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Report of the Uniform Licensure Requirements and Portability Committee

Recommendation to the Delegate Assembly

*Adopt the proposed revision to the Uniform Licensure Requirements (ULRs).*

**Rationale:**
The newly revised ULRs are the result of the 2008 Delegate Assembly Resolution that the 1999 Uniform Core Licensure Requirements (UCLRs) be reviewed for currency and relevance. The proposed 2011 revised ULRs will set new national standards for licensure and bring uniformity across all jurisdictions. Adoption of the new ULRs will also demonstrate to external stakeholders, the federal government and consumers that boards of nursing are interested in establishing uniformity and easing the portability of nurses in the U.S. The revised ULRs utilized extensive feedback from the membership and are based on available evidence.

**Background**
In 1999, NCSBN undertook a major initiative to develop minimal licensure requirements. The goal was to set minimal standards, as well as provide a uniform set of requirements for adoption across all jurisdictions. Upon recommendation by an appointed committee and approval of the NCSBN Board of Directors (BOD), the 1999 UCLRs were adopted by the Delegate Assembly. Enactment 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, many variances emerged and uniformity was not achieved.

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, especially in regards to licensure.

During the 2008 Delegate Assembly, a resolution was passed requesting that the UCLRs be reviewed and updated. In response, the current Uniform Licensure Requirements and Portability (ULR) Committee was established. The committee was originally made up of 10 members: five from compact states and five from noncompact states (although there has been some attrition of members due to various reasons). All four areas of NCSBN are represented on the committee. The committee also consists of members from both umbrella and independent BONs.

The ULR Committee’s first set of draft requirements was distributed during fall 2009 to Member Board executive officers and presidents in all jurisdictions. All feedback was carefully reviewed and discussed. Modifications were made based on the Member Boards’ feedback and a revised draft was submitted to the BOD in February 2010. The second draft of the ULRs was presented and discussed at the 2010 NCSBN Midyear Meeting. All comments and suggestions were carefully examined and discussed by committee members. Based on this feedback, revisions 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 of a 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 all states. The BOD requested that the ULR Committee reconvene to find further evidence to support the recommendations related to these issues. In addition, they requested further evidence for removing the ULR functional abilities. The BOD gave the committee an additional charge for fiscal year 2011 (FY11) to develop a common licensure application and process.

The committee has used a variety of resources in its deliberations. It consulted legal counsel; experts in the field of criminal and police psychology and education; thoroughly examined each
state’s requirements, as well as variances; considered all comments made at the 2008 UCLR Conference (two members of every BON were invited and sponsored by NCSBN to attend); and considered all feedback provided at the 2010 and 2011 NCSBN Midyear Meetings. In summary, the following resources were used by the committee:

a. 1999 UCLRs;

b. 2008 UCLR Survey to Member Boards;

c. Comments, feedback and concerns that emerged from the small-group breakout sessions at the 2008 UCLR Conference;

d. Positions of the NCSBN Delegate Assembly and BOD that relate to licensure;

e. State information on criminal background checks and fingerprint systems, including the Rap-Back System;

f. Americans with Disabilities Act (ADA);

g. NCSBN Member Board Profiles;

h. An action plan from NCSBN and the Nurse Licensure Compact Administrators (NLCA), which emerged from the 2008 focus groups; and

i. Scientific literature.

For a complete list of references, see Attachment C.

Expert consultation was provided by Victoria Priola Surowiec, PsyD, director of Police Psychology, Adler School of Professional Psychology; Stephen Griffin, PsyD, police and public safety psychologist; Thomas Abram, JD, attorney at law, Vedder Price; Nathan Goldman, JD, general council, Kentucky Board of Nursing; and Karen Holm, PhD, RN, FAAN, professor of nursing, DePaul University.

**Highlights of FY11 Activities**

FY11 charges:

1. Further refine the proposed revisions to the ULRs.

2. Develop a common licensure application and process.

The following is a comprehensive summary of the committee’s accomplishments in meeting these charges:

**FURTHER REFINE THE PROPOSED REVISIONS TO THE ULRS.**

During FY11, the committee focused primarily on the three licensure requirements that the BOD asked it to review and reconsider:

- Licensure with or without graduation;
- Criminal bars to licensure or case-by-case decisions; and
- Assessment of functional ability prior to licensure.

The following summarizes the committee’s decision in each of these areas:

**Licensure with or without graduation**

While there was no hesitancy on the part of any committee member to recommend that an applicant graduate must receive a degree from a nursing program (or have completed all requirements for the degree/graduation) prior to taking the NCLEX®, it was incumbent upon the committee to take newer models of nursing education into consideration when developing the ULRs. The programs that were of greatest concern to the committee were the 65 direct entry generic master’s programs that do not award a degree prior to having students take the NCLEX and obtain licensure. These are nursing programs for non-nurses holding a degree from another discipline. These Member Board-approved programs begin with prelicensure registered
nurse (RN) studies and students continue on through the master’s portion of the program without being awarded a bachelor’s degree. Schools are unable to award a bachelor’s degree at the time the prelicensure portion of the program is completed (for varying logistical reasons); however, they request that students be allowed to take the NCLEX and receive RN licensure if the NCLEX is successfully completed so they can partake in advanced level clinical rotations during the master’s portion of the program. Upon program completion, these students are awarded a master’s degree. While there are cases where students drop out of the program after receiving an RN license, the majority go on to finish the program (Fitzgerald Miller, & Holm, 2011). In addition to taking an in-depth look at these programs and weighing the consequences of making an exception for these students, the committee also reviewed data from a Member Board survey that focused on these programs. It spoke directly with Holm, one of two principle investigators on a study that specifically looked at the direct entry generic master’s programs from a national perspective. The committee concluded that there is no evidence of any higher rates of discipline or other issues related to public protection with these licensees. In keeping with the Institute of Medicine’s The Future of Nursing, Leading Change, Advancing Health report, the committee wanted to support innovation, advanced education and did not want to place unnecessary regulatory barriers on programs that had excellent reputations. This issue was discussed in Area Meetings at both the 2010 and 2011 NCSBN Midyear Meetings and based on feedback, the committee is recommending the following ULR:

Graduation or eligibility for graduation from a Member Board-approved RN program.

The committee added one exception for students enrolled in a second-degree generic master’s program: Successful completion of all prelicensure nursing courses with attestation from program director or dean.

Criminal bars to licensure or case by case decisions

The committee studied the literature regarding this subject and consulted two of the leading experts in this field, Priola Surowiec and Griffin. Both have an expertise in the area of criminal and police psychology. The experts pointed the committee to an abundance of data in psychology literature, which provides evidence that licensure decisions should be made on a case-by-case basis. There are numerous factors that can predict whether the individual is likely to recidivate and for this reason, the committee recommended that BONs use evidence-based criteria to make licensure decisions. The experts drew the committee’s attention to one very important exception: there is a plethora of scientific evidence that sexual predators and pedophiles should never be licensed. They stated that the recidivism rates for these diagnoses is near 100 percent and these individuals pose a major risk to public safety. They recommend that any individual charged with a sexual offense be evaluated by a BON-approved qualified expert. Any individual diagnosed as a sexual predator or pedophile should be barred from licensure. For this reason, the committee has proposed the following ULR for initial, renewal, reinstatement and endorsement licensure:

Assessment of all misdemeanor convictions, felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure on a case-by-case basis to determine board action.

Psychological evaluation for all individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person. This evaluation should be performed by a qualified expert approved by the BON. If the evaluation reveals a diagnosis of sexual predator or pedophilia the BON should deny licensure.

Assessment of functional ability prior to licensure

The committee recommends elimination of a ULR related to functional ability. This was determined by reviewing the ADA, several studies related to this topic and consultation with Abram, legal counsel for NCSBN. Goldman, legal counsel for the Kentucky of Board of Nursing, was also consulted. It was the opinion of both attorneys that a question regarding functional abilities should
not be asked on a licensure application. The committee concurred with this recommendation and the discussion was summarized in a memorandum by Abram (see Attachment C).

**DEVELOP A COMMON LICENSURE APPLICATION AND PROCESS**

The committee has developed a draft licensure application; however, the committee is aware that the ULRs need to be adopted by the Delegate Assembly first. Any changes to the ULRs by the Delegate Assembly will warrant changes in the application (see Attachment D). The committee does not feel this work is completed and did not have an opportunity to develop a common licensure process.

**Future Activities**

1. Based on the knowledge the committee has acquired, it recommends that the BOD convenes an expert panel (as with the Chemical Dependency Committee) to develop a set of guidelines for BONs to use in the evaluation of criminal convictions.
2. The committee requests reappointment in order to complete the second charge: develop a common licensure application and process.
3. An additional new charge is also recommended: develop toolkit for implementation of the ULRs.

**Attachments**

A. References
B. 2011 Uniform Licensure Requirements (ULRs)
C. Licensure Decisions Based on Functional Abilities Memorandum
D. Draft of Common Licensure Application
Attachment A

References


Additional References


Attachment B

2011 Uniform Licensure Requirements (ULRs)

ULRs are the essential prerequisites for initial, endorsement, renewal and reinstatement licensure needed across 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 of 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 NCSBN Member Boards unite in a common goal of adopting the ULRs into their state/territorial practice act/regulations by 2016.

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<tr>
<td>Graduation from or verification of completion and eligibility for graduation from state-approved registered nurse (RN) program.</td>
<td>• Graduation or eligibility for graduation from a Member Board-approved RN program.*</td>
<td></td>
<td>• Verification of graduation or eligibility for graduation from a Member Board-approved RN program</td>
<td>1. Language changed to “Member Board,” as defined in the ULR definitions, to include all jurisdictions.</td>
</tr>
<tr>
<td>*For students enrolled in a second-degree generic master's program, successful completion of all prelicensure nursing courses with attestation from program director or dean is required.</td>
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*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.
<table>
<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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<td>5. The exception is made for students from second-degree, generic master's programs. The ULR allows that these students be allowed to take the NCLEX® after they have completed the prelicensure portion of the master's program. There are 65 direct-entry generic master's programs in the U.S. These schools are well established and students have high NCLEX pass rates. Due to varying logistical reasons, these programs are unable to award a degree at the time the prelicensure portion of the program is completed; however, students enrolled in these programs need an RN license in order to complete the second half (master's portion) of the program. There is no evidence that allowing these students to take the NCLEX and be licensed as RNs prior to completing the master's portion of the program poses any risk to the public.</td>
</tr>
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</table>
| **1999 UCLR**  
<table>
<thead>
<tr>
<th>Education Requirement: LPN/VN</th>
<th><strong>2.A. 2011 Nursing Education Requirements: LPN/VN</strong></th>
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</thead>
<tbody>
<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>
</tr>
<tr>
<td></td>
<td>• Graduation or eligibility for graduation from a Member Board-approved LPN/VN program.*</td>
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<td>*Graduates from RN programs who wish to take the NCLEX-PN® must successfully completed a Member Board-approved LPN/VN role delineation course.</td>
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*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.
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<tr>
<td><strong>Graduation from nursing programs comparable to U.S. state-approved RN nursing programs as verified by credentials review agency.</strong></td>
<td><strong>Applicant Responsibility</strong>&lt;br&gt;• Graduation from a nursing program comparable to a Member Board-approved RN program.</td>
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<tr>
<td><strong>Graduation from nursing programs comparable to U.S. state-approved LPN/VN nursing programs as verified by credentials review agency.</strong></td>
<td><strong>Applicant Responsibility</strong>&lt;br&gt;• Graduation from a nursing program comparable to a Member Board-approved LPN/VN program.</td>
</tr>
<tr>
<td>1999 UCLR NCLEX® Requirements</td>
<td>5.A. 2011 NCLEX® Requirements</td>
</tr>
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<tr>
<td>U.S. Candidates-RN: NCLEX-RN, unlimited attempts.</td>
<td>Successful completion of the NCLEX-RN or NCLEX-PN.</td>
</tr>
<tr>
<td>U.S. Candidates-LPN/VN: NCLEX-PN, unlimited attempts.</td>
<td>Verification applicant successfully completed NCLEX-RN or NCLEX-PN.</td>
</tr>
<tr>
<td>Foreign-educated Candidates-RN: NCLEX-RN, unlimited attempts.</td>
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<tr>
<td>Foreign-educated Candidates-LPN/VN: NCLEX-PN, unlimited attempts.</td>
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<tr>
<td>1999 UCLR Additional Requirements for Foreign-educated Nurses</td>
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<tr>
<td><strong>6.A. 2011 Additional Requirements for Foreign-educated Candidates</strong></td>
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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 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 nursing licensure status in country of origin, if applicable.</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>3. Credentials review has been placed under 3.A and 4.A.</td>
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</tbody>
</table>

- 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.
- 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.
<table>
<thead>
<tr>
<th>1999 UCLR Criminal Background Check Requirements: RN and LPN/VN</th>
<th>7.A. 2011 Additional Public Protection Requirements: Criminal Background Check</th>
</tr>
</thead>
</table>
| 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. BONs should require psychological evaluation for all sexual offenders by a qualified expert approved by the BON. | **Applicant Responsibility**  
- Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld).  
- Submit state and federal fingerprint checks  
- Assessment of all misdemeanor convictions, felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure on a case-by-case basis to determine board action.  
- Psychological evaluation for all individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person. This evaluation should be performed by a qualified expert approved by the BON. If the evaluation reveals a diagnosis of sexual predator or pedophilia the BON should deny licensure. |
| **Board Duty**  
1. Expanded to provide BONs with maximum information to make licensure decisions regarding all violations of the law.  
2. Numerous scientific studies support this requirement. In addition, the requirement is based on the recommendation provided by two nationally recognized experts in the field of criminal psychology. |
| **Rationale for Change** |

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<tr>
<td>• Chemical Dependency: Self-report regarding any drug-related behavior that affects the candidate’s ability to provide safe and effective nursing care.</td>
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<tr>
<td>• Self-report regarding any functional ability deficit that would require accommodation to perform essential nursing functions.</td>
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<tr>
<td><strong>Applicant Responsibility</strong></td>
<td><strong>Board Duty</strong></td>
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| • Self-disclosure of any substance use disorder in the last five years. | • Verification of any applicant for licensure who may be impaired by drugs or alcohol that affects her/his ability to practice nursing safely. | 1. After reviewing the Americans with Disabilities Act (ADA) and in consultation with legal counsel, it was determined that licensure decisions based on self-disclosure regarding physical disabilities is impractical due to the many different practice settings and differing physical demands for each setting. Basing licensure on this information would require BONs to assess the individual, the functional ability deficit and the accommodations that may or may not be needed. The employer is in the best position to determine whether a nurse can function safely in a particular role and setting.
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. |
<table>
<thead>
<tr>
<th>1999 UCLR Other Licenses, Certifications and Registrations Requirements: RN and LPN/VN</th>
<th>9.A. 2011 Additional Public Protection Requirements: Other Licenses, Certifications and Registrations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applicant Responsibility</strong></td>
<td><strong>Board Duty</strong></td>
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<tr>
<td>• Self-disclosure of any actions taken or initiated against a professional or occupational license, registration or certification.</td>
<td>• Verification 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>
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## B. 2011 Renewal/Reinstatement Requirements

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<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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| Self-disclosure of all misdemeanors and/or felony convictions and plea agreements (even if adjudication was withheld) not previously reported to the BON. | • Verification of all misdemeanors, felony convictions and/or 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).  
• Psychological evaluation for all individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person. This evaluation should be performed by a qualified expert approved by the BON. If the evaluation reveals a diagnosis of sexual predator or pedophilia the BON should deny licensure renewal or reinstatement.  
• Examine all other cases on an individual basis. | 1. Recommendation adds state and federal fingerprint checks for renewal. This recommendation takes into account future technology of fingerprint and criminal background check 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 criminal background 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. Numerous scientific studies support this requirement. In addition, the requirement is based on the recommendation provided by two nationally recognized experts in the field of criminal psychology. |
### 2.B. 2011 Substance Abuse

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<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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<tr>
<td>Self-disclosure of any substance use disorder in the last five years.</td>
<td>Verification of any applicant for renewal or reinstatement of licensure who may be impaired by drugs or alcohol that affects her/his ability to practice nursing safely.</td>
<td>1. 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>
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### 3.B. 2011 Nursing Disciplinary Actions

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<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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<tr>
<td>Self-disclosure of any Member Board action taken on a nursing license or current/pending investigation by a Member Board.</td>
<td>Verification of any Member Board action taken on a nursing license or current/pending investigation by a Member Board.</td>
<td>1. 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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<tr>
<td>Check Nursys® for discipline in other jurisdictions.</td>
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### 4.B. 2011 Other Licenses, Certifications and Registrations

<table>
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<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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<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>1. 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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### C. 2011 Endorsement Requirements

#### 1.C. 2011 Education, Exam and Licensure Verification

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<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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<tr>
<td>Completion of a Member Board-approved professional nursing or practical nursing education program.</td>
<td>Verification of education.</td>
<td>1. 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 participation in an alternative to discipline program in any jurisdiction.</td>
<td>Verification of all nursing licenses.</td>
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## 2.C. 2011 Criminal Background Check

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<thead>
<tr>
<th>Applicant Responsibility</th>
<th>Board Duty</th>
<th>Rationale for Change</th>
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<tbody>
<tr>
<td>• Self-disclosure of all misdemeanors, felony convictions and plea agreements (even if adjudication was withheld).</td>
<td>• Verification of all misdemeanor and/or felony convictions and plea agreements (even if adjudication was withheld) of all individuals applying for licensure.</td>
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<tr>
<td></td>
<td>• State and federal fingerprint checks.</td>
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<td></td>
<td>• Psychological evaluation for all individuals convicted of a sexual offense involving a minor or performing a sexual act against the will of another person. This evaluation should be performed by a qualified expert approved by the BON. If the evaluation reveals a diagnosis of sexual predator or pedophilia the BON should deny licensure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• All other convictions should be determined on a case-by-case basis.</td>
<td></td>
</tr>
</tbody>
</table>

## 3.C Substance Use Disorders

<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 substance use disorder in the last five years.</td>
<td>• Verification of any applicant for licensure who may be impaired by drugs or alcohol that affects her/his ability to practice nursing safely.</td>
<td>1. 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>
</tbody>
</table>

## 4.C 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 not previously reported to the BON.</td>
<td>• Verification 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>1. This has been added to help BONs identify individuals who may currently hold or previously held a disciplined license from another profession.</td>
</tr>
</tbody>
</table>
Attachment C
Licensure Decisions Based on Functional Abilities Memorandum

ATTACHMENT C

MEMORANDUM

TO: Uniform Licensure Requirements Committee and Maryann Alexander

FROM: Thomas G. Abram, NCSBN Legal Counsel

DATE: January 19, 2011

RE: ADA Compliance of Licensure Application Questions Relating to Mental or Physical Conditions

As part of its review of core licensure requirements, the Uniform Licensure Requirements Committee has been reviewing the appropriateness and legality of license application questions that inquire into an applicant’s mental or physical condition. The legal consideration centers on such questions’ compliance with the Americans with Disabilities Act (“ADA”). Materials reviewed by the Committee gave somewhat conflicting advice as to the extent to which boards of nursing could inquire into an applicant’s mental or physical condition without violating the ADA.

A. Applicable Law

The ADA prohibits discrimination against an otherwise qualified individual with a disability by any state agency. 42 U.S.C. § 12132. In turn, the United States Department of Justice (“DOJ”), charged with enforcing the ADA in these respects, has promulgated regulations that explicitly prohibit discrimination in the administration of a state licensing program. 28 C.F.R. §§ 35.130(b)(6)-(8). An individual is a “qualified individual with a disability” if he/she meets the essential eligibility requirements for licensure, with or without reasonable accommodation. Fundamentally, a licensing agency may not refuse to license an individual simply because the person has a disability. Nor may an individual be denied licensure based on
generalizations or stereotypes about the effects that a particular disability and/or diagnosis may have on the ability to practice. In particular, 28 C.F.R. § 35.130(b)(8) provides that a state agency may not apply eligibility criteria that screen out individuals with disabilities unless the agency can show the criteria are necessary for licensure. Rather, the ADA requires that the determination that an individual cannot practice safely and effectively because of a disability be based “on an individualized assessment, based on reasonable judgment that relies on current medical evidence or on the best available objective evidence to determine: the nature, duration, and severity of the risk; the probability that potential injury will actually occur; and whether reasonable modification of policies, practices and procedures will mitigate the risk.” 28 C.F.R. pt. 35, app. A at 566.

Furthermore, the DOJ ADA regulations prohibit licensure policies or procedures that unnecessarily impose greater requirements or burdens on otherwise qualified applicants for licensure with disabilities than on nondisabled applicants; see 28 C.F.R. pt. 35, app A at 571-72.

Taken together, the statutory and regulatory provisions of the ADA prohibit nursing boards from asking the following open-ended type of question about an individual’s record of mental or physical conditions: “Have you ever been treated or diagnosed for any mental, emotional or nervous condition?” Denial of licensure on the basis of a positive response to this type of question would be taking action solely on the basis of an individual’s disability or record of disability without any nexus with the ability to practice or consideration of possible accommodations and the courts have found such questions in violation of the ADA. See, e.g. Clark v. Virginia Board of Bar Examiners, 880 F. Supp. 430 (E.D. Virginia 1995); Ellen S. v. Florida Board of Bar Examiners, 859 F. Supp. 1489 (S.D. Fla. 1994). In so ruling, these Courts relied upon the DOJ’s interpretation that 28 C.F.R. § 35.130(b)(8) prohibits state agencies from
imposing unnecessary requirements or burdens on individuals with disabilities that are not placed on others. The courts reasoned that, in asking such open-ended questions and requiring applicants who responded in the affirmative to provide additional medical records and undergo additional investigation, the state licensing boards were imposing additional burdens on applicants with disabilities without a sufficient basis to believe that the individuals may not be fit to practice based on the initial responses to such broad questions. *Jacobs v. Medical Society of New Jersey*, 1993 WL 413016 (D.N.J. Oct. 5, 1993).

Furthermore, the courts have questioned the legality of questions about an applicant’s history of mental illness regardless of its remoteness in time, reasoning that a diagnosis or treatment of a mental condition years ago may have little, if any, bearing on an applicant’s current fitness to practice. See, e.g. *In re Petition and Questionnaire for Admission to the Rhode island Bar*, 683 A.2d 1333 (R.I. 1996).

To comply with the ADA, a question as to an applicant’s mental condition must be tied to the condition’s affect on the applicant’s current ability to practice safely and effectively. Accordingly, application questions that inquire as to an individual’s current mental or physical conditions without limiting the inquiry to those conditions that may adversely affect the individual’s ability to practice are likely to be found impermissible under the ADA.

Reliance on the decision in *Applicants v. Texas Board of Bar Examiners*, 1994 WL 923404, at *1 (W.D. Tex. Nov. 11, 1994), as support for asking more open-ended application questions, probably is misplaced. True, this type of question was, indeed, found permissible in the *Texas Bd. of Bar Ex.* decision. However, in rendering its decision, the Court in *Texas Bd. of Bar Ex.* did not even consider whether these questions imposed an impermissible burden on disabled applicants or the applicable DOJ regulations. Furthermore, to the extent the Court
relied on inferences that a diagnosis of bipolar disorder, schizophrenia and other psychotic disorders would likely impact the ability of a nurse to practice safely and effectively, basing an action on such an inference (notwithstanding its perhaps common sense reasonableness) runs counter to the DOJ regulatory requirements of an individual, fact-based assessment of each applicant with a disability.

In subsequent decisions in Jacobs, Clark and Ellen S., the Courts found such open-ended questions to be insufficiently tailored to the requirements for practice and to impose an impermissible burden on otherwise qualified applicants with disabilities solely because of their disabilities. See also Doe v. Judicial Nominating Commission, 906 F. Supp. 1534 (S.D. Fla. 1995).

These decisions are not dispositive, of course, and there has been no federal circuit court of appeals decision on this issue. Therefore, there is no controlling case precedent. In addition, one might argue that an additional inquiry into the medical condition of any applicant who has been diagnosed with such a psychotic disorder is warranted, not based on any generalization regarding the effect of a diagnosed disability on the ability to practice, but to ascertain the treatment plan for the condition, whether the symptoms are under control and whether there is evidence that the applicant is complying with the treatment plan, e.g. taking the necessary medication. No court has had the occasion to consider and rule on such an argument.

However, on balance, the later decisions after Texas Bd. of Bar. Ex., e.g. Clark and Ellen S., are more carefully reasoned and take into account the applicable DOJ regulations. Because there have been no decisions on the merits of these types of questions since the late 1990s, these decisions still provide the best available guidance on what types of questions will be found to
comply with ADA.\textsuperscript{1} In addition, the DOJ regulations have not been challenged as imposing obligations and restrictions beyond the DOJ’s regulatory authority and the requirements of the ADA. The regulations, accordingly, are entitled to the typical weight and deference afforded regulatory interpretations of federal statutes.

**B. Recommendations as to Wording of Questions**

In sum, the safer course of action and the one most likely to pass muster in an ADA challenge is to limit any application question about mental or physical disabilities to questions inquiring solely into those current conditions that may affect the applicant’s present ability to practice safely and effectively. What time period is considered “current” is, of course, somewhat arbitrary without empirical research data on remission, recurrence, efficacy of treatments to control symptoms, etc. However, the courts have upheld questions limited to any diagnosis or treatment within five years of the application. See, e.g. *O’Brien v. Virginia Board of Bar Examiners*, 1998 WL 391019 (E.D. Va. Jan. 23, 1998); *In re Petition*, supra.

In addition, questions that ask whether the applicant has been “diagnosed” or “treated” for a mental condition are more precise and preferable to those that merely ask whether an individual “has had” or “has suffered” a mental condition, etc. The later type of question asks an applicant to self report the person’s own judgment of conditions the applicant may not be qualified to diagnose and invites evasive, as well as honest, but uninformed, responses.\textsuperscript{2}

\textsuperscript{1} A class recently has been certified challenging Indiana state bar application questions similar to those struck down in these earlier cases. See *Perdue v. Indiana Board of Law Examiners*, 266 F.R.D. 215 (S.D. Ind. 2010).

\textsuperscript{2} The implication of this analysis is that I generally concur with the article “Do State Medical Board Applications Violate the (ADA)” and conclude that the questions discussed in the December 4, 2006 Ohio Board of Nursing opinion letter run a substantial risk of being found to violate the ADA because the questions fail to tie explicitly the questions to the applicant’s current ability to practice. That opinion’s reliance on *Texas Bd. of Bar Ex.* is problematic for the reasons discussed above. Also, the application question at issue in *O’Brien v. Vir. Bd. of Bar Ex.*, also relied upon in the Ohio opinion, did expressly tie the question to an applicant’s current ability and the Court in *O’Brien* stated that this was the dispositive difference from the questions struck down in *Clark*.  

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**Footnotes:**

1. A class recently has been certified challenging Indiana state bar application questions similar to those struck down in these earlier cases. See *Perdue v. Indiana Board of Law Examiners*, 266 F.R.D. 215 (S.D. Ind. 2010).

2. The implication of this analysis is that I generally concur with the article “Do State Medical Board Applications Violate the (ADA)” and conclude that the questions discussed in the December 4, 2006 Ohio Board of Nursing opinion letter run a substantial risk of being found to violate the ADA because the questions fail to tie explicitly the questions to the applicant’s current ability to practice. That opinion’s reliance on *Texas Bd. of Bar Ex.* is problematic for the reasons discussed above. Also, the application question at issue in *O’Brien v. Vir. Bd. of Bar Ex.*, also relied upon in the Ohio opinion, did expressly tie the question to an applicant’s current ability and the Court in *O’Brien* stated that this was the dispositive difference from the questions struck down in *Clark*.  

