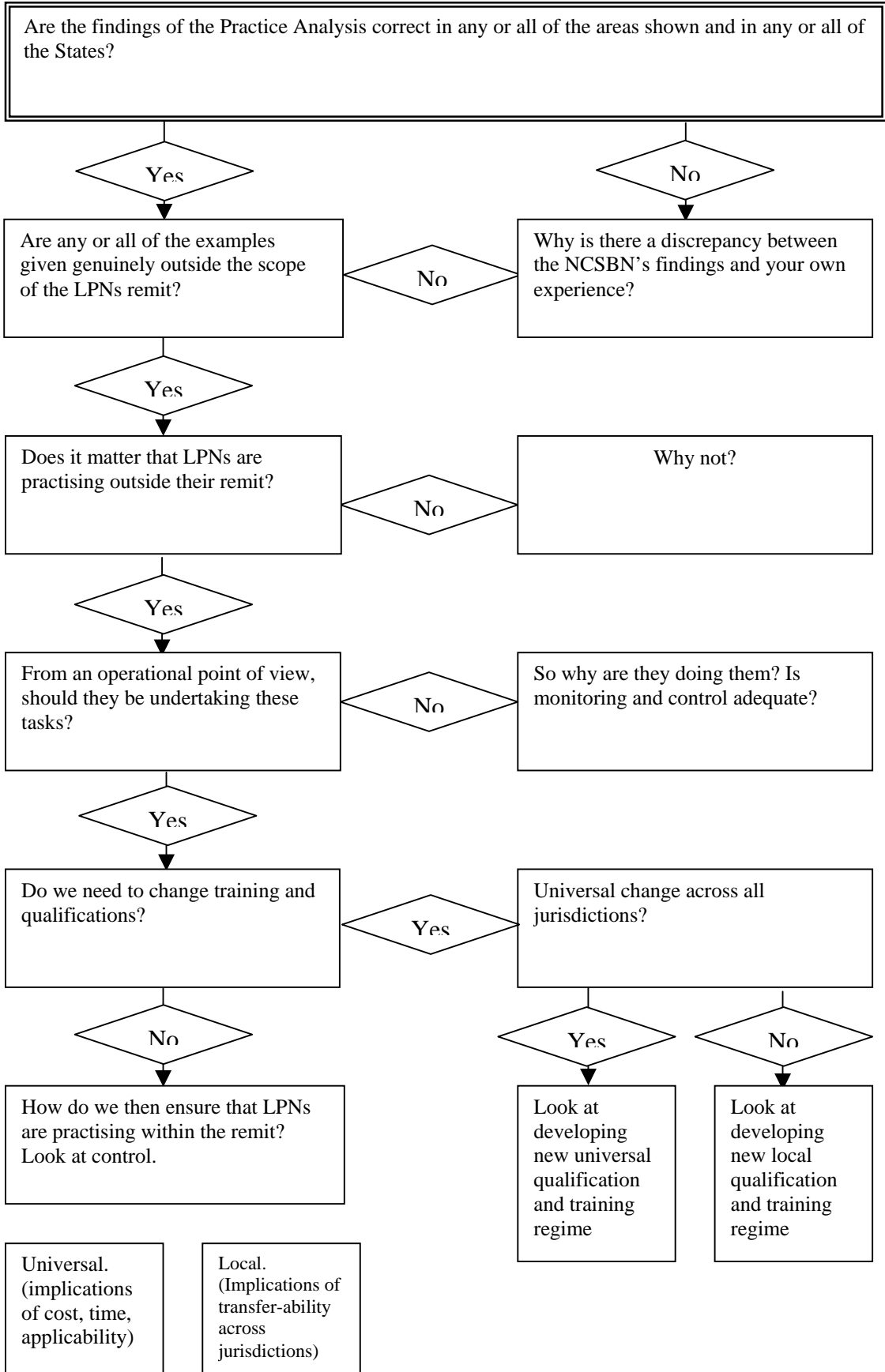
Lanette Anderson, BSN, JD, RN
Executive Secretary, West Virginia-PN Board of Nursing

Kathy Apple, MS, RN, CAE
NCSBN Executive Director

Rose Kearney-Nunnery, PhD, RN
President, South Carolina Board of Nursing

June Smith, PhD, RN
NCSBN Associate Director of Research Services (until 2004)

Appendix II
Algorithm for Discussion



Appendix iii

Now and/or Desired (Evolving)