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**Page 5**
This memo does not address questions relating to physical disabilities. In discussion with the Committee, it was the members’ preliminary assessment, in which I concur, that asking questions regarding physical disabilities is impractical due to the many different practice settings and differing physical demands for each setting and that employers were in a better position to assess the ability of a nurse with a physical disability to practice safely in a specific setting, with or without accommodations. The memo also does not address questions inquiring about conditions expressly exempted from ADA coverage such as current illegal use of drugs, compulsive gambling, pedophilia, etc.
Attachment D

Draft of Common Licensure Application

LICENSURE APPLICATION

Complete this application in its entirety. Failure to submit a complete application and fee will delay the approval of your application. Your application will not be approved until all requirements have been met and the background check has been completed and processed. Applications are processed in the order that they are received.

SECTION A: Applicant Information
Indicate your legal name as listed on your driver’s license or Picture Identification. Discrepancies in name may result in not being able to verify your identity the day of your examination.

Last Name (Print): _______________________
First Name: _______________________
Middle Name: _______________________

Previous Name(s): _______________________
Social Security Number: _____ - _____ - _____
Date of Birth: ____/____/____
                                                MO         Day           Year

(Address)                                                                                             (City)              ...               (State/Country)                                                                           (Zip/Postal Code)

(E-mail Address)                                                                                                          ...                                                                                                              Phone Number

Gender: [ ] Male [ ] Female
Ethnicity: [ ] African American [ ] Asian [ ] Caucasian [ ] Hispanic [ ] Native American [ ] Other

SECTION B: Licensure Information
Type of license you are applying for: [ ] RN [ ] LPN
Name of Nursing Education Program: __________________________________________________________
                                                (City)                                                                                                                    ...                                                                                                                 (Country)

Type of Nursing Program listed above: [ ] RN [ ] LPN

Type of Degree or Credential awarded by your Nursing Education Program:
[ ] Diploma [ ] Certificate [ ] Associate Degree [ ] Baccalaureate Degree [ ] Have met BSN requirements en route to MSN
(Programs known as entry level Masters Programs)
[ ] Masters Degree [ ] Doctoral Degree

Date of Program Completion: ____/____/____
                                                MO            Year

Have you ever taken the NCLEX®? [ ] Yes [ ] No
If yes, please provide the date: [ ] RN ____/____/____ [ ] LPN ____/____/____
                                                MO         Year            MO         Year

SECTION C: Nurse Compact Declaration
In accordance with the Nursing Practice Act, I declare the State of _________________________________ is my primary state of residence and that such constitutes my permanent and principal home for legal purposes. (*Primary state of residence* is defined as the state of a person’s declared fixed permanent and principal home for legal purposes; domicile.)

Upon licensure, in which state(s) do you intend to practice? ________________________________________________
Applicant’s Name (PRINT): ___________________________ Social Security Number: ______________

Are you currently employed in the U.S. Military (Active Duty) or the U.S. Federal Government? [ ] Yes [ ] No

Applicant’s Signature: ___________________________ Date: ______/______/______

SECTION D: Regulatory Questions

1.) Have you ever held a nursing license in any state, country, or province? [ ] Yes [ ] No
   If yes, please list all states, countries, and/or provinces: ______________________________________________________
   Type of license you held: _________________________________________________________________________________
   Is this license still active? [ ] Yes [ ] No License Number: ___________________________

2.) Have you ever been denied a nursing license (for reasons other than failure to pass State Board Exam/NCLEX®)?
   [ ] Yes [ ] No
   If you answer "YES" to any of the following questions, you must attach a letter of explanation indicating the circumstance(s) you are reporting to the Board of Nursing. The document must be signed and dated. This explanation must include the date(s) and location(s), as well as a certified copy of the Board of Nursing or any other licensing agencies action. Once we have a complete application and required documents, your file will be transferred to our Enforcement Department for review. The Board of nursing will not approve an applicant to take the NCLEX® or issue an online permit until a decision has been rendered by our Enforcement Department.

3.) Have you ever had any disciplinary action on a nursing license or a privilege to practice in any state, country, or province?
   [ ] Yes [ ] No

4.) Do you have an investigation or complaint pending on a nursing license or a privilege to practice in any state, country, or province?
   [ ] Yes [ ] No

5.) Have you, in the last 5 years, been diagnosed with a substance use disorder or participated in a chemical dependency and/or alcohol or drug treatment?
   [ ] Yes [ ] No

6.) Are you currently a participant in an alternative to discipline, diversion, or a peer assistance program? (This includes all confidential programs)
   [ ] Yes [ ] No

7.) Have you ever had any licensing or regulatory authority in any state, jurisdiction, country, or province revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew or otherwise discipline any other professional or occupational license, certificate, nurse aide registration or multistate privilege to practice that you held?
   [ ] Yes [ ] No If yes, please name the type of license: ___________________________

8.) For any criminal offense, including those pending appeal, have you:
   (You may only exclude minor traffic violations, but must report all DUI charges/convictions)
   [ ] been convicted of a misdemeanor?
   [ ] been convicted of a felony?
   [ ] pled nolo contendere, no contest, or guilty?
   [ ] received deferred adjudication?
   [ ] been placed on community supervision or court-ordered probation, whether or not adjudicated guilt?
   [ ] been sentenced to serve jail or prison time? court-ordered confinement?
   [ ] been granted pre-trial diversion?
Applicant’s Name (PRINT): ______________________________ Social Security Number: ____________

[ ] been arrested or have any pending criminal charges?
[ ] been cited or charged with any violation of the law?
[ ] been subject of a court-martial; Article 15 violation; or received any form of military judgment/punishment/action?

NOTE: Expunged and Sealed Offenses: While expunged or sealed offense, arrests, tickets, or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact, been expunged or sealed. It is recommended that you submit a copy of the Court Order expunging or sealing the record in question to our office with your application. Non-disclosure of relevant offenses raises questions related to truthfulness and character.

NOTE: Orders of Non-Disclosure: If you have criminal matters that are the subject of an order of non-disclosure you are not required to reveal those criminal matters on this form. However, a criminal matter that is the subject of an order of non-disclosure may become a character and fitness issue. If the Board of Nursing discovers a criminal matter that is the subject of an order of non-disclosure, even if you properly did not reveal that matter, the Board of Nursing may require you to provide information about any conduct that raises issue of character.

9.) Are you currently the target or subject of a grand jury or governmental agency investigation?
[ ] Yes [ ] No

SECTION E: Attestation

I, the NCLEX® Candidate whose name appears within this Application, acknowledge this document is a legal document and I attest that I understand & meet all the requirements for the type of licensure requested.

Further, I understand that it is a violation to submit a false statement to a government agency; and I consent to release of confidential information to the Board of Nursing and further authorize the Board to use and to release said information as needed for the evaluation and disposition of my application.

I understand that if I have any questions regarding this affidavit I should contact an attorney or the appropriate professional health provider.

I will immediately notify the Board if at any time after signing this affidavit I no longer meet the eligibility requirements.

Applicant’s Signature: ______________________________ Date: _____ / _____ / _____

Page 3 of 3
Report of the APRN Committee

Background
The APRN Committee is a long-standing committee at NCSBN that addresses issues related to advanced practice nursing. Since early 2000, the committee has worked toward uniform regulations for advanced practice registered nurses (APRNs). This endeavor began with the development of the NCSBN Vision Paper for APRN Regulation. While the vision paper was based on the expertise of the committee and input from others outside NCSBN, it sparked controversy in the APRN community. This led to the formation of the APRN Joint Dialogue Group. This group consisted of key representatives from 48 nursing groups who came together to collaborate on a paper that would unite advanced practice nursing, outline model regulations for APRNs and promote uniformity across all jurisdictions. Representatives from NCSBN and the APRN committee sat on the Joint Dialogue group. These individuals represented boards of nursing (BONs) and addressed licensure and other regulatory issues. Leaders from other organizations represented education, accreditation and certification. The resulting document, the Consensus Model for APRN Regulation serves as the standards and model for APRN regulation in the U.S.

Following the development of the Consensus Model, the APRN Committee subsequently developed model legislative language for use by BONs. The model language was adopted by NCSBN's Delegate Assembly in 2008. Since that time, NCSBN has been dedicated to helping states enact the regulations described in the Consensus Model. The APRN Committee has played an important advisory role in this process by lending their expertise and leadership.

Highlights of FY11 Activities
Committee highlights:
- APRN Summit
- Campaign for Consensus
- Identification of issues related to the Consensus Model that require clarification
- APRN Roundtable

ACCOMPLISHMENTS
Fiscal year 2011 (FY11) charges:
- Assist staff with the APRN Roundtable; APRN Summit; and Licensure, Accreditation, Certification and Education (LACE) meetings.
- Advise staff on how to assist Member Boards with the implementation of the Consensus Model.
- Describe the regulatory perspective of the relationship of the model with the doctor of nursing practice (DNP), the three P's (pharmacology, pathophysiology and physical assessment) and the definition of terms such as “Lifespan” and “CORE,” in collaboration with the LACE group and consistent with the Consensus Model.

Assist staff with the APRN Roundtable, APRN Summit and LACE Meetings
The APRN Roundtable is an annual event held to inform APRN stakeholders of regulatory issues related to advanced practice nursing. This year, the APRN Roundtable was held on May 18, 2011, and focused on updating stakeholders on NCSBN's Campaign for Consensus (the formalized program to help states adopt the requirements in the Consensus Model). The roundtable is a forum for eliciting the needs of APRN organizations and what NCSBN can do to help them facilitate enactment of the regulations in their perspective areas. Legislative efforts by the states was discussed and there was an opportunity for sharing of ideas and strategies.
The 2011 NCSBN APRN Summit was the kick-off event for the APRN Campaign for Consensus. Held in San Diego, Calif. Jan. 12-13, 2011, three representatives from every jurisdiction were invited by NCSBN to attend. The APRN Committee assisted staff in planning the summit agenda. Presentations at the summit focused on providing attendees with information and resources needed to get the Consensus Model regulations enacted in their jurisdiction. The summit evaluations indicated that the educational objectives for the summit were met.

The LACE Group, in which NCSBN represents licensure, is an offspring of the Joint Dialogue Group and is the primary means by which APRN groups communicate regarding their efforts to implement the Consensus Model. This group meets periodically to discuss issues of relevance related to the Consensus Model and to iron out details as they arise. They are also in the process of establishing a website to enable and enrich communication among all groups in LACE. The APRN committee has been instrumental in identifying issues that LACE needs to address. By having the LACE group clarify these issues, the BONs will be provided with answers to questions that have arisen out of the Consensus Model. Issues identified by the APRN Committee for LACE to address include:

- Acute versus primary care for adult/gerontology and pediatric populations (areas that overlap);
- Scope of practice of midwives; and
- Grandfathering: How will this be done and under what circumstances?

Advise staff on how to assist Member Boards with the implementation of the APRN Consensus Model

The committee developed a tool to classify where states were in the adoption of the components of the Consensus Model. They specifically focused on independent practice in order to capture this data. The data from the tool were collected at the summit and will be posted on the campaign website. This will help BONs know the progress of other states in adopting the Consensus Model.

Staff developed a legislative handbook for distribution to legislative staff and the committee gave feedback and suggestions.

The Committee attended the APRN Summit and assisted the staff by providing presentations and moderating sessions. These presentations provided valuable information to the attendees regarding the model and legislative successes and pitfalls.

The committee also developed a definition of independent practice that can be used by BONs:

An advanced practice registered nurse is considered an independent practitioner when given both an RN and APRN license by a state regulator. The APRN shall not be mandated to have an agreement with another health care provider. The APRN shall have full prescriptive privileges that include the administration and prescription of pharmacologic and non-pharmacologic interventions without requirement for collaboration, supervision or oversight by any other health care provider. The APRN prescriptive privilege shall not be limited to a defined formulary.

Describe the regulatory perspective of the relationship of the model with the DNP, the three P’s and the definition of terms such as “Lifespan” and “CORE,” in collaboration with the LACE group and consistent with the APRN Consensus Model

This charge grew out of a need for clarification of certain aspects of the Consensus Model. These issues have elicited ongoing discussions with LACE. The following are points that have been made by the APRN Committee regarding these topics.

The relationship between the DNP and the Consensus Model:

- BONs require “graduate” education and encourage generic DNP programs to have a common curriculum;
- Graduate education can be at the level of the master’s degree or DNP to prepare for the APRN Certification Exam;
DNPs must meet all APRN education and clinical requirements to be licensed as an APRN; and

The BON needs to verify the transcript and curriculum for the DNP.

Clarification of the core courses pharmacology, pathophysiology and physical assessment (the three P's):

- **Pharmacology:** The pharmacology course should have a broad general name to reflect broad general competencies.
- **Pathophysiology:** Pathophysiology should also be a broad general course with broad, general competencies.
- **Advanced Physical Assessment:** The current Consensus Model states that all human systems must be covered, but the course may be specific to that role.

Definition of Lifespan: All ages (this requires further clarification through LACE because the certified nurse midwives (CNMs) describe their practice as being across the lifespan).

CORE: Refers to the three P’s.

**Future Activities**

The APRN Committee has met its charges for FY11, however, work related to the enactment and implementation of the Consensus Model continues.

Many questions are arising about the certification exam criteria and it has been suggested that these criteria be reviewed by the APRN Committee in conjunction with NCSBN’s Examinations department to provide updated information to BONs.

Proposed FY12 charges:
1. Develop criteria for evaluation of APRN certification exams for use by BONs.
2. Develop guidelines to help states grandfather individuals.
3. Plan FY12 APRN Roundtable.

**Attachments**

None
Report of the Awards Committee

Background
The NCSBN awards program recognizes outstanding achievements of members and celebrates significant contributions to nursing regulation. Nominations submitted for an award category are subjected to a “blind review” by the Awards Committee. Award recipients are determined based on the nominee’s ability to meet the award criteria for the category in which they are nominated. This year, a member was selected as an honoree in the following award categories: R. Louise McManus, Meritorious Service, Exceptional Leadership, Exceptional Contribution and Regulatory Achievement. There were six executive officers that made contributions to nursing regulation being honored with the Executive Officer Recognition Award. In addition, recognition will be bestowed upon Member Boards celebrating their centennial and Institute of Regulatory Excellence (IRE) Fellows during the presentation ceremony. The awards program will be held as an evening dinner event at the Annual Meeting in Indianapolis, Ind. The awards will be presented by the NCSBN Board of Directors (BOD) president.

Highlights of FY11 Activities
- Conducted a blind review of the award nominations.
- Recommended revisions to the awards brochure to include the NCSBN mission and vision.
- Recommended to the BOD revisions to the Exceptional Leadership Award regarding criteria for selection.
- Recommended to the BOD revisions to the Distinguished Achievement Award regarding eligibility and criteria for selection.
- Identified the Member Boards that are celebrating their centennial in 2011.
- Identified executive officers who are eligible for the Executive Officer Recognition Award for five, 10 and 15 years of service.
- Reported to the BOD the 2011 awards recipients selected by the Awards Committee.
- Sent letters of notification to the award nominees and to the nominators.
- Assigned roles to committee members for participation in the awards ceremony.

2011 Award Recipients:

R. Louise McManus Award
Kathy Malloch, PhD, MBA, RN, FAAN, board vice president, Arizona State Board of Nursing

Meritorious Service Award
Julia George, MSN, RN, FRE, executive director, North Carolina Board of Nursing

Regulatory Achievement Award
Virginia Board of Nursing

Exceptional Leadership Award
Lisa Klenke, MBA, RN, past president, Ohio Board of Nursing

Exceptional Contribution Award
Judith Personett, EdD, RN, CNA, board member, Washington State Nursing Care Quality Assurance Commission
Mary Beth Thomas, PhD, RN, board staff, Texas Board of Nursing
Executive Officer Recognition Awards

5 YEARS
- Joan K. Bainer, MN, RN, NE, BC, administrator, South Carolina State Board of Nursing
- Michele Bromberg, MSN, APN, BC, nursing act coordinator, Illinois Board of Nursing
- Pamela McCue, MS, RN, executive officer, Rhode Island Board of Nurse Registration and Nursing Education
- Diane Ruan-Viville, MA, RN, executive director, Virgin Islands Board of Nurse Licensure

10 YEARS
- Lanette Anderson, JD, MSN, RN, executive director, West Virginia State Board of Examiners for Licensed Practical Nurses
- Lori Scheidt, Executive Director, Missouri State Board of Nursing

15 YEARS
- Sandra Evans, MAEd, RN, executive director, Idaho Board of Nursing

MEMBER BOARDS CELEBRATING 100 YEARS OF NURSING REGULATION
- Idaho Board of Nursing
- Oregon State Board of Nursing
- Tennessee State Board of Nursing
- Vermont State Board of Nursing

INSTITUTE OF REGULATORY EXCELLENCE FELLOWS
- Joan K. Bainer, MN, RN, NE, BC, administrator, South Carolina State Board of Nursing
- Linda D. Burhans, PhD, RN, NEA-BC, CPHQ, board staff, North Carolina Board of Nursing

Future Activities
- Select the 2012 awards recipients.

Attachment
A. 2011 Awards Brochure
Attachment A

2011 Awards Brochure

2011 NCSBN Awards Program
The NCSBN awards will be announced at the 2011 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. 18, 2011, 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 awards program cover page. 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, the nominator will be contacted 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.

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
As applicable

Please note: No nomination is necessary for the Executive Officer Recognition Award as it is presented to Executive Officers based on his or her years of service in five-year increments.
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 Bacigalupo
- 1986 – Joyce Schowalter
- 1983 – Mildred Schmidt

MERITORIOUS SERVICE AWARD
- 2010 – Ann L. O’Sullivan
- 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
- 2010 – Texas Board of Nursing
- 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
### MEMBER BOARD AWARD
- 2000 – Arkansas Board of Nursing
- 1998 – Utah State Board of Nursing
- 1997 – Nebraska Board of Nursing
- 1994 – Alaska Board of Nursing
- 1993 – Virginia Board of Nursing
- 1991 – Wisconsin Board of Nursing
- 1990 – Texas Board of Nurse Examiners
- 1988 – Minnesota Board of Nursing
- 1987 – Kentucky Board of Nursing

### EXCEPTIONAL LEADERSHIP AWARD
- 2010 – Catherine Giessel
- 2007 – Judith Hiner
- 2006 – Karen Gilpin
- 2005 – Robin Vogt
- 2004 – Christine Alichnie
- 2003 – Cookie Bible
- 2002 – Richard Sheehan
- 2001 – June Bell

### NCSBN 30TH ANNIVERSARY SPECIAL AWARD
- 2008 – Joey Ridenour
  - Sharon Weisenbeck Malin
  - Mildred S. Schmidt

### EXCEPTIONAL CONTRIBUTION AWARD
- 2010 – Valerie Smith
  - Sue Tedford
- 2009 – Nancy Murphy
  - Barbara Newman
  - Calvina Thomas
- 2008 – Lisa Emrich
- 2007 – Peggy Fishburn
- 2005 – William Fred Knight
- 2004 – Janette Pucci
- 2003 – Sandra MacKenzie
- 2002 – Cora Clay
- 2001 – Julie Gould
  - Lori Scheidt
  - Ruth Lindgren

### SILVER ACHIEVEMENT AWARD
- 2000 – Nancy Wilson
- 1998 – Joyce Schowalter

### NCSBN SPECIAL AWARD
- 2008 – Thomas Abram
- 2004 – Robert Waters
- 2002 – Patricia Benner
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: 2003, 2006, 2008 and 2010. BONs are surveyed regarding five BON functions: (1) discipline; (2) practice; (3) education program approval; (4) licensure; and (5) administrative. 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 FY11 Activities
In an effort to present comparative performance measurement data more effectively the CORE Committee revised the templates for the FY11 aggregate and state reports. Changes included:

- Organizing the state reports by BON functions: practice, licensure, discipline, education and administrative;
- Combining state, aggregate, umbrella and independent BON data into one table, thus, eliminating the need for several reports;
- Including scatter plots, when applicable, with tables for better interpretation of the data; and
- Determining if BONs are above average, average or below average when comparing their results with the aggregate data.

The FY11 aggregate and individual state reports were distributed to Member Boards in April 2011.

To support the committee in the completion of its FY11 charges, the committee requested the continued involvement of Ted Poister, PhD, MPA, a performance measurement expert. In the past Poister has assisted the committee by reviewing the CORE program and providing refinements to the CORE Logic Model. As part of his FY11 aggregate and state reports review, Poister assisted the committee by helping to identify promising practices and reasons for excellent performance among BONs. Provided that promising practices are identified, Poister will further assist the committee by suggesting strategies to attempt to validate those practices.

Poister will be retained by NCSBN to lend his expertise to the next round of data collection, expected to commence in 2012 as part of the CORE Committee responsibilities for FY12. His responsibilities in this endeavor will include continued refinement of the CORE logic model, as well as reviewing the analysis plan, survey instruments, data collection plan and reports from the FY11 data collection.

To assist BONs in implementing strategies to increase knowledge and use of CORE performance measures, NCSBN retained the services of noted author and consultant Pat Keehley, PhD, to speak at the 2011 NCSBN NLC & Consumer Conference. Keehley has consulted with the CORE Committee previously and is well acquainted with NCSBN’s work in performance measurement.

Charge #1: Develop CORE survey tool for data collection in 2012.
The Committee will review the outcomes from the 2010 data collection to revise the 2012 survey tool.

Members
Margaret Walker, EdD, RN, FRE
New Hampshire, Area IV, Chair
Vicki Lynn Allen, RN, CLNC
Idaho, Area I
Jessie Colin, PhD, RN, FAAN
Florida, Area III
Gloria Damgaard, MS, RN
South Dakota, Area II
Richard Gibbs, LVN
Texas, Area III
(August 2010-February 2011)
Marilyn Hudson, MSN, CNS, RN,
FRE
Oregon, Area I
Carllene MacMillan, MN, CNAA
Louisiana-RN, Area III
Christine Penney, PhD, MPA, RN,
FCCHL
British Columbia, Associate Member
Joey Ridenour, MN, RN, FAAN
Arizona, Area I
Chris Sansom, RN
Nevada, Area I
Calvina Thomas, PhD, RN
Arkansas, Area III
(August 2010-September 2010)
Kathy Malloch, PhD, MBA, RN,
FAAN
Arizona, Area I, Board Liaison

Staff
Casey Marks, PhD
Chief Operating Officer
Richard Smiley, MS, MA
Statistician, Research
Melissa Snyder
Project Specialist, Business Operations

Meeting Dates
- Sept. 30-Oct. 1, 2010
- Nov. 19, 2010
- Jan. 10-11, 2011
- Jan. 24, 2011
- March 7, 2011

Relationship to Strategic Plan
Strategic Initiative A
NCSBN promotes evidence-based regulation.
Strategic Objective 1
Promote regulatory excellence through a performance measurement system.
Charge #2: Identify promising practices and reasons for excellent performance.
Upon completion of the 2011 aggregate and state reports, the committee will investigate findings, with the assistance of Poister in an attempt to identify promising practices and reasons for excellent performance.

Charge #3: Validate identified promising practices.
Contingent on promising practices and reasons for excellent performance identification, the committee, with assistant from consultants, will strategize validation of promising practices.

Charge #4: Implement strategies to increase knowledge and use of CORE performance measures.
Keehley spoke at the 2011 NCSBN NLC & Consumer Conference.

Future Activities
Recommended charges for FY12 include:
1. Produce CORE 2012 research reports.
2. Identify promising practices
3. Promote increased use of CORE information.

Attachments
None
Report of the Disciplinary Resources Committee (DRC)

Background
The DRC is a long-standing NCSBN committee that has developed resources and guidelines related to disciplinary decision making for Member Boards. In the last few years this committee has worked on revising model rules to be more specific related to professional boundaries, as this has been an issue with boards of nursing (BONs). This year’s charge on developing guidelines for social media evolved from that work. Also related to professional boundaries, the committee has worked on developing an ethical decision-making online course. It provided the BONs with a video of the disciplinary hearing process, thus assisting the BONs with educating the public about the disciplinary process. This year the Board of Directors charged the DRC to:

1. Explore how Member Boards share and act on disciplinary action taken by other jurisdictions and recommend improvements;
2. Develop guidelines for social and electronic media to protect patient privacy; and
3. Develop guidelines for regulatory decision making related to criminal conduct.

Highlights of FY11 Activities
Explored how Member Boards shared and acted on disciplinary action taken by other jurisdictions and recommended improvements.
Activities included:

- Holding discussions with NCSBN staff, Nur Rajwany, director, Information Technology, and Jim Puente, Nurse Licensure Compact (NLC) associate, Executive Office, to learn from their expertise;
- Meeting with the executive committee of the NLC to discuss recommendations for sharing disciplinary data; and
- Conducting and analyzing a comprehensive survey that was sent to BONs regarding the sharing of investigations, pending disciplinary actions and final disciplinary actions.

For this charge, the committee members developed seven recommendations (Attachment A) to encourage states to share licensure data with other BONs via Nursys®:

1. NCSBN and the DRC should communicate to Member Boards the advantages of the Nurse Alert feature for sharing information about their licensees.
2. NLC states might consider using the Nurse Alert feature, rather than the Compact Tab.
3. Inform the BONs about the Automatic Discipline Alert Speed Memo. Remove the word “alert” from this system to decrease confusion between this functionality and the Nurse Alert feature.
4. Inform the BONs about sharing discipline board orders and other official documents via Nursys.
5. Inform BONs about utilizing the electronic discipline check service.
6. Inform BONs about using the Nursys. Discipline report on a regular basis.
7. All BONs should share their discipline with other Member Boards via Nursys within 10 business days of action being taken by their BON.

Developed guidelines for social and electronic media to protect patient privacy.
Activities included:

- Reviewing literature about the appropriate use of social and electronic media in health care;
- Reviewing several health care institutions’ guidelines about use of social media.
### Section II: 2011 NCSBN Annual Meeting

#### Report of the Disciplinary Resources Committee (DRC)

- Reviewing recommendations from Canada and the U.K. on the appropriate use of social media in health care;
- Conducting and analyzing a survey on the BONs’ experiences with the inappropriate use of social media; and
- Meeting with Dawn Kappel, director, Marketing & Communications, NCSBN, to learn about ways to disseminate information to nurses about the appropriate use of social media.

The committee wrote the white paper “A Nurse’s Guide to the Use of Social Media” (Attachment B). The report addresses confidentiality and privacy (including HIPAA concerns); possible consequences, including BON implications; common myths about the use of social media; and suggestions on avoiding problems. The committee included seven actual cases, presenting outcomes and how the situation could have been prevented. The committee reviewed the American Nursing Association’s statement on social media guidelines and suggested that NCSBN move forward to collaborate with them. Based on discussions with Kappel, the committee also recommended that NCSBN staff develop a video for nurses about the appropriate use of social media in health care to be posted on YouTube and develop a brochure that can be widely distributed, based on the committee’s report.

#### Developed guidelines for regulatory decision making related to criminal conduct.

Activities included:

- Reviewing the literature in criminal behavior;
- Meeting with two experts in forensic psychology to learn about recidivism in criminal behavior;
- Conducting a survey about criminal behavior;
- Reviewing guidelines obtained from six states and two Canadian provinces; and
- Holding a collaborative meeting with the Uniform Licensure Requirements and Portability Committee to discuss a mutual charge on criminal behavior.

The committee developed a systematic process by providing a grid for BONs to use when making decisions about criminal behavior (Attachment E) in an attempt to promote consistency with decision making. A step-by-step process is provided, with directions on how to integrate mitigating and aggravating factors into the decision-making process. Mitigating and aggravating factors were identified from the literature and BON experiences, and when possible, evidence supporting the factors was cited.

#### Future Activities

The committee recommends the following charge for next year:

- Work with NCSBN’s Information Technology, Interactive Services and Marketing & Communication departments to design strategies to disseminate recommendations about sharing disciplinary data.

#### Attachments

A. Recommendations for Sharing Disciplinary Data

B. Summary of Survey Results

C. White Paper: A Nurse’s Guide to the Use of Social Media

D. Summary of Social Networking Survey to Boards of Nursing (BONs)

E. Guidelines for Regulatory Decision Making Related to Criminal Conduct
Recommendations for Sharing Disciplinary Data

NCSBN's Board of Directors (BOD) charged the Disciplinary Resource Committee (DRC) to explore how Member Boards share and act on disciplinary action taken by other jurisdictions and to recommend improvements. To explore how boards of nursing (BONs) share and act on disciplinary actions taken by other BONs, the DRC conducted a survey of Member Boards (see Attachment B for a summary of the findings). The DRC also held meetings with Nur Rajwany, director, Information Technology, NCSBN; the Nurse Licensure Compact (NLC) chair; and the NLC Executive Committee.

The following recommendations encourage states to share licensure data with other BONs via Nursys®. To assist with this, NCSBN's BOD has worked to finalize a new business model that allows states to keep verification monies and the license verification process while allowing states to share licensure data with each other, as well as limited data elements with the public and emergency response organizations.

**RECOMMENDATIONS**

**Recommendation #1:** NCSBN and the DRC should communicate to Member Boards the advantages of the Nurse Alert feature for sharing information about their licensees.

**Background**

The Nurse Alert feature of Nursys was implemented in September 2009. This feature is available for use by the entire membership. A survey conducted by the DRC suggests that many BONs are not aware of this feature and there is much confusion about it. While 21 BONs reported using this feature, only four BONs were using it at the time the survey was conducted.

The Nurse Alert feature differs from the Compact Tab. It was designed for use by all Member Boards and allows participating BONs to alert other BONs about the status of a licensee. This feature can be customized to fit the BONs' needs. If a BON chooses, it can adopt a standard message or customize its own messages. The Nurse Alert feature can be extended to the public license lookup and/or the nurse license verification service. Member Boards have the option to block the alert messages to the public and/or nurse. The Nurse Alert feature may be used by any Member Board for any reason and does not need to be associated with receipt of a complaint or an open investigation.

Summary for using the Nurse Alert feature:

- Control the display of the licensees' license status without associating this option with specific verbiage, such as “investigation”; and
- Share licensure data, other than formal discipline, with other BONs via Nursys.

**Recommendation #2:** NLC states might consider using the Nurse Alert feature, rather than the Compact Tab.

**Background**

The Compact Tab, developed 10 years ago, allows NLC jurisdictions to share investigative alerts with other NLC jurisdictions; there is no information regarding the content in this particular alert. A review of Nursys has found that this function has not been consistently used by NLC states. This functionality could be replaced by the new and more comprehensive Nurse Alert feature, as described above.

Advantages of using the Nurse Alert feature instead of the Compact Tab include:

- States are still able to alert other NLC states;
- All jurisdictions would be included (currently neighboring non-NLC states are not part of the Compact tab);
Messages can be individualized to what is optimal for that jurisdiction as standardized messages can also be developed by NLC; and

Confusion might arise for NLC board staff if NLC states use both the Compact Tab and the Nurse Alert feature.

**Recommendation #3:** Inform the BONs about the Automatic Discipline Alert Speed Memo. BONs are confused between the Automatic Discipline Alert Speed Memo and the Nurse Alert feature because they each use the word “alert.” The DRC recommends that the word “alert” be removed from the Automatic Alert Speed Memo, making it simply the Automatic Discipline Speed Memo, which is what it is referred to as below.

**Background**

The Automatic Discipline Speed Memo was implemented in May 2010. The option to send a Discipline Speed Memo while entering a discipline case into Nursys has always been available to all Member Boards. This option, however, was dependent upon the Member Board staff entering and selecting the other jurisdictions to be notified. This resulted in gaps in notifications in some cases and unnecessary alerts in others. To address the issue, NCSBN’s BOD requested that NCSBN’s Information Technology (IT) department develop an automatic discipline alert feature where the Nursys system will take control of sending a discipline speed memo automatically upon creation of a discipline case in Nursys. Therefore, the Nursys system can now automatically send a discipline speed memo to all jurisdictions where the individual holds a license in the Nursys database. This is important to BONs because many indicated in the DRC survey that they can be overwhelmed by speed memos that are not relevant. Member Board staff members retain the ability to select additional jurisdictions to be notified, though this is a manual process and would take more time.

**Summary for using this Automatic Discipline Speed Memo:**

- Rely on the system to select the jurisdictions where the disciplined nurses are licensed and to automatically send those jurisdictions the notification of discipline. This will limit the number of speed memos that are sent to Member Boards, as they have complained about being overwhelmed by speed memos; and
- By sharing licensure data via Nursys, Member Boards will receive the Automatic Discipline Speed Memos.

**Recommendation #4:** Inform the BONs about sharing discipline board orders and other official documents via Nursys.

**Background**

This feature was implemented in December 2010. It was discussed and requested by the executive officers during the 2010 Delegate Assembly. Discussions brought to light that Member Boards would accept electronic board orders shared by the primary source Member Board for most of their operational work. For most BONs, a certified copy would only be required for a court hearing. Optionally, a BON may choose to “electronically stamp” (digital signature) the board orders as being certified and still offer electronic board orders via Nursys as the certified copy. The DRC survey also indicated that many BONs would like official documents to be shared via Nursys. Member Boards who fully participate in Nursys also have the option to allow public access to the board orders via Nursys.com.

**Suggestions when sharing official documents via Nursys include:**

- Use of this functionality of Nursys saves time and resources for BON operations staff, thus enhancing efficiency and reducing costs;
- Attach discipline board orders when entering a discipline case in Nursys. Attach other relevant documents, to the extent permitted by law and BON policy; and
- Apply for funding/resources from NCSBN, if not budgeted, to attach past discipline board orders for the benefit of the membership.
Recommendation #5: Inform the BONs about utilizing the electronic discipline check service.

Background

This feature was introduced in early 2010 to close the current gap for BONs not being able to electronically check on the license status of their licensees in other jurisdictions. BONs can program their renewal systems to automatically electronically check if their licensees have any encumbrances on their license from other jurisdictions. BONs can utilize this electronic discipline check at any time, for any reason. This was developed due to feedback provided by the membership identifying a functionality gap of not being able to check Nursys for discipline status during renewals. The DRC survey found that fewer BONs asked renewal candidates about investigations or pending disciplinary actions in other jurisdictions than of initial candidates. Further, most indicated only checking on licensees who said they were being investigated or had pending disciplinary actions and not on those who answered “no” to that question.

Suggestions for this new function of Nursys include:
- BONs working with NCSBN’s IT department to reconfigure their own systems so that the two systems can communicate; and
- Once the BON can use the system, the renewal checks could be automatic.

Recommendation #6: Inform the BONs about using the Nursys® Discipline Report on a regular basis.

Background

This is not a new feature, but it can be valuable to BONs. Nursys Discipline Reports provide BONs with a list of their unencumbered licensees with discipline in other jurisdictions that report licensure data to Nursys.

Suggestions for this function of Nursys:
- Initially a BON should run the discipline report for all of their licensees against the entire Nursys disciplinary database, creating a report and investigating the results, as needed.
- After the initial report is run, on a daily basis, the BON should run the report from the day before.
- This is a quick and easy process that will allow the BONs to stay proactive.

Recommendation #7: All BONs should share their discipline with other Member Boards via Nursys within 10 business days of action taken by their BON.

By timely sharing disciplinary actions in Nursys, the entire membership will be made aware of any actions that they may need to take if the individual is licensed in their state. The membership will:
- Receive appropriate Automatic Discipline Speed Memos;
- Receive action items on their discipline reports; and
- Receive discipline alerts when the discipline status is checked via electronic means during renewals or any other time as warranted.
Attachment B

Summary of Survey Results

A survey was developed at the September 2010 meeting of the Disciplinary Resources Committee (DRC) seeking information about how boards of nursing (BONs) share disciplinary action taken by other jurisdictions. This survey was developed in relationship to the committee’s charge to explore how Member Boards share and act on disciplinary action taken by other jurisdictions, and recommend improvements.

The survey was reviewed by an NCSBN expert in survey design and by Nur Rajwany, director, Information Technology, NCSBN. In October 2010 the survey was sent to all BON executive directors, as well as all members of the Disciplinary Resource Network. The survey asked that only one response from each BON be submitted. After three reminders to BONs that hadn’t completed the survey were sent, the DRC received a response rate of 44 (73 percent). The following is a summary of the results.

I. Strategies of staying abreast of other states’ disciplinary actions

1. When BONs were asked how they become aware of actions taken in other jurisdictions, many indicated multiple ways. The following themes were identified:

<table>
<thead>
<tr>
<th>Source</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursys®</td>
<td>38</td>
</tr>
<tr>
<td>BON contacts</td>
<td>16</td>
</tr>
<tr>
<td>Applicant</td>
<td>10</td>
</tr>
<tr>
<td>Media</td>
<td>6</td>
</tr>
<tr>
<td>Citizen’s Report</td>
<td>3</td>
</tr>
<tr>
<td>National Practitioner Data Bank (NPDB)/ Healthcare Integrity and Protection Data Bank (HiPDB)</td>
<td>2</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>1</td>
</tr>
</tbody>
</table>

There were six BONs (13.6 percent) that reported querying HIPDB. When asked to what extent/in what circumstances those six BONs queried HIPDB, the following was reported (number of jurisdictions in parentheses):

- For action on medication assistants or dialysis technicians (1);
- All advanced practice registered nurse (APRN)/certified registered nurse anesthetist (CRNA) applicants are cleared before issuing final certificates (1);
- Applicants are required to provide a self-query (1);
- When a case is sent to their attorney general (1);
- Queried it 20 times in 2010 (1);
- Queried it daily;
- All applications and newly opened investigations (1);
- Malpractice (2);
- Criminal actions (1); and
- Sister state actions (2).

The cost to query HIPDB was reported as between $4.25-$4.75 per query.

2. There were five BONs (11.4 percent) that reported querying NPDB. When asked to what extent/in what circumstances those five BONs queried NPDB, the following was reported (number of jurisdictions in parentheses):
All new APRN applicants (1);
20 queries in 2010 (1);
Applicants are required to provide a self-query (1);
When a case is sent to their attorney general (1);
Malpractice (1);
Actions in other jurisdictions (1);
Criminal actions (1); and
Initial or endorsement licensures (1).

The cost to query NPDB was reported as between $4.50-$4.75 per query.

3. Of the 44 BONs responding to the survey, 38 (86.4 percent) reported querying Nursys. When asked to what extent/in what circumstances those 38 BONs queried Nursys, the following was reported (number of jurisdictions in parentheses):

- Validate licensure (38);
- Action taken in other states (23);
- When investigations are opened (8);
- Statistical information (1);
- When audited for continuing education requirement (1);
- Media reports (1);
- Daily (10);
- Weekly (6); and
- Monthly (2).

4. There were 37 (84.1 percent) BONs that responded to asking initial applicants if they are being investigated in another jurisdiction; of those, 33 take action to validate by checking other sources in the following ways (number of jurisdictions in parentheses):

- Check Nursys (13);
- Contact jurisdiction (11);
- Request copies of disciplinary action (7);
- Only validate those who answer “yes” (2);
- FBI (1);
- CRC (1); and
- HIPDB/NPDB (1).

5. There were 33 (75 percent) BONs that responded to asking initial applicants if there is pending disciplinary actions in another jurisdiction; of those, 31 take action to validate by checking other sources in the following ways (number of jurisdictions in parentheses):

- Contact other BON (17);
- Nursys (8);
- Request copies of documents (6);
- Only validate those who answer “yes” (2);
- CRC (1);
6. There were 42 (95.5 percent) BONs that responded to asking initial applicants about final disciplinary actions in other jurisdictions; 41 take action to validate by checking other sources in the following ways (number of jurisdictions in parentheses):

- Nursys (16);
- Obtain copy of the order (16);
- Contact other BON (13);
- Only validate those who answer “yes” (1); and
- HIPDB/NPDB (1).

7. Of the 44 BONs that responded to the survey, 31 (70.5 percent) reported asking renewal candidates (as opposed to initial candidates) if they were being investigated in other jurisdictions; 28 take action to validate the answers by doing the following (number of jurisdictions in parentheses):

- Contact other BON (9);
- Nursys (5); and
- Request documents (3).

8. There were 29 (65.9 percent) BONs that reported asking renewal candidates (as opposed to initial candidates) if there is pending discipline in other jurisdictions; 26 take action to validate the answers by doing the following (number of jurisdictions in parentheses):

- Contact other BON (7);
- Nursys (5);
- Request documents (2); and
- HIPDB/NPDB (1).

9. More BONs (39 or 88.6 percent) reported asking renewal candidates about final disciplinary actions in other jurisdictions than they do about being investigated or having pending disciplinary actions. Of those 39 BONs, 37 take action to validate the answers by doing the following (number of jurisdictions in parentheses):

- Nursys (10);
- Request documents (10);
- Contact BON (5);
- Open a case (1);
- Check with authorities (1); and
- HIPDB/NPDB (1).

10. There were 37 (88.1 percent) BONs that indicated they have a process in place for a staff member to take action when a Nursys® Auto Alert speed memo is received. BONs frequently check those Nursys® Auto Alert speed memos (note that 41 BONs answered this question):

- Daily: 19 (51.4 percent);
- Weekly: 16 (43.2 percent);
- Monthly: 1 (2.7 percent);
- Quarterly: 1 (2.7 percent); and
II. Taking action based on other states’ discipline

11. Of the 44 BONs responding, only one (2.3 percent) cannot take disciplinary action based on another state’s action.

12. Of the 43 BONs responding, 37 (86 percent) reported that taking action based on another state’s action depends on the nature of the offense. Comments included (number of jurisdictions in parentheses):
   - Must be a violation in their state (10);
   - Case-by-case (4);
   - Not on minor violations (2); and
   - Depends on whether the nurse is active or inactive (1).

13. There were 36 BONs that discussed the information/documentation needed to take disciplinary action based on another state’s discipline, including the following (number of jurisdictions in parentheses):
   - Board order/disciplinary records (25);
   - Certified copy of action (10);
   - Findings of fact (4);
   - Licensee’s response (2);
   - Nursys printout (2);
   - Status of licensee (1);
   - Address of license (1);
   - Recommendations to other BONs (1); and
   - Evidence of remediation (1).

III. Reporting and sharing of disciplinary actions

14. Reporting systems used when taking disciplinary action (44 respondents)

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<tbody>
<tr>
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<tr>
<td>HIPDB</td>
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</tr>
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<td>NPDB</td>
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</tr>
<tr>
<td>Other National Reporting System</td>
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<td>20</td>
</tr>
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</table>

If BONs use other national reporting systems, what are they?

- Office of Inspector General (OIG) (2);
- Regional Medicare/Medicaid (1); and
- State Bureau of Health Facilities (1).
15. Beyond an automatic Nursys alert, what other forms of notifications are used to alert jurisdictions of actions taken by a BON (42 respondents)?

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<thead>
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<td>11</td>
</tr>
<tr>
<td>Other</td>
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</table>

If BONs use other forms of notification to alert jurisdictions of actions taken by a BON, what are they (number of jurisdictions in parentheses)?

- U.S. mail (8);
- Website (3); and
- Fax (1).

16. There were 21 BONs that indicated they were using the new Nurse Alert feature in Nursys, which alerts the BON, the public and the nurse with a message prepared by the BON; 16 BONs are not using this feature. Reasons given for either using or not using this feature include (number of jurisdictions in parentheses):

- Not familiar with this (4);
- Doesn’t alert nurses without discipline (2);
- Only alert if the investigation is active (1); and
- Plan to use in the future (1).

When this question was asked, only four BONs were actually using the Nurse Alert feature, thereby illustrating their confusion about this feature.

17. There were 34 BONs that indicated they have a dedicated staff person for reporting the BON’s disciplinary action to Nursys; seven BONs do not.

18. Disciplinary action is entered into Nursys after it has been finalized within the following timeframe (number of jurisdictions in parentheses):

- 1-3 days (11);
- 4-14 days (16);
- 5-30 days (10);
- 31-60 days (1);
- 61-120 days (1); and
- N/A-Don’t use Nursys (3).

19. The following reports are considered public and can be shared with either the public or other BONs:

<table>
<thead>
<tr>
<th></th>
<th>Shared with BONs - Yes</th>
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<td>Charges/notice</td>
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<tr>
<td>Action</td>
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20. Recommendations for sharing disciplinary data across jurisdictions include (number of jurisdictions in parentheses):

- Ability to upload official documents on Nursys (7);
- More selective use of speed memos (5);
- Get all states to use Nursys in a timely manner (5);
- Encourage legislation to permit sharing of investigative information (3);
- NCSBN defray cost of HIPDB/NPDB (2);
- Add investigations to Nursys for all states, and not just the NLC (2);
- Allow investigations to be shared whether or not the license is active (1);
- More personnel for the BON (1);
- Nursys for APRNs (1);
- Allow entry to Nursys without name as the sole criterion (1);
- Uniform processing of disciplinary actions (1); and
- Routine inclusion of factual findings (1).

IV. Conclusions

1. BONs are using Nursys for staying abreast of disciplinary actions, taking actions and sharing discipline. They also contact other BONs and share official documents. They do this by sending speed memos in Nursys, telephone or sending documents through email, U.S. mail or via fax.

2. HIPDB/NPDB are not used nearly as often as cost seems to be one issue; two BONs would like NCSBN to defray this cost.

3. Processes are in place at BONs for staff to report disciplinary action to Nursys and to take action when speed memos are sent.

4. BONs recommend that all BONs use Nursys for reporting discipline in a timely way.

5. BONs want a process whereby official documents can be shared.

6. BONs would like BONs to share investigative information, whenever this can be done.

7. Of the BONs answering this survey, 95 percent check Nursys® Discipline Alert Speed Memos at least weekly; 88 percent enter a finalized disciplinary action within 30 days.

8. There is confusion as to what the new Nurse Alert feature is; 21 jurisdictions reported using it when in fact only four use it at this time. Education of what is available and what will be is important.
Attachment C

White Paper: A Nurse’s Guide to the Use of Social Media

Introduction

The use of social media and other electronic communication is increasing exponentially with growing numbers of social media outlets, platforms and applications, including blogs, social networking sites, video sites, and online chat rooms and forums. Nurses often use electronic media both personally and professionally. Instances of inappropriate use of electronic media by nurses have been reported to boards of nursing (BONs) and, in some cases, reported in nursing literature and the media. This document is intended to provide guidance to nurses using electronic media in a manner that maintains patient privacy and confidentiality.

Social media can benefit health care in a variety of ways, including fostering professional connections, promoting timely communication with patients and family members, and educating and informing consumers and health care professionals.

Nurses are increasingly using blogs, forums and social networking sites to share workplace experiences particularly events that have been challenging or emotionally charged. These outlets provide a venue for the nurse to express his or her feelings, and reflect or seek support from friends, colleagues, peers or virtually anyone on the Internet. Journaling and reflective practice have been identified as effective tools in nursing practice. The Internet provides an alternative media for nurses to engage in these helpful activities. Without a sense of caution, however, these understandable needs and potential benefits may result in the nurse disclosing too much information and violating patient privacy and confidentiality.

Health care organizations that utilize electronic and social media typically have policies governing employee use of such media in the workplace. Components of such policies often address personal use of employer computers and equipment, and personal computing during work hours. The policies may address types of websites that may or may not be accessed from employer computers. Health care organizations also maintain careful control of websites maintained by or associated with the organization, limiting what may be posted to the site and by whom.

The employer’s policies, however, typically do not address the nurse’s use of social media outside of the workplace. It is in this context that the nurse may face potentially serious consequences for inappropriate use of social media.

Confidentiality and Privacy

To understand the limits of appropriate use of social media, it is important to have an understanding of confidentiality and privacy in the health care context. Confidentiality and privacy are related, but distinct concepts. Any patient information learned by the nurse during the course of treatment must be safeguarded by that nurse. Such information may only be disclosed to other members of the health care team for health care purposes. Confidential information should be shared only with the patient’s informed consent, when legally required or where failure to disclose the information could result in significant harm. Beyond these very limited exceptions the nurse’s obligation to safeguard such confidential information is universal.

Privacy relates to the patient’s expectation and right to be treated with dignity and respect. Effective nurse-patient relationships are built on trust. The patient needs to be confident that their most personal information and their basic dignity will be protected by the nurse. Patients will be hesitant to disclose personal information if they fear it will be disseminated beyond those who have a legitimate “need to know.” Any breach of this trust, even inadvertent, damages the particular nurse-patient relationship and the general trustworthiness of the profession of nursing.

Federal law reinforces and further defines privacy through the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulations are intended to protect patient privacy by defining
individually identifiable information and establishing how this information may be used, by whom and under what circumstances. The definition of individually identifiable information includes any information that relates to the past, present or future physical or mental health of an individual, or provides enough information that leads someone to believe the information could be used to identify an individual.

Breaches of patient confidentiality or privacy can be intentional or inadvertent and can occur in a variety of ways. Nurses may breach confidentiality or privacy with information he or she posts via social media. Examples may include comments on social networking sites in which a patient is described with sufficient detail to be identified, referring to patients in a degrading or demeaning manner, or posting video or photos of patients. Additional examples are included at the end of this document.

**Possible Consequences**

Potential consequences for inappropriate use of social and electronic media by a nurse are varied. The potential consequences will depend, in part, on the particular nature of the nurse's conduct.

**BON Implications**

Instances of inappropriate use of social and electronic media may be reported to the BON. The laws outlining the basis for disciplinary action by a BON vary between jurisdictions. Depending on the laws of a jurisdiction, a BON may investigate reports of inappropriate disclosures on social media by a nurse on the grounds of:

- Unprofessional conduct;
- Unethical conduct;
- Moral turpitude;
- Mismanagement of patient records;
- Revealing a privileged communication; and
- Breach of confidentiality.

If the allegations are found to be true, the nurse may face disciplinary action by the BON, including a reprimand or sanction, assessment of a monetary fine, or temporary or permanent loss of licensure.

A 2010 survey of BONs conducted by NCSBN indicated an overwhelming majority of responding BONs (33 of the 46 respondents) reported receiving complaints of nurses who have violated patient privacy by posting photos or information about patients on social networking sites. The majority (26 of the 33) of BONs reported taking disciplinary actions based on these complaints. Actions taken by the BONs included censure of the nurse, issuing a letter of concern, placing conditions on the nurse’s license or suspension of the nurse’s license.

**Other Consequences**

Improper use of social media by nurses may violate state and federal laws established to protect patient privacy and confidentiality. Such violations may result in both civil and criminal penalties, including fines and possible jail time. A nurse may face personal liability. The nurse may be individually sued for defamation, invasion of privacy or harassment. Particularly flagrant misconduct on social media websites may also raise liability under state or federal regulations focused on preventing patient abuse or exploitation.

If the nurse’s conduct violates the policies of the employer, the nurse may face employment consequences, including termination. Additionally, the actions of the nurse may damage the reputation of the health care organization, or subject the organization to a law suit or regulatory consequences.
Another concern with the misuse of social media is its effect on team-based patient care. Online comments by a nurse regarding co-workers, even if posted from home during nonwork hours, may constitute as lateral violence. Lateral violence is receiving greater attention as more is learned about its impact on patient safety and quality clinical outcomes. Lateral violence includes disruptive behaviors of intimidation and bullying, which may be perpetuated in person or via the Internet, sometimes referred to as “cyber bullying.” Such activity is cause for concern for current and future employers and regulators because of the patient-safety ramifications. The line between speech protected by labor laws, the First Amendment and the ability of an employer to impose expectations on employees outside of work is still being determined. Nonetheless, such comments can be detrimental to a cohesive health care delivery team and may result in sanctions against the nurse.

Common Myths and Misunderstandings of Social Media
While instances of intentional or malicious misuse of social media have occurred, in most cases, the inappropriate disclosure or posting is unintentional. A number of factors may contribute to a nurse inadvertently violating patient privacy and confidentiality while using social media. These may include:

- A mistaken belief that the communication or post is private and accessible only to the intended recipient. The nurse may fail to recognize that content once posted or sent can be disseminated to others. In fact, the terms of using a social media site may include an extremely broad waiver of rights to limit use of content.¹ The solitary use of the Internet, even while posting to a social media site, can create an illusion of privacy.

- A mistaken belief that content that has been deleted from a site is no longer accessible.

- A mistaken belief that it is harmless if private information about patients is disclosed if the communication is accessed only by the intended recipient. This is still a breach of confidentiality.

- A mistaken belief that it is acceptable to discuss or refer to patients if they are not identified by name, but referred to by a nickname, room number, diagnosis or condition. This too is a breach of confidentiality and demonstrates disrespect for patient privacy.

- Confusion between a patient’s right to disclose personal information about himself/herself (or a health care organization’s right to disclose otherwise protected information with a patient’s consent) and the need for health care providers to refrain from disclosing patient information without a care-related need for the disclosure.

- The ease of posting and commonplace nature of sharing information via social media may appear to blur the line between one’s personal and professional lives. The quick, easy and efficient technology enabling use of social media reduces the amount of time it takes to post content and simultaneously, the time to consider whether the post is appropriate and the ramifications of inappropriate content.

How to Avoid Problems
It is important to recognize that instances of inappropriate use of social media can and do occur, but with awareness and caution, nurses can avoid inadvertently disclosing confidential or private information about patients.

The following guidelines are intended to minimize the risks of using social media:

- First and foremost, nurses must recognize that they have an ethical and legal obligation to maintain patient privacy and confidentiality at all times.

¹ One such waiver states, “By posting user content to any part of the site, you automatically grant the company an irrevocable, perpetual, nonexclusive transferable, fully paid, worldwide license to use, copy, publicly perform, publicly display, reformat, translate, excerpt (in whole or in part), distribute such user content for any purpose.” Privacy Commission of Canada. (2007, November 7). Privacy and social networks [Video file]. Retrieved from http://www.youtube.com/watch?v=x7gjWEGhXcA
Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.

Do not share, post or otherwise disseminate any information, including images, about a patient or information gained in the nurse-patient relationship with anyone unless there is a patient care related need to disclose the information or other legal obligation to do so.

Do not identify patients by name or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy.

Do not refer to patients in a disparaging manner, even if the patient is not identified.

Do not take photos or videos of patients on personal devices, including cell phones. Follow employer policies for taking photographs or video of patients for treatment or other legitimate purposes using employer-provided devices.

Maintain professional boundaries in the use of electronic media. Like in-person relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Use caution when having online social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship. The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient.

Consult employer policies or an appropriate leader within the organization for guidance regarding work related postings.

Promptly report any identified breach of confidentiality or privacy.

Be aware of and comply with employer policies regarding use of employer-owned computers, cameras and other electronic devices and use of personal devices in the work place.

Do not make disparaging remarks about employers or co-workers. Do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic or other offensive comments.

Do not post content or otherwise speak on behalf of the employer unless authorized to do so and follow all applicable policies of the employer.

Conclusion
Social and electronic media possess tremendous potential for strengthening personal relationships and providing valuable information to health care consumers. Nurses need to be aware of the potential ramifications of disclosing patient-related information via social media. Nurses should be mindful of employer policies, relevant state and federal laws, and professional standards regarding patient privacy and confidentiality and its application to social and electronic media. By being careful and conscientious, nurses may enjoy the personal and professional benefits of social and electronic media without violating patient privacy and confidentiality.

Illustrative Cases
The following cases, based on events reported to BONs, depict inappropriate uses of social and electronic media. The outcomes will vary from jurisdiction to jurisdiction.

SCENARIO 1
Bob, a licensed practical/vocational (LPN/VN) nurse with 20 years of experience used his personal cell phone to take photos of a resident in the group home where he worked. Prior
to taking the photo, Bob asked the resident’s brother if it was okay for him to take the photo. The brother agreed. The resident was unable to give consent due to her mental and physical condition. That evening, Bob saw a former employee of the group home at a local bar and showed him the photo. Bob also discussed the resident’s condition with the former coworker. The administrator of the group home learned of Bob’s actions and terminated his employment. The matter was also reported to the BON. Bob told the BON he thought it was acceptable for him to take the resident’s photo because he had the consent of a family member. He also thought it was acceptable for him to discuss the resident’s condition because the former employee was now employed at another facility within the company and had worked with the resident. The nurse acknowledged he had no legitimate purpose for taking or showing the photo or discussing the resident’s condition. The BON imposed disciplinary action on Bob’s license requiring him to complete continuing education on patient privacy and confidentiality, ethics and professional boundaries.

This case demonstrates the need to obtain valid consent before taking photographs of patients; the impropriety of using a personal device to take a patient’s photo; and that confidential information should not be disclosed to persons no longer involved in the care of a patient.

**SCENARIO 2**

Sally, a nurse employed at a large long-term care facility arrived at work one morning and found a strange email on her laptop. She could not tell the source of the email, only that it was sent during the previous nightshift. Attached to the email was a photo of what appeared to be an elderly female wearing a gown with an exposed backside bending over near her bed. Sally asked the other dayshift staff about the email/photo and some confirmed they had received the same photo on their office computers. Nobody knew anything about the source of the email or the identity of the woman, although the background appeared to be a resident’s room at the facility. In an effort to find out whether any of the staff knew anything about the email, Sally forwarded it to the computers and cell phones of several staff members who said they had not received it. Some staff discussed the photo with an air of concern, but others were laughing about it as they found it amusing. Somebody on staff started an office betting pool to guess the identity of the resident. At least one staff member posted the photo on her blog.

Although no staff member had bothered to bring it to the attention of a supervisor, by midday, the director of nursing and facility management had become aware of the photo and began an investigation as they were very concerned about the patient’s rights. The local media also became aware of the matter and law enforcement was called to investigate whether any crimes involving sexual exploitation had been committed.

While the county prosecutor, after reviewing the police report, declined to prosecute, the story was heavily covered by local media and even made the national news. The facility’s management placed several staff members on administrative leave while they looked into violations of facility rules that emphasize patient rights, dignity and protection. Management reported the matter to the BON, which opened investigations to determine whether state or federal regulations against “exploitation of vulnerable adults” were violated. Although the originator of the photo was never discovered, nursing staff also faced potential liability for their willingness to electronically share the photo within and outside the facility, thus exacerbating the patient privacy violations, while at the same time, failing to bring it to management’s attention in accordance with facility policies and procedures. The patient in the photo was ultimately identified and her family threatened to sue the facility and all the staff involved. The BON’s complaint is pending and this matter was referred to the agency that oversees long-term care agencies.

This scenario shows how important it is for nurses to carefully consider their actions. The nurses had a duty to immediately report the incident to their supervisor to protect patient privacy and maintain professionalism. Instead, the situation escalated to involving the BON, the county prosecutor and even the national media. Since the patient was ultimately identified, the family was embarrassed and the organization faced possible legal consequences. The organization was also embarrassed because of the national media focus.
**SCENARIO 3**

A 20-year-old junior nursing student, Emily, was excited to be in her pediatrics rotation. She had always wanted to be a pediatric nurse. Emily was caring for Tommy, a three-year-old patient in a major academic medical center's pediatric unit. Tommy was receiving chemotherapy for leukemia. He was a happy little guy who was doing quite well and Emily enjoyed caring for him. Emily knew he would likely be going home soon, so when his mom went to the cafeteria for a cup of coffee, Emily asked if he minded if she took his picture. Tommy, a little “ham,” consented immediately. Emily took his picture with her cell phone as she wheeled him into his room because she wanted to remember his room number.

When Emily got home that day she excitedly posted Tommy's photo on her Facebook page so her fellow nursing students could see how lucky she was to be caring for such a cute little patient. Along with the photo, she commented, “This is my 3-year-old leukemia patient who is bravely receiving chemotherapy. I watched the nurse administer his chemotherapy today and it made me so proud to be a nurse.” In the photo, Room 324 of the pediatric unit was easily visible.

Three days later, the dean of the nursing program called Emily into her office. A nurse from the hospital was browsing Facebook and found the photo Emily posted of Tommy. She reported it to hospital officials who promptly called the nursing program. While Emily never intended to breach the patient's confidentiality, it didn't matter. Not only was the patient's privacy compromised, but the hospital faced a HIPAA violation. People were able to identify Tommy as a “cancer patient,” and the hospital was identified as well. The nursing program had a policy about breaching patient confidentiality and HIPAA violations. Following a hearing with the student, school officials and the student's professor, Emily was expelled from the program. The nursing program was barred from using the pediatric unit for their students, which was very problematic because clinical sites for acute pediatrics are difficult to find. The hospital contacted federal officials about the HIPAA violation and began to institute more strict policies about use of cell phones at the hospital.

This scenario highlights several points. First of all, even if the student had deleted the photo, it is still available. Therefore, it would still be discoverable in a court of law. Anything that exists on a server is there forever and could be resurrected later, even after deletion. Further, someone can access Facebook, take a screen shot and post it on a public website.

Secondly, this scenario elucidates confidentiality and privacy breaches, which not only violate HIPAA and the nurse practice act in that state, but also could put the student, hospital and nursing program at risk for a lawsuit. It is clear in this situation that the student was well-intended, and yet the post was still inappropriate. While the patient was not identified by name, he and the hospital were still readily identifiable.

**SCENARIO 4**

A BON received a complaint that a nurse had blogged on a local newspaper’s online chat room. The complaint noted that the nurse bragged about taking care of her “little handicapper.” Because they lived in a small town, the complainant could identify the nurse and the patient. The complainant stated that the nurse was violating “privacy laws” of the child and his family. It was also discovered that there appeared to be debate between the complainant and the nurse on the blog over local issues. These debates and disagreements resulted in the other blogger filing a complaint about the nurse.

A check of the newspaper website confirmed that the nurse appeared to write affectionately about the handicapped child for whom she provided care. In addition to making notes about her “little handicapper,” there were comments about a wheelchair and the child's age. The comments were not meant to be offensive, but did provide personal information about the patient. There was no specific identifying information found on the blog about the patient, but if you knew the nurse, the patient or the patient's family, it would be possible to identify who was being discussed.

The board investigator contacted the nurse about the issue. The nurse admitted she is a frequent blogger on the local newspaper site; she explained that she does not have a television and
SCENARIO 5
Nursing students at a local college had organized a group on Facebook that allowed the student nurses’ association to post announcements and where students could frequently blog, sharing day-to-day study tips and arranging study groups. A student-related clinical error occurred in a local facility and the student was dismissed from clinical for the day pending an evaluation of the error. That evening, the students blogged about the error, perceived fairness and unfairness of the discipline, and projected the student’s future. The clinical error was described, and since the college only utilized two facilities for clinical experiences, it was easy to discern where the error took place. The page and blog could be accessed by friends of the students, as well as by the general public.

The students in this scenario could face possible expulsion and discipline. These blogs can be accessed by the public and the patient could be identified because this is a small community. It is a myth that it can only be accessed by that small group, and as in Scenario 3, once posted, the information is available forever. Additionally, information can be quickly spread to a wide audience, so someone could have taken a screen shot of the situation and posted it on a public site. This is a violation of employee/university policies.

SCENARIO 6
Chris Smith, the brother of nursing home resident Edward Smith, submitted a complaint to the BON. Chris was at a party when his friend, John, picked up his wife’s phone to read her a text message. The message noted that she was to “get a drug screen for resident Edward Smith.” The people at the party who heard the orders were immediately aware that Edward Smith was the quadriplegic brother of Chris. Chris did not want to get the nurse in trouble, but was angered that personal information about his brother’s medical information was released in front of others.

The BON opened an investigation and learned that the physician had been texting orders to the personal phone number of nurses at the nursing home. This saved time because the nurses would get the orders directly and the physician would not have to dictate orders by phone. The use of cell phones also provided the ability for nurses to get orders while they worked with other residents. The practice was widely known within the facility, but was not the approved method of communicating orders.

The BON learned that on the night of the party, the nurse had left the facility early. A couple hours prior to leaving her shift she had called the physician for new orders for Edward Smith. She passed this information onto the nurse who relieved her. She explained that the physician must not have gotten a text from her co-worker before he texted her the orders.

The BON contacted the nursing home and spoke to the director of nursing. The BON indicated that if the physician wanted to use cell phones to text orders, he or the facility would need to provide a dedicated cell phone to staff. The cell phone could remain in a secured, private area at the nursing home or with the nurse during her shift.

The BON issued a warning to the nurse. In addition, the case information was passed along to the health board and medical board to follow up with the facility and physician.
This scenario illustrates the need for nurses to question practices that may result in violations of confidentiality and privacy. Nurse managers should be aware of these situations and take steps to minimize such risks.

**SCENARIO 7**

Jamie has been a nurse for 12 years, working in hospice for the last six years. One of Jamie’s current patients, Maria, maintained a hospital-sponsored communication page to keep friends and family updated on her battle with cancer. Jamie periodically read Maria’s postings, but had never left any online comments. One day, Maria posted about her depression and difficulty finding an effective combination of medications to relieve her pain without unbearable side effects. Jamie knew Maria had been struggling and wanted to provide support, so she wrote a comment in response to the post, stating, “I know the last week has been difficult. Hopefully the new happy pill will help, along with the increased dose of morphine. I will see you on Wednesday.” The site automatically listed the user’s name with each comment. The next day, Jamie was shopping at the local grocery store when a friend stopped her and said, “I didn’t know you were taking care of Maria. I saw your message to her on the communication page. I can tell you really care about her and I am glad she has you. She’s an old family friend, you know. We’ve been praying for her but it doesn’t look like a miracle is going to happen. How long do you think she has left?” Jamie was instantly horrified to realize her expression of concern on the webpage had been an inappropriate disclosure. She thanked her friend for being concerned, but said she couldn’t discuss Maria’s condition. She immediately went home and attempted to remove her comments, but that wasn’t possible. Further, others could have copied and pasted the comments elsewhere.

At her next visit with Maria, Jamie explained what had happened and apologized for her actions. Maria accepted the apology, but asked Jamie not to post any further comments. Jamie self-reported to the BON and is awaiting the BON’s decision.

This scenario emphasizes the importance for nurses to carefully consider the implications of posting any information about patients on any type of website. While this website was hospital sponsored, it was available to friends and family. In some contexts it is appropriate for a nurse to communicate empathy and support for patients, but they should be cautious not to disclose private information, such as types of medications the patient is taking.

**References**


Attachment D

Summary of Social Networking Survey to Boards of Nursing (BONs)

This survey was conducted in November 2010. Of the 46 BONs that responded, 33 have received complaints about nurses who have violated patient privacy by posting information about patients or photos on social networking sites. Of these 33 BONs, 26 have disciplined nurses for violating patient privacy in the following ways:

- Censuring;
- Letters of concern;
- Voluntary action (such as agreeing to conditions on practice or voluntary suspension) to resolve the complaint; and
- Informal discipline and education.

The BONs indicated that they are making decisions on a case-by-case basis.

When asked whether BONs have social networking guidelines in place for protecting patient privacy, most do not (40 BONs). Of the six BONs that do, they referred to their general guidelines on protecting patient confidentiality.

General comments included:

- Need for social networking guidelines/information (nine BONs);
- Suggest using confidentiality/privacy regulations (four BONs); and
- Challenges for regulators:
  - Difficult to get access to the information posted;
  - Sites ignore subpoenas;
  - Nurses don't realize that the Internet is public;
  - How far should regulation go? We can't regulate personal lives. Need to let nurses debrief;
  - Generational vs. societal values are clashing;
  - In the future nurses may change their identity so the information cannot be used against them; and
  - We should focus on prevention, rather than disciplining bad outcomes.
Attachment E
Guidelines for Regulatory Decision Making Related to Criminal Conduct

NCSBN’s Disciplinary Resources Committee developed a systematic process for boards of nursing (BONs) to use that promotes more consistency as they make difficult decisions related to criminal behavior. As a foundation for this work, the committee reviewed the literature, met with experts in criminal background behavior and surveyed BONs for any guidelines.

This process allows for each BON to integrate its unique laws and definitions into the process and was developed with the assumption that generally, decisions are made on a case-by-case basis. However, absolute bars can be added.

Mitigating and aggravating circumstances were identified from BON experiences and the literature reviewed. Research supporting these factors is provided to promote evidence-based regulatory decision making; however, more work needs to be done in this area.

Reviewing the grid below, there is a two-step process for individualizing it to a BON:

1. BONs will determine their own tier descriptions under Nature/Severity based on their law and the nature/severity of the criminal offense (see below for additional guidance).

2. BONs will determine their range of disciplinary sanctions, which may be different from those illustrated in the grid.

<table>
<thead>
<tr>
<th>Disciplinary Outcomes Depending on Unique Circumstances of Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Low (Non-serious)</td>
</tr>
<tr>
<td>Moderate (More serious)</td>
</tr>
<tr>
<td>Severe (Egregious)</td>
</tr>
</tbody>
</table>

**GUIDANCE ON USE OF THIS GRID**

When presented with a case, BONs will determine which tier the nurse’s crime fits based on its nature/severity (low, moderate or severe). As BONs develop their own tier descriptions, options to distinguish between “lower” gravity offenses and “more serious” criminal offenses might include their state’s classifications of crimes, e.g., misdemeanors for the “low” tier and Class A felonies for the “severe” tier. BONs could also develop their own crime categories for the tier analysis, such as crimes “against property” versus “crimes against persons”; “nonviolent versus violent”; crimes involving “deceit” versus “other” crimes, etc. In cases where there are multiple convictions this can be viewed as a significant aggravating factor.

Next, the BON will determine the range of disciplinary actions, based on the unique factors of the case. The BON identifies the unique, salient facts of the nurse’s past criminal conduct and using these “aggravating” or “mitigating” factors, selects the severity of the sanction within the identified tier. Aggravating factors move the appropriate sanctions towards the maximum end of the tier range. Mitigating factors move the appropriate sanctions towards the minimum end of the tier range. BONs should start at the middle range – oversight for two years.
The goal is not to remove all discretion and establish a rigid formula for meting out sanctions, but instead imbue the BON’s decision-making process with an analytical framework to ensure that sanctions are not viewed as arbitrary or inconsistent. BONs should complete the above grid with notes as to which tier was identified as appropriate and which unique factors were used to arrive at the appropriate sanction.

MITIGATING AND AGGRAVATING CIRCUMSTANCES TO CONSIDER

The following nonexclusive list identifies factors that may mitigate or aggravate the sanctions that should be imposed.

Aggravating Factors

- Sexual predator: Recommended to be an absolute bar. Research particularly finds the following range of behaviors to be predictors of recidivism in sexual offenders, though no single factor is absolutely linked to recidivism. The single strongest predictor is sexual interest in children as measured by phallometric measurement ($r=0.32$, with a total sample of 4,853 and a total of seven studies). The next five include:
  - Any deviant sexual preference ($r=0.22$; sample size 570; five studies);
  - Prior sexual offenses ($r=-0.19$; sample size 11,294; 29 studies);
  - Treatment drop out ($r=-0.17$; sample size 806; six studies);
  - Any stranger victims ($r=0.15$; sample size 465; four studies); and
  - Anti-social personality ($r=0.14$; sample size 811; six studies).
  (Hanson & Bussière, 1998; Hanson, 2000)

Investigators should be required to check the sex offender registry or the Falsified Identity Tracking System (FITS) to see if the nurse being investigated is on the list.

- “Criminal thinkers” (as described by Surowiec, 2010): There is a strong link between antisocial personality, and particularly psychopathy with criminal behavior. Psychopathy is a more severe disorder where the individual lacks remorse and shows antisocial behaviors (Surowiec, 2010). See Appendix I for guidance on psychological tests for assessing criminality and Appendix II for selecting an evaluator.

- Repeat offenders: The Boston University Law Review reports that all states consider prior convictions to be an aggravating sentencing factor (Hessick, 2008). Bouffard, Bry, Smith and Bry (2008) found that hypothetical criminal decision making differed in a sample of known offenders relative to a sample of university students, which suggests that repeat offenders are “criminal thinkers.” However, this group should be considered cautiously, as repeat offending is not a reliable measure of recidivism, and yet it is widely considered when sentencing (Surowiec, 2010).

- Recency of the crime: If it has been more than five years since the last crime, nurses are less likely to recidivate (based on BON experiences).

- Status of the victim: The relationship between the victim and the perpetrator and any unique vulnerabilities attributed to the victim should be considered. Crimes against strangers are linked to higher recidivism (Hanson & Bussière, 1998; Hanson, 2000).

- Nurse’s attitude and degree of responsibility for the outcome: Lack of remorse, candor, admission of key facts and whether they self-reported and/or cooperated with the BON investigation should be considered (based on BON experiences, though lack of remorse can be associated with a psychopathic personality and psychological testing might be considered [American Psychiatric Association, 2000; Surowiec, 2010]).

1 Salekin, Rogers, Listad and Sewell (1998) report that 15 to 30 percent of incarcerated offenders are psychopathic.
Abuse of trust: Did the crime involve professional boundary violations, breach of fiduciary duty, privacy or anything that abuses the relationship? Did the nurse take advantage of the victim? (based on BON experiences)

Intentional or deliberative act(s): Degree of intent (forethought, planning, etc.), selfish motivation; a dishonest act done for personal gain (based on BON experiences).

Past disciplinary record: Particularly if it indicates a pattern (Zhong, Kenward, Sheets, Doherty & Gross, 2009), though must evaluate cautiously.

Obstruction of the investigation or discipline process or proceedings: For example, presenting false evidence, statements or deceptive practices during the investigation or discipline process or proceedings (deceit is one of the characteristics of antisocial personality disorder, which is a well-established link to criminal behavior [American Psychiatric Association, 2000; Surowiec, 2010]).

Mitigating Factors

Co-morbidity: Mental health issues at the time of the crime; however, mental illness when combined with substance abuse has been identified as an aggravating factor (Elbogen & Johnson, 2009; Castillo & Alarid, 2011).

Personal circumstances at the time of the crime: Such as poverty or good support system (based on BON experiences).

Evidence of good character or moral fitness: For example, presenting good character references from work associates who can vouch for nurse’s reliability since crime (based on BON experiences; Hessick [2008] does not present research findings, but she analyzes why bad acts are considered in sentencing, though good acts often are not. She suggests that courts should consider good acts to be a mitigating sentence factor).

Offender socio-demographic variables: This is a complex relationship, but generally increasing age and violence against a family member is associated with decreased recidivism. Yet, one study suggests that with increasing age, one is significantly more likely to be involved in an acquaintance or family homicide, but significantly less likely to be involved with a stranger homicide (Cao, Hou, & Huang, 2008).

Voluntary restitution: Remedial action (based on BON experiences; Hessick, 2008, as above).

Evidence of successful rehabilitation: For example, education and work experience; presents evidence of competence to practice (based on BON experiences; Hessick, 2008, as above).

PSYCHOLOGICAL TESTS FOR CRIMINALITY

The link between anti-social personality disorder (APD) and criminal behavior is well established, according to Surowiec (2010). Studies have found that APD can negatively impact how people perceive and interact with the world, causing poor judgment and behavior problems (Surowiec, 2010; Sevecke, Lehmkuhl, & Krischer, 2009). Psychopathy is an even more severe form of APD because these individuals experience a lack of remorse or guilt about their actions and demonstrate antisocial behavior. Salekin, Rogers, Ustad and Sewell (1998) assert that 15-30 percent of all incarcerated offenders are psychopathic. Substance abuse and certain mental illnesses (e.g., schizophrenia, bipolar disorder, major depression) can further increase the chance of criminal activity in people with antisocial traits (Gendreau, Little, & Goggin, 1996; Surowiec, 2010).

Therefore, when BONs evaluate criminal behavior in nurses, it is highly recommended that the nurse be comprehensively evaluated by a qualified psychologist. The following are three recommended tools for assessing criminality:
1. Psychological Inventory of Criminal Thinking Styles (PICTS) is a well-researched tool developed to identify criminal-thinking behaviors. It not only identifies maintaining criminal lifestyles, but also is useful in predicting recidivism (Surowiec, 2010; Gonsalvez, Scalora & Huss, 2009; Walters, 2002; Walters, 2010).

2. It is recommended that PICTS be used with the Psychopathy Checklist-Revised (PCL-R) (Hare, 2003) to look at recidivism. PICTS does not incorporate behavioral items and a combination of cognitive and behavioral items may improve prediction of future criminal behavior (Gonsalvez et al., 2009; Surowiec, 2010).

3. The Historical, Clinical and Risk Management Scales (HCR-20) have also been used to predict violent behavior (Douglas, Ogloff, Nicholls, & Grant, 1999; Douglas & Webster, 1999; Grann, Belfrage, & Tengstrom, 2000; Surowiec, 2010; Strand, Belfrage, Fransson, & Levander, 1998). These scales evaluate clinical state and effectiveness of risk management strategies.

SELECTING AN EVALUATOR FOR CRIMINAL BEHAVIOR

Predicting whether criminal offenders will recidivate is very difficult (Surowiec, 2010). Selecting a qualified evaluator for assessing criminal thinking in the offender will be very important. Psychological tests should be administered by a trained professional, such as a licensed clinical psychologist. Evaluators should be selected based on their membership in and adherence to the practice and ethical standards espoused by the professional associations and BONs, such as the American Psychological Association.

BONs can visit http://locator.apa.org to find a psychologist as an evaluator in their area.

The following is a list of qualified professionals that BONs may want to contact:

- David M. Corey, PhD (Oregon and Washington)
- Phil Trompetter, PhD (California)
- Jocelyn Roland, PsyD (California)
- John Nicoletti, PhD (Colorado)
- Jeni McCutcheon, PsyD (Arizona)
- Doug Craig, PsyD (Illinois)
- Matt Guller, PhD, JD (New Jersey)
- Greg DeClue, PhD (Florida)
- Heather McElroy, PhD (Georgia)
- Herb Gupton, PhD (Hawaii)
- Gary Fischler, PhD (Minnesota)
- Byron Greenberg, PhD (Virginia)
- Darren Higginbotham, PsyD (Indiana)
- Terry McDaniel, PhD (Tennessee)
- Hank Paine, PhD (Alabama)
- Susan Hurt, PhD (North Carolina)
- Jon Moss, PhD (Virginia)
- Jay Supnick, PhD (New York)
- Peter Weiss, PhD (Connecticut)
REFERENCES


Report of the Finance Committee

Background
The Finance Committee advises the NCSBN 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 FY11 Activities
- Reviewed and discussed with management and the organization’s independent accountant the organization’s audited financial statements as of and for the fiscal year ending Sept. 30, 2010. With and without management present, the committee discussed and reviewed the results of the independent accountant’s examination of the internal controls and financial statements. Based on the review and discussions referred to 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, 2011.
- 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 with NCSBN staff and the organization’s investment consultant, Becker Burke, quarterly. Informed the BOD that the current investment policy and strategy appear to be appropriate for NCSBN.
- Reviewed and discussed with the insurance brokers from USI Midwest the property and professional liability coverage for NCSBN. Informed BOD that the organization is appropriately insured.
- Recommended revisions to financial policies.

Future Activities
- There are no recommendations. The purpose of this report is for information only.
- At a future meeting, the committee will review the budget proposal for the fiscal year beginning Oct. 1, 2011.

Attachments
A. Report of the Independent Auditors FY10
Attachment A

Report of the Independent Auditors FY10

Blackman Kallick

Blackman Kallick, LLP  
10 South Dearborn Plaza, 9th Floor  
Chicago, IL 60406  
Phone 312-707-0440

Report of Independent Auditors

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

We have audited the accompanying statement of financial position of National Council of State Boards of Nursing, Inc. (NCSBN) as of September 30, 2010, and the related statements of activities and cash flows for the year then ended. These financial statements are the responsibility of NCSBN’s management. Our responsibility is to express an opinion on these financial statements based on our audit. The financial statements of National Council of State Board of Nursing, Inc. as of and for the year ended September 30, 2009 were audited by other auditors whose report, dated December 10, 2009, expressed an unqualified opinion on those statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the 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 audit provides 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, 2010, and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

Blackman Kallick, LLP  
December 13, 2010
### National Council of State Boards of Nursing, Inc.

#### Statements of Financial Position

September 30, 2010 and 2009

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
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<tr>
<td>Cash</td>
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<td>Accounts receivable</td>
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<td>Due from test vendor</td>
<td>7,473,879</td>
<td>5,811,596</td>
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<td>Accrued investment income</td>
<td>348,850</td>
<td>560,601</td>
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<td>Prepaid expenses</td>
<td>1,689,167</td>
<td>1,450,468</td>
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<td>Investments</td>
<td>88,580,701</td>
<td>101,666,473</td>
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<tr>
<td>Property and equipment - net</td>
<td>4,666,506</td>
<td>4,670,912</td>
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<tr>
<td>Intangible asset - net</td>
<td>1,031,250</td>
<td>1,156,250</td>
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<tr>
<td>Cash held for others</td>
<td>452,292</td>
<td>409,060</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td><strong>$160,162,730</strong></td>
<td><strong>$145,080,183</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIABILITIES</strong></td>
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<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>$1,238,299</td>
<td>$1,071,956</td>
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<tr>
<td>Accrued payroll, payroll taxes and compensated absences</td>
<td>646,765</td>
<td>568,047</td>
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<tr>
<td>Due to test vendor</td>
<td>10,472,628</td>
<td>10,260,493</td>
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<tr>
<td>Deferred revenue</td>
<td>187,500</td>
<td>311,552</td>
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<tr>
<td>Grants payable</td>
<td>636,717</td>
<td>562,570</td>
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<tr>
<td>Deferred rent credits</td>
<td>174,264</td>
<td>248,962</td>
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<tr>
<td>Cash held for others</td>
<td>452,292</td>
<td>409,060</td>
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<tr>
<td><strong>Total liabilities</strong></td>
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<td><strong>13,432,640</strong></td>
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</table>

**UNRESTRICTED NET ASSETS**

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>146,354,265</td>
<td>131,647,543</td>
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</table>

**Total liabilities and net assets**

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$160,162,730</strong></td>
<td><strong>$145,080,183</strong></td>
<td></td>
</tr>
</tbody>
</table>

See accompanying notes to financial statements.

- 2 -
# National Council of State Boards of Nursing, Inc.

## Statements of Activities

Years Ended September 30, 2010 and 2009

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE</strong></td>
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<td></td>
</tr>
<tr>
<td>Examination fees</td>
<td>$59,431,200</td>
<td>$60,650,700</td>
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<td>Other program services income</td>
<td>6,055,024</td>
<td>5,583,909</td>
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<tr>
<td>Net realized and change in unrealized gain (loss) on investments</td>
<td>4,747,266</td>
<td>(722,547)</td>
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<tr>
<td>Interest and dividend income</td>
<td>3,249,677</td>
<td>3,651,908</td>
</tr>
<tr>
<td>Membership fees</td>
<td>186,000</td>
<td>181,500</td>
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<tr>
<td><strong>Total revenue</strong></td>
<td>73,669,167</td>
<td>69,345,470</td>
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<tr>
<td><strong>EXPENSES</strong></td>
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<tr>
<td>Program services</td>
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<td></td>
</tr>
<tr>
<td>Nurse competence</td>
<td>41,264,703</td>
<td>36,320,749</td>
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<tr>
<td>Nurse practice and regulatory outcome</td>
<td>6,552,005</td>
<td>5,085,136</td>
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<tr>
<td>Information</td>
<td>8,186,682</td>
<td>7,070,994</td>
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<tr>
<td><strong>Total program services</strong></td>
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<td>48,476,879</td>
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<td>Supporting services</td>
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<td></td>
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<td>Management and general</td>
<td>2,959,055</td>
<td>2,957,949</td>
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<tr>
<td><strong>Total expenses</strong></td>
<td>58,962,445</td>
<td>51,434,828</td>
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**NET INCREASE**

14,706,722 17,910,642

**UNRESTRICTED NET ASSETS**

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<th>2009</th>
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<tbody>
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<td>Beginning of year</td>
<td>131,647,543</td>
<td>113,736,901</td>
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<td>End of year</td>
<td>$146,354,265</td>
<td>$131,647,543</td>
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</tbody>
</table>

See accompanying notes to financial statements.
## National Council of State Boards of Nursing, Inc.

**Statements of Cash Flows**

*Years Ended September 30, 2010 and 2009*

### CASH FLOWS FROM OPERATING ACTIVITIES

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net increase</td>
<td>$14,706,722</td>
<td>$17,910,642</td>
</tr>
<tr>
<td>Adjustments to reconcile net increase to net cash provided by operating activities</td>
<td></td>
<td></td>
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<tr>
<td>Depreciation and amortization</td>
<td>2,887,546</td>
<td>2,503,815</td>
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<tr>
<td>Net realized and change in unrealized (gain) loss on investments</td>
<td>(4,747,266)</td>
<td>722,547</td>
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<tr>
<td>(Increase) decrease in assets</td>
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<tr>
<td>Accounts receivable</td>
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<td>Due from test vendor</td>
<td>(1,662,283)</td>
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<td>Accrued investment income</td>
<td>211,751</td>
<td>(52,889)</td>
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<tr>
<td>Prepaid expenses</td>
<td>(238,699)</td>
<td>(132,827)</td>
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<tr>
<td>Increase (decrease) in liabilities</td>
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<td>Accounts payable</td>
<td>166,343</td>
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<td>Accrued payroll, payroll taxes and compensated absences</td>
<td>78,718</td>
<td>19,938</td>
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<td>Due to test vendor</td>
<td>212,135</td>
<td>318,752</td>
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<td>Deferred revenue</td>
<td>(124,052)</td>
<td>(26,858)</td>
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<td>Grants payable</td>
<td>74,147</td>
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<td>Deferred rent credits</td>
<td>(74,698)</td>
<td>(74,699)</td>
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<td><strong>Net cash provided by operating activities</strong></td>
<td><strong>11,461,882</strong></td>
<td><strong>20,317,259</strong></td>
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### CASH FLOWS FROM INVESTING ACTIVITIES

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<tr>
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</thead>
<tbody>
<tr>
<td>Purchases of property and equipment</td>
<td>(2,758,140)</td>
<td>(2,950,774)</td>
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<tr>
<td>Purchase of intangible assets</td>
<td>-</td>
<td>(1,250,000)</td>
</tr>
<tr>
<td>Purchases of investments</td>
<td>(17,962,958)</td>
<td>(73,142,286)</td>
</tr>
<tr>
<td>Proceeds on sale of investments</td>
<td>35,795,996</td>
<td>37,650,175</td>
</tr>
<tr>
<td><strong>Net cash provided by (used in) investing activities</strong></td>
<td><strong>15,074,898</strong></td>
<td><strong>(39,692,885)</strong></td>
</tr>
<tr>
<td><strong>Net increase (decrease)</strong></td>
<td><strong>26,536,780</strong></td>
<td><strong>(19,375,626)</strong></td>
</tr>
</tbody>
</table>

### CASH

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning of year</td>
<td>$29,246,205</td>
<td>$48,621,831</td>
</tr>
<tr>
<td><strong>End of year</strong></td>
<td><strong>$55,782,985</strong></td>
<td><strong>$29,246,205</strong></td>
</tr>
</tbody>
</table>

See accompanying notes to financial statements.
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 as a whole have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America (GAAPUSA).

Basis of Presentation - 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)

Revenue Recognition - Revenue from NCLEX fees is recognized when an exam registration is complete, rather than when the registrant either takes the examination or is no longer eligible to do so. NCSBN does not believe its policy regarding this revenue and the corresponding test vendor costs to be a significant departure from GAAP USA.

Revenue from member dues is recorded in the applicable membership period.

Revenue from member service conference fees is recognized in the period the conference is held.

Revenue for E-Learning Course sales is recognized at registration when access is granted to the course.

Revenue for licensure verification fees is recognized when a verification request is submitted.

Revenue from publication sales is recognized when customers complete the subscription process.

Accounts Receivable - Represents amounts owed to NCSBN for services dealing with board membership fees, meeting fees and online course revenue. Accounts receivable at September 30, 2010 and 2009 were $137,100 and $108,618, respectively. An allowance for doubtful accounts was not considered necessary.

Investments - 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.

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).

Money market funds are valued at fair value.

Certificates of deposit values are determined from new issue market and direct dealer quotes.
NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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.

Fair Value Measurements - During 2009, NCSBN adopted the new GAAPUSA guidance on fair value measurements and disclosures for all financial assets and liabilities carried at fair value. The new guidance defined fair value, established a framework for measuring fair value and expanded disclosures about fair value measurements. In September 2009, NCSBN adopted the guidance for nonrecurring fair value measurements of certain debt securities, which guidance had been previously deferred. The adoption of this guidance had no material effect on NCSBN’s financial statements.

In September 2009, the Financial Accounting Standards Board (FASB) issued new guidance regarding the use of net asset value per share provided by the investee as a practical expedient to estimate the fair value of alternative investments. NCSBN’s adoption of this new guidance had no material effect on its financial statements, but did result in additional, or changed, disclosures.

Due from Test Vendor - Due from test vendor represents amounts due from Pearson VUE for accrued volume discounts. NCSBN has contracted with Pearson VUE to administer and deliver nurse licensure examinations. Pearson VUE uses a tier-based volume pricing schedule to determine its fee price to provide the examination. Base price fees before calculating discounts are paid to Pearson VUE for administered exams during the year. Volume discounts are accrued during the year. The amounts owed by Pearson VUE at September 30, 2010 and 2009 were $7,473,879 and $5,811,596, respectively.

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: useful life or life of lease
NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Intangible Asset - The intangible asset represents the purchase of the intellectual property rights for the National Nurse Aide Assessment Program nurse aid 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 10-year period. Amortization expense for the years ended September 30, 2010 and 2009 was $125,000 and $93,750, respectively.

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual property</td>
<td>$1,250,000</td>
<td>$1,250,000</td>
</tr>
<tr>
<td>Less accumulated amortization</td>
<td>(218,750)</td>
<td>(93,750)</td>
</tr>
<tr>
<td></td>
<td>$1,031,250</td>
<td>$1,156,250</td>
</tr>
</tbody>
</table>

Due to Test Vendor - NCSBN accrues a base price fee for each candidate for whom a completed candidate application to take NCLEX is processed by Pearson VUE. At the end of each month, NCSBN pays an amount equal to the base price multiplied by the number of candidates who were administered the examinations during the preceding month.

Due to test vendor includes accrued amounts totaling $6,775,400 at September 30, 2010 and $7,033,000 at September 30, 2009 for registered candidates who at year end had not taken the exam. Also included is the amount payable to Pearson VUE for administered exams that had not been paid at the end of the year.

Deferred Revenue - Deferred revenue consists of membership fees of $187,500 for 2010 and $181,500 for 2009 and online course revenue of $0 for 2010 and $130,052 for 2009.

Grants Payable - 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 $150,300 to $300,000 during the current year. At September 30, 2010, the amount remaining to be paid on grants awarded for 2010 and 2009 is $561,767 and $74,950, respectively.

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, 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.
NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Estimates - The preparation of financial statements in conformity with GAAPUSA 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 - NCSBN has evaluated subsequent events through December 13, 2010, the date the 2010 financial statements were available to be issued and December 10, 2009 with respect to the comparative 2009 financial statements.

NOTE 3. INCOME TAX

NCSBN is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code (the 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).

NCSBN’s adoption of the Income Tax Topic regarding uncertain tax positions of GAAPUSA on September 30, 2009 had no effect on its financial position as management believes NCSBN has no material unrecognized income tax benefits, including any potential risk of loss of its not-for-profit status. NCSBN would account for any potential interest or penalties related to possible future liabilities for unrecognized income tax benefits as interest, which would be included in the statement of activities supporting services management and general expenses. NCSBN is no longer subject to examination by federal, state or local tax authorities before 2007. Prior to adoption of the Income Tax Topic, NCSBN accounted for tax positions under a contingent loss model, requiring recognition of a tax liability when it was both (1) probable that it had been incurred at fiscal year-end and (2) the amount could be reasonably estimated.
NOTE 4. CASH CONCENTRATIONS

The cash balance at September 30, 2010 and 2009 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>JP Morgan Chase</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking account</td>
<td>7,395</td>
<td>5,153,039</td>
</tr>
<tr>
<td>Money market account</td>
<td>14,043,202</td>
<td>23,372,418</td>
</tr>
<tr>
<td>Savings account</td>
<td>16,403,892</td>
<td>-</td>
</tr>
<tr>
<td><strong>Wells Fargo Bank</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking account</td>
<td>799,684</td>
<td>672,777</td>
</tr>
<tr>
<td><strong>Harris Bank</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money market account</td>
<td>24,486,471</td>
<td>100</td>
</tr>
<tr>
<td>Credit card merchant accounts</td>
<td>42,091</td>
<td>47,621</td>
</tr>
<tr>
<td>Petty cash</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$55,782,985</td>
<td>$29,246,205</td>
</tr>
</tbody>
</table>

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 December 31, 2012. The majority of the balances in the accounts above exceed insured limits.

NOTE 5. FAIR VALUE MEASUREMENTS

GAAPUSA defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. GAAPUSA describes three approaches to measuring the fair value of assets and liabilities: the market approach, the income approach and the cost approach. Each approach includes multiple valuation techniques. The topic does not prescribe which valuation technique should be used when measuring fair value, but does establish a fair value hierarchy that prioritizes the inputs used in applying the various techniques. Inputs broadly refer to the assumptions that market participants use to make pricing decisions, including assumptions about risk. Level 1 inputs are given the highest priority in the hierarchy while Level 3 inputs are given the lowest priority. Financial assets and liabilities carried at fair value are classified in one of the following three categories based upon the inputs to the valuation technique used:

- Level 1 - Observable inputs that reflect unadjusted quoted prices for identical assets or liabilities in active markets at the reporting date. Active markets are those in which transactions for the asset or liability occur in sufficient frequency and volume to provide pricing information on an ongoing basis.
NOTE 5.  FAIR VALUE MEASUREMENTS (CONTINUED)

- Level 2 - Observable market-based inputs or unobservable inputs that are corroborated by market data.

- Level 3 - Unobservable inputs that are not corroborated by market data. These inputs reflect management’s best estimate of fair value using its own assumptions about the assumptions a market participant would use in pricing the asset or liability.

The following tables set forth by level within the fair value hierarchy NCSBN’s financial assets and liabilities that were accounted for at fair value on a recurring basis at September 30, 2010 and 2009. As required by GAAPUSA, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. NCSBN’s assessment of the significance of a particular input to the fair value measurement requires judgment, and may affect their placement within the fair value hierarchy levels. Total NCSBN investment assets at fair value classified within Level 3 were $3,987,136 and $2,741,621 at September 30, 2010 and 2009, respectively, which consists of NCSBN’s real estate investment trust funds. Such amounts were approximately 4% and 3% of total investments as reported on the statement of net assets available for benefits at fair value at September 30, 2010 and 2009, respectively.

### Recurring Fair Value Measurements as of Reporting Date Using:

<table>
<thead>
<tr>
<th>Fixed Income</th>
<th>Quoted Prices in Active Markets for Identical Assets (Level 1)</th>
<th>Significant Other Observable Inputs (Level 2)</th>
<th>Significant Unobservable Inputs (Level 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Government and Government Agency obligations</td>
<td>$31,389,093</td>
<td>$17,555,214</td>
<td>$13,833,879</td>
</tr>
<tr>
<td>Corporate bonds</td>
<td>$12,395,676</td>
<td>-</td>
<td>$12,395,676</td>
</tr>
<tr>
<td>Mutual funds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spartan Extended Market Index Fund</td>
<td>$8,195,830</td>
<td>$8,195,830</td>
<td>-</td>
</tr>
<tr>
<td>Spartan International Index Fund</td>
<td>$4,763,500</td>
<td>$4,763,500</td>
<td>-</td>
</tr>
<tr>
<td>DWS Equity 500 Index Fund</td>
<td>$24,035,652</td>
<td>$24,035,652</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>$63,570</td>
<td>$63,570</td>
<td>-</td>
</tr>
<tr>
<td>International equity fund -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited liability company</td>
<td>$3,467,847</td>
<td></td>
<td>$3,467,847</td>
</tr>
<tr>
<td>Real estate investment trust</td>
<td>$3,987,136</td>
<td></td>
<td>$3,987,136</td>
</tr>
<tr>
<td>Total</td>
<td>$88,298,304</td>
<td>$54,613,766</td>
<td>$29,697,402</td>
</tr>
</tbody>
</table>
### NOTE 5. FAIR VALUE MEASUREMENTS (CONTINUED)

| Recurring Fair Value Measurements as of Reporting Date Using: | Quoted Prices |
| --- | --- | --- | --- | --- |
|  | Fair Values | Markets for Significant Inputs | Other Significant Inputs | Identical Observable Inputs |
|  | as of September 30, 2009 (Level 1) | (Level 2) | (Level 3) |
| **Fixed Income** |  |  |  |
| U.S. Government and Government Agency obligations | $27,869,552 | $14,780,962 | $13,088,590 | - |
| Corporate bonds | 12,207,601 | - | 12,207,601 | - |
| **Mutual funds** |  |  |  |
| Spartan Extended Market Index Fund | 6,476,947 | 6,476,947 | - | - |
| Spartan International Index Fund | 4,615,274 | 4,615,274 | - | - |
| DWS Equity 500 Index Fund | 20,196,047 | 20,196,047 | - | - |
| Other | 47,199 | 47,199 | - | - |
| International equity fund - Limited liability company | 3,163,536 | - | 3,163,536 | - |
| Real estate investment trust | 2,741,621 | - | - | 2,741,621 |
| **Total** | $77,317,777 | $46,116,429 | $28,459,727 | $2,741,621 |

Not included in the tables is $282,397 and $24,348,696 in money market funds and certificates of deposit at September 30, 2010 and 2009, respectively.

**LEVEL 1**

**Fixed Income**
The estimated fair values for NCSBN’s fixed income securities were based on quoted market prices in an active market.

**Mutual Funds**
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.
NOTE 5.  FAIR VALUE MEASUREMENTS (CONTINUED)

LEVEL 2

**Fixed Income**
Fixed income securities are 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.

**International Equity Fund - Limited Liability Company**
In 2010, the estimated fair value of the international equity fund is based on net asset values, which is determined by reference to the fund’s underlying assets and liabilities.

In 2009, the estimated fair value was based off prices on one or more national securities or commodities exchanges or generally accepted pricing services to determine the fair value of publicly traded assets.

LEVEL 3

**Real Estate Investment Trust**
In 2010, the estimated fair value of the real estate investment trust was based on net asset values, which is determined by reference to the fund’s underlying assets and liabilities.

In 2009, the fair value was 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.
NOTE 5.  FAIR VALUE MEASUREMENTS (CONTINUED)

The tables below set forth a summary of changes in the fair value of Level 3 assets for the years ended September 30, 2010 and 2009:

<table>
<thead>
<tr>
<th>Fair Value Measurements Using Significant Unobservable Inputs (Level 3)</th>
<th>Real Estate Investment Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 10/1/09</td>
<td>$ 2,741,621</td>
</tr>
<tr>
<td>Contributions</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Net realized and unrealized gain on investments</td>
<td>45,356</td>
</tr>
<tr>
<td>Interest and dividend income</td>
<td>244,897</td>
</tr>
<tr>
<td>Sale of investments</td>
<td>(44,738)</td>
</tr>
<tr>
<td>Balance at 9/30/10</td>
<td>$ 3,987,136</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fair Value Measurements Using Significant Unobservable Inputs (Level 3)</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>

Redemption

Unfunded Frequency (If Redemption Commitments Currently Eligible) Notice Period

<table>
<thead>
<tr>
<th>Fair Value</th>
<th>Unfunded Commitments</th>
<th>Redemption Frequency (If Currently Eligible)</th>
<th>Redemption Notice Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>International equity fund - Limited liability company (a)</td>
<td>$ 3,467,847</td>
<td>$ -</td>
<td>Monthly</td>
</tr>
<tr>
<td>Real estate investment trust (b)</td>
<td>$ 3,987,136</td>
<td>$ -</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

- 14 -
NOTE 5. FAIR VALUE MEASUREMENTS (CONTINUED)

(a) The international equity fund invests in equity securities of issuers: which are organized, headquartered, or domiciled in any country included in the Europe Australasia Far East Index (the EAFE Index), or whose principal listing is on a securities exchange in any country included in the EAFE Index. Under normal conditions, the fund will invest in a minimum of 30 issuers, and is restricted from investing more than 10% of its total assets in the equity securities of any single issuer.

(b) The real estate investment trust represents an ownership interest in a private equity fund. The real estate investment trust invests in a diversified portfolio of primarily institutional quality real estate assets within the United States. The fund has a long-term investment objective of delivering an 8-10% total return over a market cycle. All portfolio assets are acquired through Clarion Lion Properties Fund Holdings, L.P., a limited partnership. The properties within the portfolio are valued on a quarterly basis to establish market value estimates of the fund’s assets for the purpose of establishing the fund’s net asset value. Ownership interests and redemptions are calculated based upon net asset value. The values of the properties are established in accordance with the fund’s independent property valuation policy. Each property is appraised by third-party appraisal firms identified and supervised by an independent appraisal management firm retained by the investment manager. Shares will be redeemed at the net asset value at the last day of the calendar quarter immediately preceding the redemption date. To the extent that liquid assets are insufficient to satisfy redemption requests, interests will be redeemed as liquid assets become available.

NOTE 6. PROPERTY AND EQUIPMENT

The composition of property and equipment at September 30, 2010 and 2009 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td>$1,437,865</td>
<td>$1,437,879</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>18,880,967</td>
<td>16,288,240</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>440,183</td>
<td>440,183</td>
</tr>
<tr>
<td>Less accumulated depreciation and amortization</td>
<td>(16,364,238)</td>
<td>(13,767,119)</td>
</tr>
<tr>
<td>Net property and equipment</td>
<td>$4,666,506</td>
<td>$4,670,912</td>
</tr>
</tbody>
</table>

Depreciation and amortization expense was $2,762,546 and $2,410,065 for the years ended September 30, 2010 and 2009, respectively. Amortization expense on the intangible asset is not included in the above amount.
NOTE 7. OPERATING LEASE

NCSBN has a lease agreement for office and storage space which expires on January 31, 2013. The following is a summary by year of future minimum lease payments required under the office and storage space lease at September 30, 2010:

<table>
<thead>
<tr>
<th>Year ending September 30,</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$549,019</td>
</tr>
<tr>
<td>2012</td>
<td>565,469</td>
</tr>
<tr>
<td>2013</td>
<td>190,412</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,304,900</strong></td>
</tr>
</tbody>
</table>

Rent expense for the years ended September 30, 2010 and 2009 was $533,173 and $517,610, respectively. Property taxes and common area maintenance expenses for the years ended September 30, 2010 and 2009 were $423,351 and $402,681, respectively.

NOTE 8. 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. Retirement plan expense was $506,591 and $479,696 for the years ended September 30, 2010 and 2009, respectively.

In the year ended September 30, 2007, NCSBN instituted a 457(b) non-qualified deferred compensation plan covering an employee with a contractual arrangement. The benefits under the plan are contingent upon completion of contractual obligations and are valued on an annual basis to reflect the return on NCSBN’s investments.

NOTE 9. 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 was canceled or if guarantees for room blocks are not fulfilled. At September 30, 2010, the requirements to fulfill these commitments approximated $132,106.

NCSBN has also entered into various contracts for future services. At September 30, 2010, the requirements to fulfill these commitments approximate $1,269,375 and are expected to be completed within one year.
Report of the Institute of Regulatory Excellence (IRE) Committee

Background
Fiscal year 2010-2011 (FY10-11) was the eighth year of the IRE Fellowship Program, a four-year educational and professional development program for nursing regulators. Board members and staff, as well as associate board members and staff, are qualified to apply for participation in the program. The program requires the application of evidence-based concepts in decision making and leadership, prepares its graduates to be leaders in nursing regulation, and is designed to contribute to the body of knowledge related to nursing regulation through research and scholarly work. Throughout the program, participants design and implement a project that contributes to nursing regulation and networks with other participants and regulators, as well as with a mentor who assists them in their projects. They also participate in an annual IRE Conference, which focuses on four overall themes:

1. Public protection/role development of regulators;
2. Discipline;
3. Competency and evaluation/remediation strategies; and
4. Organizational structure/behavior (leadership and management).

Currently, there are a total of 23 participants in the program. They belong to the following cohorts:

- Year 4 (2008 cohort): Three fellows (one will move to the 2009 cohort, and two are completing in 2011)
- Year 3 (2009 cohort): Seven fellows (one will move to the 2010 cohort)
- Year 2 (2010 cohort): Five fellows
- Year 1 (2011 cohort): Eight fellows

Highlights of FY11 Activities
The following is a report on the committee's 2010 charges:

- Select 2011 IRE fellows and mentors, and approve project proposals and final reports.
  - There were eight applicants to the program for the 2011 cohort. The committee reviewed all applications for admission to the fellowship and determined they all met the criteria for an IRE fellowship.
  - Although the committee has now decided that mentors are to be chosen during the second year of the fellowship program, the 2011 fellows are actively engaged in identifying an appropriate mentor.
  - Literature reviews, project proposals and project reports have been reviewed, and feedback has been provided to the fellows.
- Advise staff on issues related to the implementation of the IRE Fellowship Program.
  - Evaluation of the fellowship program is ongoing with the goal of continuous improvement.
  - Based on feedback from IRE participants and staff, review and approval of projects by an Institutional Review Board (IRB) will be required for all proposals. This will provide assurance of protection of human subjects' confidentiality and anonymity. All fellows are expected to communicate their findings by presentation and publication.
Approve the content of the annual IRE conference.

The theme of the 2011 conference centered around leadership and management: “Leadership: Using the Power of Imagination to Ignite Excellence.” Presentations at the preconference included an overview of the research process, writing a literature review and preparing a proposal. New content was added on IRB history and process, as well as writing an IRB application. The evaluations of speakers and content from both the preconference and conference were highly positive.

The 2012 IRE Conference will be held in San Antonio, Tex. on the theme of public protection and role development of regulators.

Explore strategies to continue engagement of inducted Fellows.

The committee discussed several strategies, such as inviting inducted Fellows to the IRE conference, and having a celebration at Midyear or Annual Meeting. It was decided to continue this charge for further discussion as part of the 2012 IRE Committee.

**Future Activities**

FY12 charges:

- Select 2012 IRE Fellows and mentors, and approve project proposals and final reports.
- Advise staff on continuous improvement of the IRE Fellowship program.
- Collaborate to determine the content of the annual IRE conference.
- Explore strategies to continue engagement of inducted IRE Fellows.

**Attachments**

None
Report of the Model Act & Rules Committee

Background
Since the adoption of the original NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules, several subsequent additions and alterations have been made to the substance and format of the document. The Model Act and Rules were revised by the 2004 NCSBN Delegate Assembly. Article XVIII was added and adopted by the 2005 NCSBN Delegate Assembly. Additional language regarding the authority to conduct criminal background checks was adopted in 2006 and the APRN legislative language was adopted during the 2008 NCSBN Delegate Assembly.

In fiscal year 2011 (FY11), the Model Act and Rules Committee was formed to ensure organization, consistency and relevancy of all the Model Act and Rules provisions.

Highlights of FY11 Activities
The committee was charged to:

- Review and revise the NCSBN Model Act and Rules as needed.

To this end, the committee has accomplished the following during FY11:

The committee surveyed the Member Boards for input to guide the direction of their revisions. According to their feedback, Member Boards recommended that the Model Act and Rules be more concise and consistent. The committee used these recommendations in their in-depth review of the Model Act and Rules. The committee focused their revisions on streamlining and clarifying the entire model.

The committee first determined a common format and organization for the Model Act and Rules. The committee decided that the Model Act and Rules should be published in two formats: act and rule side-by-side, as well as separate documents. Certain articles and sections were shifted and/or combined to increase clarity and readability of the document. Uniform word choice was also decided. For example, “jurisdiction” was chosen to replace “state” in order to include all Member Boards; the term “patient” is used instead of “client” due to the recent trend in literature that favors the use of that term.

The committee reformatted and revised a substantial portion of the Model Act and Rules, including the following sections: Title and Purpose; Definitions; The Board of Nursing; Violations and Penalties; Discipline and Proceedings; Emergency Relief; Reporting; and Revenue and Fees. Additionally, the committee began revising the nursing scope of practice and nursing assistive personnel articles and sections. For the definitions, the committee reviewed the use of each definition to determine whether inclusion or revision of those terms was appropriate. Legal definitions and other definitions deemed unnecessary were removed. In the committee’s revision of the discipline provisions, language from the HIPDB/Nursys® Action Codes was incorporated into the act and rules. This was done in order to more closely align the Model Act and Rules with the HIPDB reporting terms and categories.

Revision of the licensure, education, and compact articles and sections were deferred for recommendation from the respective committees/groups.

Future Activities
Due to the detailed manner of the work required and the concurrent objectives with other committees, the Model Act & Rules Committee recommends the continuation of their work through FY12. The committee anticipates revising the remaining articles and sections according to the recommendations of the committee and per any language adopted at the 2011 Delegate Assembly. The committee feels it is important that the recommendations be incorporated by the Model Act and Rules Committee to maintain consistency and organization.
Attachments
None
Report of the NCLEX® Examination Committee (NEC)

Background
As a standing committee of NCSBN, the NEC is charged with advising the NCSBN Board of Directors (BOD) 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. 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 also 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 chair of the subcommittee on a rotating basis. Highlights of the NEC and NIRSC activities follow.

Highlights of FY11 Activities
The following lists the highlights and accomplishments in fulfilling the NEC charge for fiscal year 2011 (FY11).

Joint Research Committee (JRC)
The JRC is composed 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 NCLEX examination as a valid measurement of initial nursing licensure. The JRC also investigates possible future enhancements to the examination programs.

Several new pieces of research have been completed. These projects include a validation study of NCLEX pass/fail decision criteria; a simulation study on alternate item rubrics; an investigation of examinee behaviors when interacting with various innovative item types; and a study comparing the efficacy of various hybrid item selection procedures to use in a computerized adaptive testing (CAT) examination.

The JRC also reviewed a number of research proposals during FY11. These proposals included a study of alternate Rasch testing models of the innovative item types; an examination of the effect of skills and response latency on the NCLEX; an investigation of the robustness of NCLEX ability estimates; and a comparison of scores and passing decisions on various item pool designs.

RN and PN Continuous Practice Analysis Studies
In 2009, NCSBN began development on the 2009 RN Continuous Practice Analysis study. Using the Internet, NCSBN began administering the 2009 RN Continuous Practice Analysis survey instruments in June 2009. The study was separated into four periods of administration and four forms of the survey instrument were administered in each period. The four survey forms contained a demographic survey and job task statements relevant to entry-level nursing practice.

Following each period, data sets from each survey form were combined, and demographic frequency analyses, as well as average rating analyses, were reported. Following the fourth period, all period data sets were analyzed collectively. The purpose of the 2009 RN Continuous Practice Analysis is to more readily evaluate the content of the NCLEX-RN to ensure it reflects current practice of registered nurses (RNs) in the U.S. and its Member Board territories. In addition, the study provides validity evidence for the appropriateness of NCLEX-RN content. Data analyses and final report of this study are near completion.

Currently, the 2011 RN Continuous Practice Analysis and 2011 PN Continuous Practice Analysis studies are underway. Data collection for these two studies began in December 2010. The data...
### Meeting Dates

- Oct. 25-26, 2010 (NCLEX® Examination Committee Business Meeting)
- Dec. 6-9, 2010 (NCLEX® Item Review Subcommittee Meeting)
- Jan. 24-26, 2011 (NCLEX® Examination Committee Business Meeting)
- March 28-31, 2011 (NCLEX® Item Review Subcommittee Meeting)
- June 27-30, 2011 (NCLEX® Item Review Subcommittee Meeting)
- August 22-25, 2011 (NCLEX® Item Review Subcommittee Meeting)

### RN Practice Analysis and Knowledge Skills and Ability (KSA) Study

The triennial NCLEX-RN practice analysis and KSA study are currently underway. In November 2010, an RN panel of subject matter experts (SMEs) met to develop a comprehensive list of entry-level nursing activity statements that will be used to inform the test plan. A separate panel of SMEs was convened in the same month to generate knowledge statements relevant to entry-level registered nursing to survey new graduates, faculty and supervisors. The KSA survey will be used to inform item development for the NCLEX-RN. Both studies are scheduled to be completed in FY12.

### Item Pool Rotation Plan

NCSBN has been working to reduce the amount of time that 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 would 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 preparation for the implementation of the quarterly item pools, the JRC conducted a series of studies to develop optimal NCLEX item pool design. The guiding principle for these studies is that the NCLEX CAT examinations generated from quarterly pools will be comparable to the semi-annual 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 semi-annual to quarterly pool rotation.

### 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 NCSBN Examinations content staff and Pearson VUE content staff finalized a strategy for the development and delivery of alternate item types that can include multimedia.

### NCLEX® Test Center Enhancements

Pearson VUE opened two new Pearson Professional Centers (PPCs) in the U.S. and expanded seating capacity at seven other test centers during 2010. Based on the Memorandum of
Understanding and through research on test center capacity, NCSBN identified Harlingen, Tex. as a new PPC, which opened in June 2011. In addition, Pearson VUE will be opening 12 new PPCs in the U.S., two in Canada and will expand seating at 10 domestic PPCs in 2011. Member Boards are notified of these PPC updates prior to implementation.

**Evaluated and Monitored NCLEX® Examination Policies and Procedures**

The committee reviews the BOD’s examination-related policies and procedures, as well as the NEC’s policies and procedures annually, and updates them as necessary.

**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 the NIRSC (1) reviewed RN and PN operational and pretest items; (2) provided direction regarding RN and PN multiple-choice and alternate format items; and (3) made decisions addressing revisions to content coding, operational definitions for client needs, cognitive codes, integrated processes and the NCLEX® Style Manual. In addition to 100 percent validation by Pearson VUE staff, the NIRSC and NCSBN staff currently evaluate 10 percent of all validations for pretest items and 10 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 subcommittee is 16, 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. NCLEX® Item Development Panels’ 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 is available to Member Boards and candidates in the NCLEX® Candidate Bulletin, candidate tutorial and on the NCSBN website.

**Table 1. RN Item Development Productivity Comparison**

<table>
<thead>
<tr>
<th>Year</th>
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<th>Item Writers</th>
<th>Items Written</th>
<th>Review Sessions</th>
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<td>3208</td>
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- April 11-12, 2011 (NCLEX® Examination Committee Business Meeting)
- July 19, 2011 (NCLEX® Examination Committee Conference Call)
- Sept. 26-29, 2011 (NCLEX® Item Review Subcommittee Meeting)

**Relationship to Strategic Plan**

**Strategic Initiative C**
NCSBN provides state-of-the-art competence assessments.

**Strategic Objective 1**
NCLEX development, security, psychometrics, administration and quality assurance processes are consistent with Member Boards examination needs.
Table 2. PN Item Development Productivity Comparison

<table>
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NCSBN Item Development Sessions Held at Pearson VUE

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 meanings 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. NCLEX staff and scheduled committee representatives continue to oversee each panel. 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 a few critical variables outlined in the NCLEX test plan; however, the quality control checks performed afterward are based on 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 exams 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 performance of the NCLEX examinations 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 this review, 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 2010 the committee reviewed the items referred from the April 2010 Member Board Review. The NEC provided direction on the resolution of each 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 semi-annual opportunities to review NCLEX items. For the October 2010 review, six Member Boards participated; in April 2011, there were eight.

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 report 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 NEC continued to monitor the status and effectiveness of the candidate-matching algorithm. On a semi-annual basis, Pearson VUE conducts a check for duplicate candidate records on all candidates that have tested within the last six months.

Monitored the Security Related to Publication and Administration of the NCLEX®
The NEC continues to approach security proactively, and has developed and implemented formal evaluation procedures to identify and correct potential breaches of security.

NCSBN and Pearson VUE provide mechanisms and opportunities for individuals to inform NCSBN about possible examination eligibility and administration violations. In addition, NCSBN works directly with two third party security firms to patrol the Internet for websites and social media sites that may contain secure examination material/information or provide an environment for electronic dissemination of secure examination materials/information.

NCSBN also develops and maintains an annual site visit plan for its domestic and international test centers. The plan is designed to conduct unannounced onsite visits of test centers for the purpose of ensuring that NCSBN's established procedural/security measures are being consistently implemented by Pearson VUE test administration staff. NCSBN, Pearson VUE and the NEC are committed to vigilance in ensuring the security of the NCLEX examination.

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, 2010 to Dec. 31, 2010, Pearson VUE reported four potential violations against compliance; each of which was resolved. Pearson VUE has a dedicated department that continues to analyze center utilization levels in order to project future testing volumes and meet the testing needs of all of their testing clients. As an early indicator of center usage, Pearson VUE reports to NCSBN staff on a weekly basis when sites exceed 80 percent capacity levels.

Responded to Member Board Inquiries Regarding NCLEX® Examination Administration
As part of its activities, the NEC and NCSBN Examinations staff responded to Member Boards’ questions and concerns regarding administration of the NCLEX examinations.

More specific information regarding the performance of the NCLEX test service provider, Pearson VUE, can be found in the Annual Report of Pearson VUE for the National Council Licensure Examinations (NCLEX®), available in Attachment A of this report.

Administered NCLEX® at International Sites
International test centers meet the same security specifications and follow the same administration procedures as the professional centers located in Member Board jurisdictions. See Attachment A of this report for the 2010 candidate volumes and pass rates for international testing centers.
**EDUCATE STAKEHOLDERS**

**NCLEX® Research Presentations**

At the 2011 American Educational Research Association (AERA) and National Council of Measurement in Education (NCME) joint annual meeting, two papers, “Extended Time Accommodations and Their Impact on High-stakes Licensure Examinations Differential Item Functioning” and “Assessing Drift in Item Parameters and Item Response Times in Computerized Adaptive Tests” were presented. AERA and NCME are internationally recognized professional organizations with the primary goal of advancing educational research and its practical application.

In addition to presenting scientific papers, NCSBN and test service psychometric staff conducted a workshop on item response theory (IRT) at the 2010 Association of Test Publishers (ATP) Annual Conference. This workshop provided a basic introduction to the principles, procedures and interpretations of IRT for non-technical persons in the testing industry. ATP is an organization representing providers of tests, assessment tools and services. Its annual conference 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 Examinations staff conducted numerous NCLEX informational presentations, webinars and workshops. This included the following presentations:

- “Extended Time Accommodations and Their Impact on High-stakes Licensure Examinations Differential Item Functioning” and “Assessing Drift in Item Parameters and Item Response Times in Computerized Adaptive Tests” at the Joint Annual Meetings of AERA and NCME in New Orleans, La.;
- “Item Response Theory” and “Security Best Practices and Communicating Your Test Security Message” at the ATP Annual Conference in Phoenix, Ariz.; and

In collaboration with test service, Examinations staff also published an article entitled “Understanding the Impact of Enemy Items on Test Validity and Measurement Precision” in the CLEAR Exam Review, which is published by the Council of Licensure, Enforcement and Regulation. It focuses on issues relevant to the licensure testing community and is geared toward a general audience.

In order to ensure NCSBN membership was kept current on the NCLEX program, the Examinations department hosted four informational webinars for Member Boards.

Additionally, as part of the department’s outreach activities, content staff conducted seven NCLEX® Regional Workshops. Regional workshops are presented for the purpose of providing information to educators who are preparing students to take the NCLEX examination. The BONs that hosted a regional workshop were Florida, Illinois, Missouri, Nebraska, New Jersey, New York and Oklahoma. These opportunities assist NCSBN’s Examinations department in educating stakeholders about the examination, as well as recruit for NCSBN item development panels.

The NEC continues to oversee development of various publications that accurately reflect the NCLEX examination process.
NCLEX® Member Board Manual
The NCLEX® Member Board Manual contains policies and procedures related to the development and administration of the NCLEX examination. Each quarter, NCSBN updates the Member Board Manual to reflect any changes to policy and procedures. Recent changes included updates on readability, clarity and the addition of hyperlinks for easy access to forms and to the Member Board Review process.

NCLEX® Candidate Bulletin and NCLEX® Candidate Bulletin At-A-Glance
The candidate bulletin contains procedures and key information specific to candidates preparing to test for the NCLEX examination. The candidate bulletin is updated on an annual basis and can be obtained in electronic and/or hard copy format. An abbreviated at-a-glance version is also available.

NCLEX® Invitational
Historically, Examinations staff has coordinated and hosted an NCLEX Invitational in order to provide Member Boards, educators and other stakeholders an opportunity to learn about the NCLEX program. The 2010 NCLEX® Invitational was held in Atlanta, Ga. on Sept. 13, 2010, with approximately 338 participants. In 2011, the name for the NCLEX Invitational changed to the NCLEX Conference. The 2011 NCLEX® Conference is scheduled for Sept. 26, 2011, at the Hotel Nikko in San Francisco, Calif.

NCLEX® Program Reports
Examinations staff monitors production of the NCLEX® Program Reports as delivered by the vendor. 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. The Web-based system also allows subscribers to distribute the reports via email to people who need them most: faculty and staff that design curriculum and teach students. Subscribers may also copy and paste relevant data, including tables and charts, into their own reports and presentations. This is particularly beneficial if the program uses these reports to supplement the academic accreditation process.

Historically, NCLEX® Program Reports are offered on a semi-annual basis. Starting with the April 2010 reporting cycle, subscribers can now purchase an annual report, in addition to semi-annual reports. This allows subscribers to have an aggregate annual summary of graduate performance on the NCLEX. This also benefits smaller nursing programs that may not otherwise benefit from the semi-annual reports due to small graduating classes.

NCLEX® Unofficial Quick Results Service
BONs, through NCSBN, offer candidates the opportunity to obtain their “unofficial results” (official results are only available from the BONs) 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, 47 BONs participate in offering this service to their candidates. In 2010, approximately 145,000 candidates utilized this service.

Future Activities
- Complete the continuous online RN and PN practice analyses.
- 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 Conference, NCLEX® Regional Workshops and other presentations.
- Evaluate ongoing international testing.
- Host the 2011 NCLEX® Conference.
- Introduce additional alternate format item types.
- Explore additional item writing strategies for the NCLEX.
- Conduct the RN practice analysis and KSA Study

**Attachment**

A. Annual Report of Pearson VUE for the NCLEX®
Attachment A

Annual Report of Pearson VUE for the NCLEX®

This report represents information gained during Pearson VUE's eighth full year of providing test delivery services for the NCLEX® examination program to NCSBN®. This report summarizes the activities of the past year.

Pearson VUE Organizational Changes

Jason Schwartz assumed the role of director of Test Development for the Pearson VUE NCLEX® team on Jan. 19, 2010. Schwartz’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., where he designed innovative tools and processes to automate and streamline the company's online publishing activities. While at Pacific Metrics and in his earlier work with CTB/McGraw-Hill, Schwartz made major contributions to the planning, design and implementation of numerous state, national, and international testing programs, including working with the Maryland State Department of Education, Louisiana Department of Education, Florida Department of Education, Wisconsin Department of Public Instruction and the U.S. Department of Defense. Schwartz has been a frequent presenter at conferences for such organizations as National Council of Teachers of Mathematics (NCTM), American Educational Research Association (AERA), and Council of Chief State School Officers (CCSSO). He has a Master of Science (MS) degree in mathematics from the University of Oregon and a Bachelor of Arts (BA) degree in mathematics from the University of California, Berkeley, where he graduated Phi Beta Kappa.

In July 2010, James Mooney joined the Pearson VUE NCLEX team as program manager. Before joining Pearson VUE in 2007, Mooney served as program manager for the National Association of Boards of Pharmacy (NABP) and the Pharmacy Technician Certification Board (PTCB). Prior assessment experience includes working for the College Board as associate director of Program Management. Responsibilities included coordinating strategic planning for the Advanced Placement (AP) Program and the PSAT, and working with the U.S. Department of Education and state education agencies to implement programs expanding professional development opportunities and student access to advanced education. A graduate of Marshall University, Mooney is currently pursuing an MBA at the University of Minnesota.

Greg Applegate assumed the role of psychometric intern for the Pearson VUE NCLEX team in August 2010. Applegate’s core area of expertise is in item development. He is currently working on completing his dissertation in educational psychology with a specialty in educational measurement from Purdue University in West Lafayette, Ind. Before coming to Pearson VUE, Applegate taught courses in educational psychology and statistics. He holds BA and Master of Business Administration (MBA) degrees from Indiana University.

Test Development

Psychometric and statistical analyses of 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, graphics 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

NCSBN approved a quarterly cycle for operational pool deployment for the NCLEX-RN® and NCLEX-PN® examinations beginning April 1, 2010. The goal is to improve the operational pools with quarterly rotations enabling NCSBN to introduce new nursing content into the operational pools more quickly and reducing the time period in which a pool of operational items has
been exposed to the testing population. Starting from April 1, 2010, the standard NCLEX-RN® Examination pool contains 1,472 items and the standard NCLEX-PN® Examination pool contains 1,239 items.

Along with the change of pool deployment cycle, NCSBN has approved the NCLEX-RN cut-score to be raised from -0.21 logits to -0.16 logits beginning April 1, 2010. A new NCLEX-RN Test Plan was also approved and went into effect on April 1, 2010. Although the RN cut-score was raised in April 2010, there is no noticeable pattern of change in the passing rates for the overall candidates or first-time U.S.-educated candidates. The yearly statistics indicate that the NCLEX-RN Examination continues to be psychometrically sound. In addition, the NCLEX-PN® Standard Setting Workshop was conducted in Chicago Sept. 20-22, 2010. The standard setting was conducted using the modified Angoff method with 11 judges’ ratings. The NCLEX-PN cut-score will be changed from -0.37 logits to -0.27 logits in effect on April 1, 2011.

Measurement and Research
The Joint Research Committee (JRC) met at the Pearson offices in Chicago on Aug. 20, 2010. In attendance were JRC members Gage Kingsbury, Mark Reckase, Steve Wise and Ed Wolfe; NCSBN staff Phil Dickison, Sarah Hagge, Weiwei Liu, Casey Marks and Ada Woo; and Pearson VUE staff Betty Bergstrom, Jerry Gorham, Shu-chuan Kao and Xin Li. There were four JRC guest researchers also present: Kirk Becker, Ira Bernstein, Kathy Haynie and Hong Jiao.

The JRC received updates on several ongoing projects, including the Decision Rule Study by Kingsbury; the Polytomous Item Scoring Study by Haynie, Jiao, Wolfe et al.; the Examinee Behavior with Innovative Items Study by Harmes and Wise; the Enemy Item Relation Study by Becker and Lai; and the Comparison of Hybrid Progressive Item Selection Procedures for Adaptive Tests Study by Bontempo, Kingsbury and Zara. Final reports of these studies were approved. The Partial Credit Scoring Study by Wolfe et al. is ongoing and an update was presented at the March 2011 meeting. The JRC also included discussion of Pretest Items Selection Criteria and NCLEX® Item Inventory Status.

Pearson VUE Meetings with NCSBN
- Jan. 25-26, 2010 NCLEX® Examination Committee Business Meeting
- March 4, 2010 NCSBN Test Content Meeting
- March 8-10, 2010 Midyear Meeting
- April 1, 2010 NCLEX® Development Meeting
- April 12-13, 2010 NCLEX® Examination Committee Business Meeting
- April 22-23, 2010 NCLEX® Operational Meeting
- May 20, 2010 NCSBN® Business Review
- June 3, 2010 NCLEX® Development Meeting
- July 20, 2010 NCLEX® Examination Committee Business Meeting
- Aug. 5, 2010 NCLEX® Channel/Security Meeting
- Aug. 10-13, 2010 NCSBN Annual Meeting
- Sept. 2, 2010 NCLEX® Development Meeting
- Sept. 13, 2010 2010 NCLEX® Invitational
- Oct. 25-26, 2010 NCLEX® Examination Committee Business Meeting
- Nov. 30, 2010 NCSBN Contract Evaluation Meeting
- Dec. 2, 2010 NCLEX® Development Meeting
- Dec. 3, 2010 NCLEX® Channel/Security 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 2010 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 2009, the overall candidate volumes were lower for the NCLEX-RN (about -2.1 percent), but higher for the NCLEX-PN (about +2.1 percent). The RN passing rate for the overall group was 1.0 percentage points higher for 2010 than for 2009 and the passing rate for the reference group was 1.0 percentage points lower for this period compared to 2009. The PN overall passing rate was higher by 2.2 percentage points from 2009 and the PN reference group passing rate was 1.4 percentage points higher than in 2009. 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 2010 testing year for the NCLEX-RN Examination:

- Overall, 197,776 NCLEX-RN Examination candidates tested during 2010, as compared to 202,029 during the 2009 testing year. This represents a decrease of approximately 2.1 percent.
- The candidate population reflected 140,887 first-time, U.S.-educated candidates who tested during 2010, as compared to 134,725 for the 2009 testing year, representing a 4.6 percent increase.
- The overall passing rate was 74.2 percent in 2010, compared to 73.2 percent in 2009. The passing rate for the reference group was 87.4 percent in 2010 and 88.4 percent in 2009.
- Approximately 49.5 percent of the total group and 51.9 percent of the reference group ended their tests after a minimum of 75 items were administered. This is slightly lower than in the 2009 testing year in which 51.7 percent of the total group and 55.4 percent of the reference group took minimum-length exams.
- The percentage of maximum-length test takers was 14.4 percent for the total group and 13.1 percent for the reference group. This is slightly higher than last year’s figures (14.3 percent for the total group and 12.5 percent for the reference group).
- The average time needed to take the NCLEX-RN Examination during the 2010 testing period was 2.5 hours for the overall group and 2.3 hours for the reference group (close to last year’s average times of 2.5 hours and 2.2 hours, respectively).
- A total of 56.6 percent of the candidates chose to take a break during their examinations (compared to 56.0 percent last year).
- Overall, 1.9 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 2009 testing year (2.2 percent and 1.0 percent, respectively).
- In general, the NCLEX-RN Examination summary statistics for the 2010 testing period indicated patterns that were similar to those observed for the 2009 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 2010 testing year for the NCLEX-PN Examination:

- Overall, 82,519 PN candidates tested in 2010, as compared to 80,854 PN candidates tested during 2009. This represents an increase of approximately 2.1 percent.

- The candidate population reflected 66,830 first-time, U.S. educated candidates who tested in 2010, as compared to 63,534 for the 2009 testing year (an increase of approximately 5.2 percent).

- The overall passing rate was 78.1 percent in 2010 compared to 75.9 percent in 2009, and the reference group passing rate was 87.1 percent in 2010 compared to 85.7 percent in 2009.

- There were 56.2 percent of the total group and 60.8 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 2009 testing year in which 55.1 percent of the total group and 59.6 percent of the reference group took minimum-length exams.

- The percentage of maximum-length test takers was 15.8 percent for the total group and 13.4 percent for the reference group. These figures are slightly lower than last year’s percentages (16.5 percent for the total group and 14.1 percent for the reference group).

- The average time needed to take the NCLEX-PN Examination during the 2010 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 2.3 and 2.1 hours, respectively).

- A total of 55.1 percent of the candidates chose to take a break during their examinations (compared to 55.2 percent last year).

- Overall, 1.7 percent of the total group and 0.9 percent of the reference group ran out of time before completing the test (slightly lower than last year’s figures of 2.0 percent and 1.0 percent, respectively).

- In general, the NCLEX-PN Examination summary statistics for the 2010 testing period indicated patterns that were similar to those observed for the 2009 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 2010 Testing Year

<table>
<thead>
<tr>
<th></th>
<th>Jan 10 - Mar 10</th>
<th>Apr 10 - Jun 10</th>
<th>Jul 10 - Sep 10</th>
<th>Oct 10 - Dec 10</th>
<th>Cumulative 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>Overall</td>
<td>Overall</td>
<td>Overall</td>
<td>Overall</td>
<td>Overall</td>
</tr>
<tr>
<td>Number Testing</td>
<td>49,595</td>
<td>35,259</td>
<td>52,766</td>
<td>40,250</td>
<td>68,602</td>
</tr>
<tr>
<td>Percent Passing</td>
<td>76.1</td>
<td>89.9</td>
<td>77.7</td>
<td>84.9</td>
<td>80.5</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>117.8</td>
<td>112.6</td>
<td>119.7</td>
<td>123.7</td>
<td>121.2</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>53.0</td>
<td>55.8</td>
<td>51.4</td>
<td>47.7</td>
<td>49.0</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>12.7</td>
<td>10.9</td>
<td>14.1</td>
<td>12.6</td>
<td>16.3</td>
</tr>
<tr>
<td>Ave. Test Time (hrs)</td>
<td>2.5</td>
<td>2.3</td>
<td>2.3</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>56.6</td>
<td>49.4</td>
<td>50.1</td>
<td>61.5</td>
<td>60.9</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>2.2</td>
<td>1.1</td>
<td>1.3</td>
<td>1.5</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Table 2: 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>Overall</td>
<td>Overall</td>
<td>Overall</td>
<td>Overall</td>
<td>Overall</td>
<td>Overall</td>
</tr>
<tr>
<td>Number Testing</td>
<td>46,891</td>
<td>31,060</td>
<td>52,565</td>
<td>35,468</td>
<td>73,790</td>
</tr>
<tr>
<td>Percent Passing</td>
<td>71.8</td>
<td>88.1</td>
<td>74.8</td>
<td>88.2</td>
<td>83.3</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>120.8</td>
<td>115.2</td>
<td>118.4</td>
<td>114.5</td>
<td>120.9</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>52.1</td>
<td>55.9</td>
<td>54.0</td>
<td>51.9</td>
<td>54.4</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>14.1</td>
<td>12.3</td>
<td>13.4</td>
<td>14.5</td>
<td>13.1</td>
</tr>
<tr>
<td>Ave. Test Time (hrs)</td>
<td>2.5</td>
<td>2.2</td>
<td>2.4</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>56.3</td>
<td>48.8</td>
<td>53.4</td>
<td>45.3</td>
<td>64.6</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>2.0</td>
<td>1.0</td>
<td>2.1</td>
<td>1.9</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Table 3: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2010 Testing Year*

### Operational Item Statistics

<table>
<thead>
<tr>
<th>Jan 10 - Mar 10</th>
<th>Apr 10 - Jun 10</th>
<th>Jul 10 - Sep 10</th>
<th>Oct 10 - Dec 10</th>
<th>Cumulative 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point-Biserial</td>
<td>0.21</td>
<td>0.09</td>
<td>0.22</td>
<td>0.21</td>
</tr>
<tr>
<td>Ave. Item Time</td>
<td>74.2</td>
<td>34.5</td>
<td>71.4</td>
<td>32.5</td>
</tr>
</tbody>
</table>

### Pretest Item Statistics

<table>
<thead>
<tr>
<th></th>
<th>Jan 10 - Mar 10</th>
<th>Apr 10 - Jun 10</th>
<th>Jul 10 - Sep 10</th>
<th>Oct 10 - Dec 10</th>
<th>Cumulative 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Items</td>
<td>714</td>
<td>1,090</td>
<td>1,762</td>
<td>202</td>
<td>3,768</td>
</tr>
<tr>
<td>Ave. Sample Size</td>
<td>655</td>
<td>553</td>
<td>449</td>
<td>530</td>
<td>522</td>
</tr>
<tr>
<td>Mean Point-Biserial</td>
<td>0.08</td>
<td>0.08</td>
<td>0.08</td>
<td>0.09</td>
<td>0.08</td>
</tr>
<tr>
<td>Mean P+</td>
<td>0.50</td>
<td>0.61</td>
<td>0.56</td>
<td>0.55</td>
<td>0.56</td>
</tr>
<tr>
<td>Mean b</td>
<td>0.30</td>
<td>-0.33</td>
<td>-0.09</td>
<td>-0.10</td>
<td>-0.09</td>
</tr>
<tr>
<td>SD b</td>
<td>1.63</td>
<td>1.67</td>
<td>1.84</td>
<td>1.72</td>
<td>1.76</td>
</tr>
<tr>
<td>Total Number Flagged</td>
<td>321</td>
<td>495</td>
<td>792</td>
<td>93</td>
<td>1,701</td>
</tr>
<tr>
<td>Percent Items Flagged</td>
<td>45.0</td>
<td>45.4</td>
<td>44.9</td>
<td>46.0</td>
<td>45.1</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 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>Operational Item Statistics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Point-Biserial</td>
<td>0.20</td>
<td>0.21</td>
<td>0.21</td>
<td>0.21</td>
<td>0.20</td>
</tr>
<tr>
<td>Std. Dev.</td>
<td>0.08</td>
<td>0.09</td>
<td>0.09</td>
<td>0.09</td>
<td>NA</td>
</tr>
<tr>
<td>Ave. Item Time (secs)</td>
<td>71.8</td>
<td>73.9</td>
<td>36.5</td>
<td>72.8</td>
<td>35.9</td>
</tr>
<tr>
<td>Std. Dev.</td>
<td>17.4</td>
<td>36.5</td>
<td>36.4</td>
<td>76.6</td>
<td>36.4</td>
</tr>
<tr>
<td><strong>Pretest Item Statistics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Items</td>
<td>826</td>
<td>305</td>
<td>657</td>
<td>316</td>
<td>2,104</td>
</tr>
<tr>
<td>Ave. Sample Size</td>
<td>532</td>
<td>1,542</td>
<td>586</td>
<td>513</td>
<td>692</td>
</tr>
<tr>
<td>Mean Point-Biserial</td>
<td>0.08</td>
<td>0.07</td>
<td>0.07</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>Mean P+</td>
<td>0.52</td>
<td>0.50</td>
<td>0.52</td>
<td>0.50</td>
<td>0.51</td>
</tr>
<tr>
<td>Mean b</td>
<td>0.17</td>
<td>0.34</td>
<td>0.15</td>
<td>0.25</td>
<td>0.20</td>
</tr>
<tr>
<td>SD b</td>
<td>1.79</td>
<td>1.76</td>
<td>1.62</td>
<td>1.35</td>
<td>1.67</td>
</tr>
<tr>
<td>Total Number Flagged</td>
<td>368</td>
<td>154</td>
<td>315</td>
<td>116</td>
<td>953</td>
</tr>
<tr>
<td>Percent Items Flagged</td>
<td>44.6</td>
<td>50.5</td>
<td>47.9</td>
<td>36.7</td>
<td>45.3</td>
</tr>
</tbody>
</table>

*Data do not include research and retest items.

### Table 5: Longitudinal Technical Summary for the NCLEX-PN® Group Statistics for 2010 Testing Year  

<table>
<thead>
<tr>
<th></th>
<th>Jan 10 - Mar 10</th>
<th>Apr 10 - Jun 10</th>
<th>Jul 10 - Sep 10</th>
<th>Oct 10 - Dec 10</th>
<th>Cumulative 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number Testing</td>
<td>18,793</td>
<td>15,099</td>
<td>18,006</td>
<td>26,673</td>
<td>19,047</td>
</tr>
<tr>
<td>Percent Passing</td>
<td>77.2</td>
<td>86.3</td>
<td>74.8</td>
<td>81.8</td>
<td>89.1</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>116.0</td>
<td>111.8</td>
<td>116.8</td>
<td>111.4</td>
<td>115.3</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>54.0</td>
<td>58.4</td>
<td>54.2</td>
<td>59.7</td>
<td>63.4</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>16.4</td>
<td>14.1</td>
<td>17.2</td>
<td>14.1</td>
<td>14.3</td>
</tr>
<tr>
<td>Ave. Test Time (hours)</td>
<td>2.3</td>
<td>2.1</td>
<td>2.3</td>
<td>2.1</td>
<td>2.2</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>57.4</td>
<td>51.1</td>
<td>56.3</td>
<td>49.0</td>
<td>50.7</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>2.0</td>
<td>0.9</td>
<td>2.0</td>
<td>1.0</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>1st Time U.S. ED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number Testing</td>
<td>18,006</td>
<td>13,926</td>
<td>26,673</td>
<td>22,953</td>
<td>19,047</td>
</tr>
<tr>
<td>Percent Passing</td>
<td>77.2</td>
<td>86.3</td>
<td>81.8</td>
<td>89.1</td>
<td>86.3</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>116.8</td>
<td>111.6</td>
<td>111.4</td>
<td>108.2</td>
<td>115.3</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>54.2</td>
<td>59.7</td>
<td>63.4</td>
<td>55.4</td>
<td>59.8</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>17.2</td>
<td>89.1</td>
<td>12.4</td>
<td>14.3</td>
<td>14.3</td>
</tr>
<tr>
<td>Ave. Test Time (hours)</td>
<td>2.3</td>
<td>2.1</td>
<td>2.2</td>
<td>2.0</td>
<td>2.1</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>56.3</td>
<td>49.0</td>
<td>50.7</td>
<td>45.8</td>
<td>51.2</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>2.0</td>
<td>1.0</td>
<td>1.2</td>
<td>0.5</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>1st Time U.S. ED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number Testing</td>
<td>18,006</td>
<td>26,673</td>
<td>22,953</td>
<td>19,047</td>
<td>14,852</td>
</tr>
<tr>
<td>Percent Passing</td>
<td>77.2</td>
<td>89.1</td>
<td>86.3</td>
<td>76.8</td>
<td>71.4</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>116.4</td>
<td>108.2</td>
<td>115.3</td>
<td>110.6</td>
<td>114.5</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>54.0</td>
<td>63.4</td>
<td>55.4</td>
<td>60.1</td>
<td>56.2</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>16.4</td>
<td>14.3</td>
<td>14.3</td>
<td>13.4</td>
<td>15.8</td>
</tr>
<tr>
<td>Ave. Test Time (hours)</td>
<td>2.3</td>
<td>2.2</td>
<td>2.0</td>
<td>2.1</td>
<td>2.3</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>51.1</td>
<td>45.8</td>
<td>57.8</td>
<td>51.2</td>
<td>55.1</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>2.0</td>
<td>1.2</td>
<td>2.0</td>
<td>1.7</td>
<td>2.1</td>
</tr>
<tr>
<td><strong>Cumulative 2010</strong></td>
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</tr>
<tr>
<td>Number Testing</td>
<td>18,793</td>
<td>14,852</td>
<td>22,953</td>
<td>19,047</td>
<td>14,852</td>
</tr>
<tr>
<td>Percent Passing</td>
<td>77.2</td>
<td>85.1</td>
<td>86.3</td>
<td>76.8</td>
<td>71.4</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>116.0</td>
<td>110.6</td>
<td>114.5</td>
<td>115.3</td>
<td>118.1</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>54.0</td>
<td>55.4</td>
<td>56.2</td>
<td>56.6</td>
<td>55.1</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>16.4</td>
<td>15.8</td>
<td>15.8</td>
<td>14.1</td>
<td>16.5</td>
</tr>
<tr>
<td>Ave. Test Time (hours)</td>
<td>2.3</td>
<td>2.1</td>
<td>2.3</td>
<td>2.1</td>
<td>2.3</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>51.1</td>
<td>55.1</td>
<td>55.1</td>
<td>55.1</td>
<td>55.1</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>2.0</td>
<td>2.1</td>
<td>2.0</td>
<td>2.1</td>
<td>2.1</td>
</tr>
</tbody>
</table>

### Table 6: Longitudinal Technical Summary for the NCLEX-PN® 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>Overall</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number Testing</td>
<td>18,684</td>
<td>14,683</td>
<td>16,873</td>
<td>12,302</td>
<td>26,849</td>
</tr>
<tr>
<td>Percent Passing</td>
<td>74.1</td>
<td>84.0</td>
<td>72.2</td>
<td>80.4</td>
<td>88.0</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>116.6</td>
<td>113.1</td>
<td>117.1</td>
<td>111.5</td>
<td>120.2</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>53.7</td>
<td>57.5</td>
<td>53.9</td>
<td>59.7</td>
<td>66.8</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>16.9</td>
<td>15.0</td>
<td>17.6</td>
<td>14.5</td>
<td>15.0</td>
</tr>
<tr>
<td>Ave. Test Time (hours)</td>
<td>2.2</td>
<td>2.1</td>
<td>2.3</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>53.7</td>
<td>47.1</td>
<td>57.4</td>
<td>48.9</td>
<td>50.8</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>1.8</td>
<td>1.0</td>
<td>2.4</td>
<td>1.2</td>
<td>1.7</td>
</tr>
</tbody>
</table>
### Table 7: Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2010 Testing Year*

<table>
<thead>
<tr>
<th>Operational Item Statistics</th>
<th>Jan 10 - Mar 10</th>
<th>Apr 10 - Jun 10</th>
<th>Jul 10 - Sep 10</th>
<th>Oct 10 - Dec 10</th>
<th>Cumulative 2010</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>0.21</td>
<td>0.08</td>
<td>0.22</td>
<td>0.08</td>
<td>0.22</td>
</tr>
<tr>
<td>Ave. Item Time (secs)</td>
<td>67.4</td>
<td>22.4</td>
<td>67.9</td>
<td>19.4</td>
<td>65.5</td>
</tr>
</tbody>
</table>

**Pretest Item Statistics**

| # of Items                  | 627             | 540             | 1,091           | 604             | 2,862           |
| Av. Sample Size             | 586             | 645             | 500             | 563             | 560             |
| Mean Point-Biserial         | 0.09            | 0.12            | 0.11            | 0.13            | 0.11            |
| Mean P+                     | 0.41            | 0.46            | 0.52            | 0.52            | 0.49            |
| Mean b                      | 0.62            | 0.37            | 0.09            | 0.02            | 0.24            |
| SD b                        | 1.44            | 1.57            | 1.70            | 1.66            | 1.63            |
| Total Number Flagged        | 283             | 185             | 413             | 177             | 1,058           |
| Percent Items Flagged       | 45.1            | 34.3            | 37.9            | 29.3            | 37.0            |

*Data do not include research and retest items.

### Table 8: Longitudinal Technical Summary for the NCLEX-PN® Examination: Item Statistics for 2009 Testing Year*

<table>
<thead>
<tr>
<th>Operational Item Statistics</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>0.21</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**

| # of Items                  | 303             | 572             | 866             | 356             | 2,097           |
| Av. Sample Size             | 1,157           | 489             | 651             | 493             | 653             |
| Mean Point-Biserial         | 0.11            | 0.11            | 0.09            | 0.09            | 0.10            |
| Mean P+                     | 0.51            | 0.47            | 0.41            | 0.42            | 0.44            |
| Mean b                      | 0.05            | 0.35            | 0.70            | 0.55            | 0.49            |
| SD b                        | 1.63            | 1.69            | 1.56            | 1.46            | 1.61            |
| Total Number Flagged        | 102             | 218             | 387             | 149             | 856             |
| Percent Items Flagged       | 33.7            | 38.1            | 44.7            | 41.9            | 40.8            |

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

Pearson VUE has a total of 219 PPCs in the U.S. and 18 PPCs internationally in Australia, Canada, Hong Kong, India, Japan, Mexico, the Philippines, Puerto Rico, Taiwan and the United Kingdom, for a total of 236 test centers globally.

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

**Table 9: NCLEX® International Test Center Volume by Member Board** Jan 1–Dec 31, 2010

| Member Board | Total | Sydney, Australia | Burnaby, Canada | Montreal, Canada | Toronto, Canada | Frankfurt, Germany | Hong Kong, Hong Kong | Bangalore, India | Chennai, India | New Delhi, India | Hyderabad, India | Mumbai, India | Chiyoda-ku, Japan | Osaka-shi, Japan | Mexico City, Mexico | Managua, Nicaragua | Manila, Philippines | San Juan, Puerto Rico | Taipei, Taiwan | London, United Kingdom |
|--------------|-------|------------------|-----------------|------------------|----------------|------------------|---------------------|-----------------|----------------|-----------------|-----------------|---------------|-----------------|----------------|------------------------|-----------------|---------------------|------------------------|------------------|
| Alabama      | 2     | 0                | 0               | 0                | 0              | 0                | 0                   | 0               | 0             | 0               | 0               | 0             | 0               | 0               | 0                      | 0               | 0                   | 0                      | 0                |
| Alaska       | 4     | 0                | 0               | 0                | 1              | 0                | 0                   | 0               | 0             | 0               | 0               | 0             | 0               | 3               | 0                      | 0               | 0                   | 0                      | 0                |
| Arizona      | 40    | 1                | 3               | 1                | 5              | 0                | 0                   | 0               | 0             | 0               | 0               | 0             | 0               | 0               | 0                      | 0               | 0                   | 0                      | 0                |
| Arkansas     | 119   | 3                | 0               | 0                | 1              | 0                | 0                   | 0               | 0             | 0               | 0               | 0             | 0               | 0               | 113                     | 0               | 0                   | 2                      | 0                |
| California-RN | 5448 | 35               | 68              | 22               | 105            | 11              | 160                 | 16              | 23            | 62              | 2               | 8             | 25              | 3               | 6                       | 4568            | 3                     | 85                      | 246              |
| California-VN | 12   | 0                | 1               | 0                | 0              | 1               | 0                   | 0               | 0             | 0               | 1               | 0             | 0               | 9               | 0                      | 0               | 0                   | 0                      | 0                |
| Colorado     | 7     | 1                | 0               | 0                | 0              | 0               | 0                   | 0               | 0             | 0               | 1               | 0             | 0               | 0               | 0                      | 0               | 0                   | 0                      | 4                |
| Connecticut  | 6     | 0                | 0               | 0                | 0              | 0               | 0                   | 0               | 0             | 0               | 0               | 0             | 0               | 0               | 5                      | 0               | 0                   | 0                      | 0                |
| Delaware     | 4     | 0                | 0               | 0                | 0              | 0               | 0                   | 0               | 0             | 0               | 0               | 0             | 0               | 0               | 0                      | 0               | 0                   | 0                      | 0                |
| District of Columbia | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 |
| Florida      | 110   | 2                | 0               | 0                | 4              | 1               | 4                   | 3               | 2             | 0               | 1               | 0             | 0               | 0               | 74                      | 3               | 0                   | 16                      | 0                |
| Georgia-PN   | 1     | 0                | 0               | 0                | 0              | 0               | 0                   | 0               | 0             | 0               | 0               | 0             | 0               | 0               | 0                      | 0               | 0                   | 0                      | 1                |
| Georgia-RN   | 9     | 0                | 0               | 0                | 1              | 1               | 0                   | 0               | 0             | 0               | 1               | 0             | 0               | 1               | 0                      | 0               | 0                   | 5                      | 0                |
| Hawaii       | 32    | 2                | 4               | 0                | 0              | 0               | 0                   | 0               | 0             | 0               | 2               | 1             | 0               | 15              | 3                       | 0               | 5                   | 5                      | 0                |
| Idaho        | 2     | 0                | 0               | 0                | 1              | 0               | 0                   | 0               | 0             | 0               | 0               | 1             | 0               | 0               | 0                      | 0               | 0                   | 0                      | 0                |
| Illinois     | 223   | 0                | 0               | 0                | 1              | 0               | 2                   | 10              | 1             | 0               | 0               | 1             | 0             | 0               | 203                     | 0               | 0                   | 5                      | 0                |
| Indiana      | 7     | 0                | 0               | 0                | 0              | 0               | 0                   | 1               | 1             | 0               | 0               | 0             | 0             | 0               | 0                      | 3               | 2                   | 0                      | 0                |
| Kansas       | 1     | 0                | 0               | 0                | 0              | 0               | 0                   | 0               | 0             | 0               | 0               | 0             | 0             | 0               | 0                      | 1               | 0                   | 0                      | 0                |
| Kentucky     | 2     | 0                | 0               | 0                | 0              | 0               | 0                   | 0               | 0             | 0               | 0               | 0             | 0             | 0               | 2                      | 0               | 0                   | 0                      | 0                |
| Maryland     | 53    | 0                | 0               | 0                | 1              | 7               | 3                   | 1               | 0             | 0               | 0               | 0             | 0             | 1               | 0                      | 30              | 0                   | 0                      | 10               |
| Massachusetts | 20  | 0                | 1               | 0                | 3              | 0               | 0                   | 0               | 1             | 0               | 0               | 0             | 0             | 0               | 8                       | 1               | 0                   | 6                      | 0                |
| Michigan     | 52    | 1                | 2               | 0                | 11             | 0               | 1                   | 1               | 0             | 1               | 0               | 0             | 1             | 0               | 33                      | 0               | 0                   | 0                      | 1                |
| Minnesota    | 167   | 1                | 35              | 14               | 92             | 2               | 1                   | 0               | 1             | 0               | 0               | 0             | 0             | 0               | 19                      | 0               | 0                   | 1                      | 0                |
| Missouri     | 7     | 1                | 0               | 0                | 0              | 0               | 0                   | 0               | 0             | 0               | 0               | 0             | 0             | 0               | 1                      | 0               | 0                   | 5                      | 0                |
| Nevada       | 36    | 1                | 0               | 0                | 1              | 0               | 1                   | 0               | 0             | 1               | 0               | 0             | 0             | 2               | 0                       | 0               | 0                   | 0                      | 1                |
## Table 9: NCLEX® International Test Center Volume by Member Board* Jan. 1–Dec. 31, 2010

| Member Board          | Total | Sydney, Australia | Burnaby, Canada | Montreal, Canada | Toronto, Canada | Frankfurt, Germany | Hong Kong, Hong Kong | Bangalore, India | Chennai, India | New Delhi, India | Hyderabad, India | Mumbai, India | Chiyoda-ku, Japan | Osaka-shi, Japan | Mexico City, Mexico | Manila, Philippines | San Juan, Puerto Rico | Taipei, Taiwan | London, United Kingdom | New Hampshire | New Jersey | New Mexico | New York | North Carolina | Northern Mariana Islands | Ohio | Oregon | Pennsylvania | Rhode Island | South Carolina | Tennessee | Texas | Utah | Vermont | Virgin Islands | Virginia | Washington | West Virginia-PN | Wisconsin | Total |
|-----------------------|-------|-------------------|-----------------|------------------|-----------------|------------------|--------------------|-------------------|----------------|----------------|------------------|--------------|-------------------|----------------|-----------------------|----------------------|----------------------|----------------|-----------------|-----------------|--------------|---------------|-------------------|----------|--------|-------------|-----------|---------------|----------|------|--------|---------|----------------|---------|-----------|----------------|----------|--------|
|                       | 9911  | 74                | 151             | 48               | 282             | 35               | 447               | 113               | 113            | 140            | 13               | 43           | 448               | 206            | 17                    | 7082                 | 180                   | 454            | 185            | 185          | 185        | 185           | 185                 | 185      | 185    | 185         | 185      | 185        | 185      | 185 | 185    | 185     | 185    | 185   |

*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, 2010

| Member Board | Total | Sydney, Australia | Barbados, Canada | Montreal, Canada | Toronto, Canada | Frankfurt, Germany | Hong Kong, Hong Kong | Bangalore, India | Chennai, India | New Delhi, India | Hyderabad, India | Mumbai, India | Chiyoda-ku, Japan | Osaka-shi, Japan | Mexico City, Mexico | Manila, Philippines | San Juan, Puerto Rico | Taipei, Taiwan | London, United Kingdom |
|--------------|-------|------------------|------------------|------------------|----------------|-------------------|---------------------|-----------------|----------------|----------------|----------------|--------------|----------------|----------------|----------------|------------------|----------------|-------------------|
| Australia    | 24    | 20               | 1                | 0                | 2              | 0                 | 1                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Barbados     | 1     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Bulgaria     | 1     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Cambodia     | 1     | 0                | 0                | 0                | 0              | 0                 | 1                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Canada       | 233   | 65               | 24               | 142              | 0              | 1                 | 0                   | 0               | 0              | 0              | 0             | 0            | 1              | 0              | 0               | 0                | 0                | 0                |
| China        | 49    | 2                | 1                | 2                | 37             | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 6                |
| Costa Rica   | 1     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 1            | 0              | 0              | 0               | 0                | 0                | 0                |
| Egypt        | 1     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Ethiopia     | 2     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 1            | 0              | 0              | 0               | 0                | 0                | 1                |
| Finland      | 2     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| France       | 1     | 0                | 0                | 1                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Gambia       | 1     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 1                |
| Germany      | 12    | 0                | 0                | 0                | 7              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 5                |
| Ghana        | 5     | 1                | 1                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Guyana       | 1     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Haiti        | 1     | 0                | 0                | 1                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Hong Kong    | 4     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| India        | 438   | 9                | 0                | 17               | 0              | 109              | 92                  | 123             | 13             | 34             | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Indonesia    | 6     | 0                | 0                | 0                | 1              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 5               | 0               | 0                | 0                | 0                |
| Iran         | 6     | 1                | 0                | 2                | 0              | 0                 | 0                   | 0               | 0              | 2              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Ireland      | 2     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 2                | 0                |
| Israel       | 6     | 0                | 0                | 0                | 1              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 5                |
| Jamaica      | 6     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Japan        | 28    | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 25             | 3             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Jordan       | 2     | 0                | 0                | 0                | 1              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 1                |
| Kenya        | 2     | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 0              | 0             | 2            | 0              | 0              | 0               | 0                | 0                | 0                |
| Korea, South | 920   | 8                | 3                | 0                | 4              | 0                | 225                 | 0               | 0              | 0              | 0             | 0            | 1              | 0              | 0               | 409              | 196             | 0                |
| Lebanon      | 1     | 0                | 0                | 0                | 1              | 0                 | 0                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Malaysia     | 1     | 0                | 0                | 0                | 0              | 0                 | 1                   | 0               | 0              | 0              | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
| Mexico       | 11    | 0                | 0                | 0                | 0              | 0                 | 0                   | 0               | 0              | 11             | 0             | 0            | 0              | 0              | 0               | 0                | 0                | 0                |
### Table 10: NCLEX® International Test Center Volume by Country of Education Jan. 1–Dec. 31, 2010

<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>New Delhi, India</th>
<th>Hyderabad, India</th>
<th>Mumbai, India</th>
<th>Chiyoda-ku, Japan</th>
<th>Osaka-shi, Japan</th>
<th>Mexico City, Mexico</th>
<th>Manila, Philippines</th>
<th>San Juan, Puerto Rico</th>
<th>Taipei, Taiwan</th>
<th>London, UK</th>
<th>United Kingdom</th>
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Table 12: NCLEX® International Testing Volume Pass Rate: Jan. 1–Dec. 31, 2010
Report of the Nurse Licensure Models Committee

Background
During fiscal year 2010 (FY10), the Uniform Licensure Requirements (ULR) Committee was charged with recommending “solutions for issues identified regarding the interface between the two licensure models.” In its report to the NCSBN Board of Directors (BOD), the ULR committee made many recommendations and among them, it proposed that a group comprised of members representing both licensure models be convened to further explore the issues they identified. In response, the BOD established the Nurse Licensure Models Committee. The committee consists of representatives from both compact and noncompact states, including the dual appointment of the committee chairs.

Highlights of FY11 Activities
In FY11, the committee was charged to:
- Identify and recommend solutions to address current and emerging licensure issues that impact patient safety in all jurisdictions.
- Develop communication processes for regular sharing of information and promotion of dialogue to enhance the interface among all licensure models.

The following is a review of the committee's fulfillment of these charges.

Identify and recommend solutions to address current and emerging licensure issues that impact patient safety in all jurisdictions
The committee reviewed the recommendations of the 2010 ULR Committee and had extensive discussions regarding these issues and others that were identified. Its primary focus was on public protection and licensure. During its dialogue, the committee also identified additional issues that affect the interface of the two licensure models. All of these were incorporated into the Issues, Solutions and Strategies Table (see Attachment A).

The committee disseminated a draft of Issues, Solutions and Strategies to the Member Board executive officers for their input. While 15 executive officers responded, the committee would like to provide more time for the executive officers to review the recommendations and provide further feedback.

Develop communication processes for regular sharing of information and promotion of dialogue to enhance the interface among all licensure models
In response to this charge, the committee has made the following recommendations:
1. Boards of nursing (BONs) should use NCSBN's Nurse Alert Feature available to Member Boards as a tool to help communicate investigative and other information regarding a licensee. This will assist with the sharing of information.
2. Allow time for a dialogue at the Executive Officer’s Seminar to discuss regulation and the licensure models. Nonattendees should be allowed participation by conference call. Gather input and develop a plan based on the executive officers' feedback. This will assist the communication process overall.
3. Structure opportunities for a routine dialogue on this subject for attendees at various meetings to keep communication lines open. Communication between BONs about licensure issues is imperative to public protection. This should be an ongoing process and opportunities should be interspersed during regularly scheduled meetings such as the Midyear and the Annual Meetings.
Highlights:
- Identification of issues, solutions and strategies related to licensure that will enhance public protection.
- Feedback from Member Boards.
- Recommendations for improved communication among all BONs.

Assessment:
- Further work is needed on Issues, Solutions and Strategies. The committee would like to identify best practices for communication among varying licensure models and identify who will be responsible. It would also like more feedback from Member Boards.
- The committee believes more work could be done on developing the communication processes outlined in Charge #2.
- The committee suggests that a plan for implementation of the strategies outlined in Issues, Solutions and Strategies be developed by the committee as a next step.

Future Activities
Recommended charges for FY12:
1. Review Issues, Solutions and Strategies, obtain further input from Member Boards and refine recommendations.
2. Develop a plan to implement the strategies identified in Issues, Solutions and Strategies.
3. Continue work to develop communication processes for regular sharing of information and dialogue to enhance the interface among all licensure models.

Attachment
A. Issues, Solutions and Strategies Table
### Attachment A

**Issues, Solutions and Strategies Table**

<table>
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<tr>
<th>Issues</th>
<th>Solutions</th>
<th>Strategies</th>
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| 1. Timeliness in resolving discipline cases varies from state to state. | - Sharing of investigative information by all boards of nursing (BONs) will allow states to make an informed decisions regarding licensure of an individual, even if the investigation is not complete and the case is not resolved. | - Participation in Nursys® by all jurisdictions  
  - Utilization of the alert feature  
  - Access applicable discipline reports  
  - Reform state laws to allow sharing of investigative information among all jurisdictions.  
  - Expedite the removal of nurses from practice when there is an immediate threat to the public.  
  - Adoption of model language for sharing investigative information (being developed by Model Act and Rules Committee) and then enactment by BONs.  
  - Arrange for an open dialogue of issues at Executive Officer’s Seminar.  
  - Identify existing state models for handling discipline and due process. Merge with CORE data to identify promising or best practices.  
  - Present models of efficient and effective state discipline processes at Attorney/Investigator Conference.  
  - Identify methods to streamline case resolution. |
| 2. Sharing of discipline and/or investigative information or notice that an investigation has been initiated.  
  - Some states are prevented by law to not allow for the sharing of investigative information.  
  - Some states do not have processes in place to allow sharing of investigative information. | | |
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<th>Strategies</th>
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| 3. Perceptions, government structure and policies, and other issues that prevent states from revising their nursing laws with legislation that would allow sharing of information. | - Individual state issues/challenges/needs are identified and assistance is provided where needed.  
- Education and resources are available that address this. | - Focus a presentation at the Leadership and Public Policy Seminar on “Opening the Practice Act.”  
- Develop talking points to help states with legislative barriers.  
- Develop a toolkit for implementing legislative change.  
- Initiate dialogue at strategic meetings and webcast when relevant. |
| 4. State and federal fingerprint-based criminal background checks (CBCs) done in all jurisdictions. | - Adoption of state and federal fingerprint checks by all states for initial licensure, at minimum. | - Continue to supply resources and support to states needing to adopt CBCs.  
- Share stories among BONs (Anecdotal Evidence Bank). These can be used for legislative testimony.  
- Monitor movement at the federal level regarding ability to share fingerprint results. |
| 5. Employer verification of nursing licenses. There are inconsistencies in verifying authority to work by employers. | - Education of employers, nurses and the public.  
- Employers check Nursys for up-to-date information on nurses they are hiring. | - Develop video to educate employers.  
- Link to Nursys on BON website. |
| 6. Mandatory reporting requirements for reporting nurse practice act violations to the BON. | - Mandatory reporting or otherwise obligate licensees to take steps to protect the public when they identify an unsafe practitioner. | - Recommend to the Model Act and Rules Committee that language is incorporated into the updated Model Act and Rules.  
- Enactment of immunity legislation for reporting nurse practice act violations. |
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<td>7. Decisions made in one jurisdiction or licensure model can impact other jurisdictions and/or licensure models.</td>
<td>• Recognition that decisions made in one jurisdiction or licensure model can impact other jurisdictions or licensure models.</td>
<td>• Education sessions at appropriate meetings.</td>
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<td>• Structure a presentation for the Executive Officer Seminar and/or Midyear Meeting to focus on regulatory issues among states and “The Chain Reaction of Board Decisions.”</td>
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<td>• Structure opportunities for open dialogue on this subject for attendees at various meetings.</td>
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<td></td>
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<td>• Utilize the work by the Nurse Licensure Models Interface group.</td>
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<td>• Address newly emerging issues.</td>
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<td>• Continue to collect date regarding the value of nursing regulation on public protection.</td>
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<td>8. Alternative to discipline programs vary from state to state. Variances in:</td>
<td>• Consistency across all jurisdictions.</td>
<td>• Adoption (by all states) of the new model guidelines for substance use published in Substance Use Disorder in Nursing.</td>
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<td>• Participation following recidivism;</td>
<td>• Knowledge by BON as to who is participating in the Alternative to Discipline Program in their state.</td>
<td>• BONs wishing to reform their programs should consult the Citizen’s Advocacy Center. It is able to evaluate programs and make recommendations.</td>
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<td>• Response to relapse; and</td>
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<td>• Periodic education on substance use disorder via presentations and in the Journal of Nursing Regulation.</td>
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<td>• Management of contract violators.</td>
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<td>• Adoption of legislation that lets BONs know who is enrolled in an alternative program or an agreement between the program and BON that the BON will be notified when a nurse relapses.</td>
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<td>9. Consistency in licensure decisions.</td>
<td>• Consistent application of standard criteria.</td>
<td>• Adoption of Uniform Licensure Requirements (ULRs) by Delegate Assembly followed by enactment and implementation of ULRs by Member Board jurisdictions.</td>
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<td>• Provide toolkit for the adoption of ULRs.</td>
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# Report of the Nursing Education Committee

## Background
Recently the approval process has presented some challenges to boards of nursing (BONs). New programs are burgeoning, taking much BON staff time and yet, state resources are shrinking. According to a survey sent to the BONs, they estimate it costs them, on average, $2,000 for each initial approval of a program and $1,800 for continuing approval. The question was asked: Why are BONs involved in the approval process? Based on these concerns, in September 2010 the NCSBN Board of Directors (BOD) convened the Nursing Education Committee and charged it to:

1. Analyze and present data from Member Boards regarding implementation of education program regulations that result in initial and continued approval compliance actions.
2. Examine differences between BONs’ requirements and accreditation standards for nursing education programs approved by Member Boards.
3. Assess the current and future purpose and focus for BON approval of nursing education programs.

## Highlights of FY11 Activities
- Analyze and present data from Member Boards implementation of education program regulations that result in initial and continued approval compliance actions.
  - Conducted a comprehensive survey of the Member Boards (Attachment B).
  - Reviewed the literature and past NCSBN work, including a white paper on approval, and two surveys to education consultants from 2010 (joint site visits) and 2009 (fees for approval).
  - Reviewed current and proposed NCSBN model education rules and met with the Model Act & Rules Committee to discuss mutual charges.
  - Reviewed the Member Board Profiles chapter on education.
- Examine differences between BONs requirements and accreditation standards for nursing education programs approved by Member Boards.
  - Held a collaborative conference call with the two national nursing accreditors (National League for Nursing Accrediting Commission [NLNAC] and the Commission on Collegiate Nursing Education [CCNE]) to clarify questions about the accreditation process, with follow-up written responses to questions.
  - Held conference call with the education consultants from the BONs to discuss advantages and disadvantages of joint site visits.
  - Held conference call with staff from BONs that currently require accreditation to learn the advantages and challenges.
  - Analyzed crosswalks for approval versus accreditation from Texas and Minnesota Boards of Nursing.
- Assess the current and future purpose and focus for BON approval of nursing education programs.
  - Asked nurse leaders (Patricia Benner, PhD, RN, FAAN, Carnegie Study of Nursing Education; Susan Hassmiller, PhD, RN, FAAN, Robert Wood Johnson Foundation; Polly Bednash, PhD, RN, FAAN, American Association of Colleges of Nursing; and Beverly Malone, PhD, RN, FAAN, National League for Nursing) to respond to questions about the preferred future of the approval process.
  - Reviewed the Institute of Medicine’s (IOM’s) Future of Nursing report.

## Members
| Susan L. Woods, PhD, RN, FAHA, FAAN |
| Washington, Area I, Chair |
| Bibi Schultz, MSN, RN |
| Missouri, Area II |
| Joe Baker, Jr. |
| Florida, Area III |
| Katie Daugherty, MN, RN |
| California-RN, Area I |
| Katie L. Drake-Speer, MSN |
| Alabama, Area III |
| Margaret Hourigan, EdD, RN |
| Maine, Area IV |
| Marilyn Krasowski, EdD, MSN, RN |
| Minnesota, Area II |
| Peggy S. Matteson, PhD, RN, FCN |
| Rhode Island, Area IV |
| Tish Smyer, DNSc, RN, CNE |
| Nevada, Area I |
| Shirley Brekken, MS, RN |
| Minnesota, Area II, Board Liaison |

## Staff
- Nancy Spector, PhD, RN, Director, Regulatory Innovations
- Linda Olson, PhD, RN, Institute of Regulatory Excellence Associate, Nursing Regulation

## Meeting Dates
| Dec. 14-15, 2010 |
| Jan. 18-19, 2011 |
| March 22-23, 2011 |
| March 31, 2011 (Conference Call) |
| April 4, 2011 (Conference Call) |

## Relationship to Strategic Plan
**Strategic Initiative A**
 NCSBN promotes evidence-based regulation.

**Strategic Objective 2**
Provide models and resources for evidence-based regulation.
Reviewed Carnegie Study of Nursing Education.

Wrote a report entitled “A Preferred Future for Prelicensure Nursing Program Approval” (Attachment A), which integrates the work of all three charges and outlines the following recommendations for BONs:

- Work toward requiring national nursing accreditation of all prelicensure nursing programs (licensed practical/vocational nurse, associate degree in nursing, diploma, baccalaureate and master’s entry) by the year 2020.

- BONs would retain the following responsibilities:
  - Have statutory authority over nursing programs;
  - Make initial approval visits and decisions;
  - Make individual or joint visits with the accreditors for complaints or issues that arise; and
  - Accept the accreditors’ annual and site visit reports.

- NCSBN will support the BONs as they move toward requiring national nursing accreditation by:
  - Establishing best practices for assisting nonaccredited programs to become accredited;
  - Assessing the funding situation for programs to become accredited and develop some recommendations for BONs;
  - Developing guidelines for BONs to make joint visits with the accreditors;
  - Meeting with the national nursing accreditors to develop a shared understanding so that requiring accreditation will be successful; and
  - Hosting a conference with national nursing accreditors, BONs and educators to dialogue about how to make the accreditation requirement a success.

**Future Activities**

Recommended charges for FY12 include:

1. Facilitate a conversation with CCNE and NLNAC about a shared understanding of nursing program approval processes and accreditation.

2. Hold a Collaborative Nursing Education Program Accreditation and Approval Summit no later than February 2012 to meet the deadline of the Model Act & Rules Committee.


4. Examine best practices for assisting schools for attaining initial accreditation.

**Attachment**

A. A Preferred Future for Prelicensure Nursing Program Approval

B. Survey on Prelicensure Nursing Education Program Approval
Attachment A

A Preferred Future for Prelicensure Nursing Program Approval

NURSING EDUCATION COMMITTEE MEMBERS

Susan L. Woods, PhD, RN, FAHA, FAAN, board member, Washington State Nursing Care Quality Assurance Commission, Committee Chair

Bibi Schultz, MSN, RN, board staff, Missouri State Board of Nursing

Joe Baker, Jr., executive director, Florida Board of Nursing

Katie Dougherty, MN, RN, board staff, California Board of Registered Nursing

Katie Drake-Speer, MSN, RN, board staff, Alabama Board of Nursing

Margaret Hourigan, EdD, RN, board member, Maine State Board of Nursing

Marilyn Krasowski, EdD, RN, board member, Minnesota Board of Nursing

Peggy Matteson, PhD, FCN, RN, board member, Rhode Island Board of Nurse Registration and Nursing Education

Tish Smyer, DNSc, RN, CNE, board member, Nevada State Board of Nursing

Nancy Spector, PhD, RN, director, Regulatory Innovations, NCSBN

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EXECUTIVE SUMMARY

NCSBN’s Board of Directors (BOD) convened a Nursing Education Committee in September 2011 and charged it to:

- Analyze and present data from Member Boards regarding implementation of education program regulations that result in initial and continued approval compliance actions.

- Examine differences between boards of nursing (BONs) requirements and accreditation standards for nursing education programs approved by Member Boards.

- Assess the current and future purpose and focus for BON approval of nursing education programs.

The Nursing Education Committee integrated their findings into a report updating NCSBN’s 2004 white paper (NCSBN, 2004) on the approval processes in BONs. Since that time, there has been more research supporting evidence-based nursing education strategies and two major national reports (Benner, Sutphen, Leonard, & Day, 2010; Committee, 2011) on nursing education. Both national reports call for nurses to have higher levels of nursing education and a system that promotes seamless academic progression. The Institute of Medicine (IOM)’s Future of Nursing report recommends that by 2020, 80 percent of the nursing workforce be educated with a baccalaureate degree. In order for nurses to continue their education, they must graduate from accredited nursing programs.
Since 2004, approval process models used by BONs have changed and increased from the five outlined in the white paper to the seven reflected in Appendix 1. The majority of BONs continue to approve nursing education programs separately from national nursing accreditation. Yet, in a 2011 comprehensive survey to BONs (N=51; Attachment B), a majority of BONs see collaboration with the accreditors as their preferred future for program approval.

The differences between accreditation and approval are outlined and a crosswalk of the standards between the national nursing accreditor’s standards, the NCSBN model education rules and NCSBN's Member Board Profiles is provided.

Recommendations for BONs were identified and include:

1. Work toward requiring national nursing accreditation of all prelicensure nursing programs (licensed practical/vocational nurse [LPN/VN], associate degree in nursing [ADN], diploma, baccalaureate and master’s entry) by the year 2020.

2. BONs would retain the following responsibilities:
   - Have statutory authority over nursing programs;
   - Make initial approval visits and decisions;
   - Make individual or joint visits with the accreditors for complaints or issues that arise; and
   - Accept the accreditors’ annual and site visit reports.

3. NCSBN will support the BONs as they move toward requiring national nursing accreditation by:
   - Establishing best practices for assisting nonaccredited programs to become accredited;
   - Assessing the funding situation for programs to become accredited and develop some recommendations for BONs;
   - Developing guidelines for BONs to make joint visits with the accreditors;
   - Meeting with national nursing accreditors to develop a shared understanding so that requiring accreditation will be successful; and
   - Hosting a conference with national nursing accreditors, BONs and educators to dialogue about how to make the accreditation requirement a success.

In summary, if the BONs were to harmonize their processes with national nursing accreditors, they could benefit by saving on resources expended during the approval process and still protect the public.

INTRODUCTION

In 2004 NCSBN published a white paper (NCSBN, 2004), approved by the BOD, which appraised the status of the prelicensure approval processes in BONs. This white paper explored the history of the approval process in BONs; reviewed earlier work by NCSBN on the approval process, including that of the Practice, Education and Regulation in Congruence Committee; analyzed the International Council of Nursing (ICN)’s perspective on approval; and identified five models that BONs were then using to approve nursing programs. The IOM competencies across health care professions (Greiner & Knebel, 2003) had just been released (patient-centered care, interdisciplinary teams, evidence-based practice, informatics and quality improvement), and one recommendation for the future was that approval processes should incorporate these in their program assessments. The paper also examined new education programs that were being developed at the time (clinical nurse leader, doctorate of nursing practice) and recommended moving toward evidence-based nursing education practices. Additionally, the paper addressed the possibility of program approval for APRN programs.

Nursing has made great strides since that paper was published. The clinical nurse leader and doctorate of nursing practice programs are flourishing, and the APRN Consensus Model
(Chorniak, 2010) has recommended preapproval of programs by the national nursing accrediting bodies. The body of research supporting nursing education has grown (Adams & Valiga, 2009; Ard & Valiga, 2009; Benner et al., 2010; Halstead, 2007; Lasater & Nielsen, 2009; Oermann, M., 2007; Schultz, 2009), thus providing more foundation for nurse educators, though much more needs to be done to advance nursing education into the future (Benner et al., 2010; Committee, 2011). This updated report on approval processes makes some bold evidence-based recommendations for the future.

BACKGROUND

Recently the approval process has presented some challenges to BONs (Smyer & Colosimo, 2011). New programs are burgeoning (Spector, 2010), taking much BON staff time, and yet state resources are shrinking. According to a survey sent to the BONs (Attachment B), BONs estimate it costs them, on average, $2,000 for each initial approval of a program and $1,800 for continuing approval. The question was asked: Why are BONs involved in the approval process? Based on these concerns, the NCSBN BOD convened the Nursing Education Committee and charged it with the following:

1. Analyze and present data from Member Boards regarding implementation of education program regulations that result in initial and continued approval compliance actions.
2. Examine differences between BONs requirements and accreditation standards for nursing education programs approved by Member Boards.
3. Assess the current and future purpose and focus for BON approval of nursing education programs.

In order to answer the proceeding questions, the following evidence was collected and reviewed from September 2010 to March 2011:

- Conducted comprehensive survey sent to all BONs with a response rate of 51 (see Attachment B);
- Held a collaborative conference call with the two national nursing accreditors (National League for Nursing Accrediting Commission [NLNAC] and the Commission on Collegiate Nursing Education [CCNE]) on Jan. 18, 2011, to clarify questions about the accreditation process with follow-up written responses to questions;
- Reviewed past NCSBN work, including a white paper (NCSBN, 2004) on approval, book chapter on approval (Spector, 2010) and two surveys sent to education consultants from 2010 (joint site visits) and 2009 (fees for approval);
- Held conference calls with the education consultants from the BONs to discuss advantages and disadvantages of joint site visits;
- Asked nurse leaders (Patricia Benner, PhD, RN, FAAN, Carnegie Study of Nursing Education; Susan Hassmiller, PhD, RN, FAAN, Robert Wood Johnson Foundation; Polly Bednash, PhD, RN, FAAN, American Association of Colleges of Nursing; and Beverly Malone, PhD, RN, FAAN, National League for Nursing) to respond to questions about the preferred future of the approval process;
- Held conference calls with staff from BONs that currently require accreditation to learn of the advantages and any challenges or issues;
- Reviewed IOM Future of Nursing report (Committee, 2011);
- Reviewed Carnegie Study of Nursing Education (Benner et al., 2010);
- Reviewed current and proposed NCSBN model education rules and met with the Model Act & Rules Committee to discuss our mutual charges;

1 NCLEX® program codes show that 264 new registered nurse (RN) programs and 320 new programs were established between 2001-2005 while 421 new RN programs and 388 new LPN/VN programs were established between 2006-2010.
Reviewed Member Board Profiles chapter on education; and

Analyzed crosswalks for approval versus accreditation from Texas and Minnesota Boards of Nursing.

AN ANALYSIS OF THE CONTEXT OF THE BON APPROVAL PROCESS

Most BONs have authority to grant initial and continuing approval of nursing education programs. Exceptions are the Mississippi and New York State Boards of Nursing, which are not involved in program approval as this is done by another state agency in those states. Additionally, the Florida Board of Nursing is engaged in initial program approval (only if a nursing education program is not nationally accredited) and continuing approval under specific statutory guidelines.

This regulatory mandate varies across states. See Appendix 1 for the seven approval models that were identified and how many BONs are in each category. No significant differences (p=0.8) were found in NCLEX® pass rates across the templates, though there were small numbers in some of the categories.

In a February 2011 survey of BONs (Attachment B), 27 out of 53 respondents approve programs separately from the national nursing accreditors, NLNAC and CCNE. Additionally, 100 percent of respondents indicated that they do the initial approval of nursing programs. Fewer (35 of 50 respondents), however, approve nursing education programs on a continuing basis.

When asked in the survey (Attachment B) about their “preferred future” for program approval, fewer BONs preferred the separate approval process (37 percent), while the majority preferred a collaborative model (61 percent) and more consistency among BONs. For example, one survey respondent said, “I’d like to see a conference devoted to approval of education programs…the nitty gritty. I realize states differ, but there must be some general guidelines.” Yet, they report that they were satisfied with their current initial and continuing approval processes (67 percent and 84 percent, respectively). These findings suggest the BONs perceive that their current approval model is accomplishing their missions of public protection, though they are interested in evaluating additional models as they move into the future.

BONs approve nursing programs as part of their mission of public protection. BONs recognize that nursing is a practice discipline where clinicians make life and death decisions daily about patients. Additionally, BONs are concerned about patient safety, which has become a national focus in health care; medical injuries affect 10 percent of hospitalized patients and cause hundreds of thousands of deaths per year (Leape, 2009). Therefore, maintaining minimum standards of nursing education programs is crucial for public protection because nurses are often the last line of defense for the patients (Benner et al., 2010).

Yet, some have asked, Why is nursing one of the only professions to be involved in program approval? In most other professions, such as medicine, pharmacy or physical therapy, the regulatory boards do not approve their programs. After all, the national nursing accreditors, NLNAC and CCNE, evaluate many of the same parameters that BONs review. One difference is that unlike many health care professions, prelicensure nursing programs generally are at the undergraduate level; thus, there are many more nursing programs to track. Further, nursing has two accrediting bodies, whereas most other health care professions have one and accreditation is not required in most states. Also unlike other health professions, nursing has multiple points of entry and exit, including LPN/VN (diploma or associate degree), diploma, associate degree and baccalaureate or master’s educated RNs. Considering this last point, if nursing is to move to 80 percent baccalaureate educated nurses by 2020 as recommended by the IOM’s Future of Nursing report (Committee, 2011), then the accreditation of programs will be an important factor for promoting educational mobility.

However, a more comprehensive answer to this question lies in the heart of nursing regulation. Licensure in nursing is a two-pronged system. In order for nursing graduates to be eligible to take the NCLEX®, 2010 there were 197,775 RN and 82,519 LPN/VN candidates who passed the NCLEX.

The Carnegie Study of Nursing Education recommends collaboration between the two national nursing accrediting bodies to ensure that articulation efforts are successful (Benner et al., 2010, p. 229).
the NCLEX, the U.S. nursing regulatory model dictates that the new nurse must show evidence of graduating from a BON-approved nursing program. By making students eligible to take the NCLEX, nursing faculty verify that nursing students are competent to practice. Therefore, nurse educators have enormous power in the licensure model in the U.S. BONs rely on each other to make sound program approval decisions so that mobility across jurisdictions can be as seamless as possible.

There is no doubt that redundancy exists between program approval by BONs and national nursing accreditation. A summary comparison of NLNAC, American Association of Critical-Care Nurses (AACN), NCSBN model education rules (adopted by NCSBN’s membership) and Member Board Profiles (a comparison of education requirements across jurisdictions) can be found in Appendix 2; this summary highlights many of the overlaps between BON approval and accreditation. If the BONs were to harmonize their processes with the national nursing accreditors, they could benefit by saving on resources expended during the approval process, while still protecting the public.

While there is redundancy in program approval and accreditation, there are also uniquenesses that support the BONs having legal authority in the approval process. These are highlighted below:

- The missions of national nursing accreditations and BONs approval differ; the accreditors assess quality and continuous quality improvement, while BONs, with their missions of public protection, evaluate and enforce minimum standards.
- BONs are strategically positioned to assure that all of these programs meet minimal standards. BONs are particularly in close touch with developing programs.
- BONs, by virtue of being state/jurisdiction-based, have the unique opportunity of being able to understand the nursing education issues in that specific jurisdiction, as compared to the national accreditors.
- National nursing accreditation is voluntary in most states, while BON approval is required. Were approval removed from the authority of the BON, some programs (particularly practical nursing and associate degree nursing) would have no oversight at all.
- The national nursing accreditors do not have the authority to close nursing programs that don’t meet their standards, while BONs have this legal authority over programs. In medicine, for example, if a school is not accredited, it affects their federal funding, so the school immediately reacts.
- BONs often investigate fraudulent nursing programs, working closely with state agencies to issue cease and desist orders.
- A BON’s oversight of nursing education programs serves the public’s best interest by curtailing programs that are shown to have high attrition and/or licensure exam failure rates.
- BONs share information about fraudulent programs through conference calls and webinars and they are able to communicate with each other about questionable programs through NCSBN’s Members-only, Web-based program, the Falsified Identity Tracking System (FITS).

THE FUTURE OF APPROVAL

Given recent calls for innovations in nursing education (Benner et al., 2010; Committee, 2011) and the BONs’ desires to consider a new model for the future (Appendix B), the time is ripe for BONs to work toward harmonizing their approval processes with the national nursing accreditors. Therefore, based on the evidence reviewed, NCSBN recommends requiring national accreditation by 2020. This date is in line with the IOM’s Future of Nursing report, which recommends increasing the proportion of nurses with a baccalaureate degree to 80 percent by 2020 (Committee, 2011). If nurses from LPN/VN, ADN or diploma program graduate from nonaccredited programs, it will be more difficult for them to further their education.
It is clear, however, that this change cannot be accomplished quickly and will require working with NLNAC, CCNE, educators and BONs. Currently statistics show (See Appendix 3) that whereas virtually all Bachelor of Science in Nursing (BSN) programs are accredited (some are accredited by both CCNE and NLNAC) 54 percent of ADN programs, 78 percent of diploma programs, and only nine percent of LPN/VN programs are accredited, so there is much to be done. For this to happen, BONs, NLNAC, CCNE and educators need to collaborate to create a shared understanding. As Benner et al. recommended in their study of nursing education, it would be essential for CCNE and NLNAC to work together cooperatively in order to promote seamless academic progression, as well as to develop consistency between their standards (2010).

See the figure below for a visual description of the preferred future for approval. Some of the unique differences between the BON approval process and national nursing accreditation can be seen in the stand-alone sections of the two circles. The overlap of the circles is larger, and represents the shared responsibilities and accountabilities of BONs and the accreditors, and is the preferred future of the BON program approval.

![Collaborative Model of Continuing Program Approval](image)

Premises for the preferred future for approval include:

1. Accreditation and BONs enhance patient safety and quality of programs.
2. BONs have legal authority over programs in their missions of public protection.
3. There is a need for more consistency in education rules and regulations to promote seamless transitions between jurisdictions.
4. There is a considerable overlap of the BONs’ and accreditors’ standards and requirements.
5. Utilization of resources will be improved by reducing duplication of continuing approval processes.
6. Articulation is fostered when students graduate from accredited programs.

The recommendations for BONs include:

1. Work toward requiring national nursing accreditation of all prelicensure nursing programs (LPN/VN, ADN, diploma, baccalaureate and master’s entry) by the year 2020.
2. BONs will retain the following responsibilities:

- Have statutory authority over nursing programs.
  
  Rationale: National nursing accreditors only have the authority to deny accreditation; they cannot stop a program from operating.

- Make initial approval visits and decisions.
  
  Rationale: BONs are better able to understand the local/regional issues in their jurisdictions than accreditors are, particularly related to feasibility of approving new programs, the scarcity of clinical placements and qualified faculty, the increasing numbers of fraudulent programs, etc.

- Make individual or joint visits with accreditors for complaints or issues that arise.
  
  Rationale: The accreditation cycle is eight to 10 years, and in the interim, BONs can receive complaints, hear about sudden faculty or student attrition, or other critical situations.

- BONs will not require a separate report from the programs, but instead will review the accreditors’ annual and site visit reports.
  
  Rationale: There is duplication between BONs and accreditors’ annual and approval reports, creating more work for faculty and BONs.

3. NCSBN will support the BON in this endeavor:

- The Nursing Education Committee will establish, for BONs, best practices for assisting nonaccredited programs with becoming accredited.

- A major concern for some programs will be funding. The Nursing Education Committee will assess the funding situation and develop some recommendations for BONs.

- NCSBN will work with accreditors to develop guidelines for BONs to make joint visits with accreditors. This will be a first step as BONs move forward with requiring accreditation in order to learn about the process. According to the NCSBN survey, currently only 23 BONs make joint visits with accreditors. BONs also may want to make joint visits with accreditors occasionally, once they begin to require accreditation.

- The Nursing Education Committee will meet with the national nursing accreditors to work out some issues so that requiring accreditation will be successful.

  - Currently accreditation reports are not shared with BONs. The BONs, given their legal authority of program approval, want to see a summary of the accreditors’ reports.

  - During a faculty shortage, many BONs give program waivers/exemptions for meeting faculty qualifications. Accreditors, by virtue of their missions to evaluate program quality, have more rigorous standards. Some level of understanding will need to be developed so that programs that struggle to find qualified faculty can stay open if their outcomes are satisfactory.

  - Given that nursing is a practice profession, BONs require sufficient clinical experiences at the level of licensure being sought to meet program outcomes (NCSBN, 2005). The accreditors and BONs need to develop a shared understanding of this requirement.

  - Develop cooperation between the accreditors’ reporting of data and accreditation cycles.

  - Accreditors expressed interest in NCSBN working with them to collect annual pass rate data.

  - NCSBN will host a conference with national nursing accreditors, BONs and educators to dialogue about BONs requiring national nursing accreditation, and to begin a conversation about setting quality indicators for nursing education programs.
CONCLUSION
BONs currently use seven different models for approving nursing programs, and nursing education rules and regulations in BONs are not consistent across jurisdictions. As nursing moves to the future and implements the IOM's Future of Nursing report, it will become essential for students to graduate from accredited programs. Now is the time for BONs to require national nursing accreditation by 2020. This date is consistent with IOM's Future of Nursing date for increasing the proportion of BSN-educated nurses to 80 percent. NCSBN will support the BONs as they move ahead with this, recognizing the challenges that BONs may experience.

REFERENCES
APPENDIX 1: PRELICENSURE NURSING EDUCATION PROGRAM APPROVAL PROCESSES IN BONS

1. **BONs are independent of the national nursing accreditors (27 BONs).**
   These BONs approve nursing programs separately and distinctly from the national nursing accrediting bodies. Initial approval processes are conducted before accreditation takes place.

2. **Collaboration of BONs and national nursing accreditors (five BONs).**
   BONs share reports with the national nursing accrediting bodies and/or make visits with them, sharing information. However, the final decision about approval is made by the BON, independent of decisions by national nursing accreditors. Initial approval processes are conducted before accreditation takes place.

3. **Accept national nursing accreditation as meeting BON approval (four BONs).**
   BONs accept national nursing accreditation as meeting state approvals, though they continue to approve those schools that don’t voluntarily get accredited. The BON is available for assistance with statewide issues (e.g., the nursing shortage in that state); BONs retain the ability to make emergency visits to schools of nursing, if requested to do so by a party reporting serious problems; and the BON has the authority to close a school of nursing, either on the advice of national nursing accreditors or after making an emergency visit with evidence that the school of nursing is causing harm to the public. Initial approval processes are conducted before accreditation takes place.

4. **Accept national nursing accreditation as meeting BON approval with further documentation (eight BONs).**
   Similar to Process #3, these BONs accept national nursing accreditation as meeting state approvals, but they may require more documentation, such as complaints, NCLEX results, excessive student attrition, excessive faculty turnover or lack of clinical sites. Initial approval processes are conducted before accreditation takes place.

5. **BONs require national nursing accreditation (six BONs).**
   BONs require their nursing programs to become accredited by a national nursing accreditation body and will use Process #3 or #4 to approve them. Initial approval processes are conducted before accreditation takes place.

6. **BONs have no jurisdiction over programs that have national nursing accreditation (one BON).**
   Nonaccredited programs are only initially approved by the BON and under specific statutory requirements.

7. **BONs are not involved with the approval system at all (two BONs).**
   The BON is not given the authority to approve nursing programs; this is done by another state/jurisdiction authority.
## APPENDIX 2: SUMMARY OF DIFFERENCES BETWEEN MODEL EDUCATION RULES AND NATIONAL NURSING ACCREDITATION STANDARDS

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<thead>
<tr>
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<tbody>
<tr>
<td><strong>Standard I: Mission and Administrative Capacity</strong></td>
<td><strong>Standard I: Mission and Governance</strong></td>
<td><strong>Chapter 9 – Education Practice Act and Rules</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Mission reflects core values.</td>
<td>▪ Mission congruent with parent institution.</td>
<td>▪ Less emphasis on institution.</td>
<td></td>
</tr>
<tr>
<td>▪ Specifics on program administrator qualifications.</td>
<td>▪ Reference BON approval status.</td>
<td>▪ Administrator qualifications specified.</td>
<td></td>
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</tbody>
</table>

### Standard II: Faculty and Staff

- Specific criteria with percentages of Master of Science in Nursing (MSN) or doctorates.
- Scholarship of faculty and use of evidence-based teaching strategies.

<table>
<thead>
<tr>
<th>Standard II: Institutional Commitment and Resources</th>
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<tbody>
<tr>
<td>▪ More general chief nurse/faculty criteria with rationale for not having graduate degrees.</td>
<td></td>
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<td></td>
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<tr>
<td>▪ Faculty-student ratios meet regulatory requirements.</td>
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</tr>
<tr>
<td>▪ Preceptors are an extension of faculty.</td>
<td></td>
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<tr>
<td>▪ Program encourages teaching, scholarship and service.</td>
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</table>

### Standard III: Students

- Policies are congruent with mission.
- Services meet student needs.
- Student records are within state and federal guidelines.

<table>
<thead>
<tr>
<th>Student policies in Standard I.</th>
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</thead>
<tbody>
<tr>
<td>▪ Accurate program information.</td>
<td></td>
<td></td>
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<tr>
<td>▪ Students participate in planning.</td>
<td></td>
<td></td>
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</table>

### Member Board Profiles

- Less emphasis on institution.
- Administrator qualifications specified, but vary across jurisdictions.
- Faculty qualifications specified, but vary across jurisdictions.
- 47 states specify faculty-student ratios.
- Nothing related to scholarship of faculty.
- Question not addressed.
|--------------|-------------|-------------------|----------------------|
| **Standard IV:** Curriculum (relates to CCNE Standard III)  
  - Program length is congruent with outcomes.  
  - Methodologies reflect good practice and innovations are fostered.  
  - Clinical experiences reflect best practices and patient health and safety goals. | **Standard III:** Curriculum and Teaching-Learning Practices  
  - Expected outcomes are clear.  
  - Essentials of Baccalaureate Education for Professional Nursing Practice are used (specify need for clinical experiences).  
  - Regular evaluations of students. | **Use of IOM competencies**  
  - Clinical experiences sufficient to meet program outcomes.  
  - Across lifespan. | **Some jurisdictions dictate numbers of hours of clinical experiences and didactic teaching.**  
  - A few dictate percentage of simulation replacing clinical experiences.  
  - Some dictate actual courses, while others say across the lifespan. |
| **Standard V:** Resources  
  - Resources are sufficient to promote stated outcomes. | **Standard II:** Addressed Resources | **Resources adequate to support program processes, security and outcomes.** | **Question not addressed.** |
| **Standard VI:** Outcomes  
  - Systematic plan for evaluation.  
  - Outcomes identified as:  
    - NCLEX at national norm;  
    - Program completion;  
    - Program satisfaction; and  
    - Job placement. | **Standard IV:** Aggregate Student and Faculty  
  - Student outcomes identified include, but are not limited to: NCLEX, certification, employment rates and graduation.  
  - Faculty outcomes consistent with mission of institution.  
  - Formal complaints are used as evidence. | **Systematic plan for evaluation and continuous improvement.** | **There are 49 BONs that require a specified NCLEX pass rate.** |
APPENDIX 3: ACCREDITATION DATA FROM NATIONAL NURSING ACCREDITORS
(NUMBER OF PROGRAMS BY NCLEX® CODES FOR 2010)

<table>
<thead>
<tr>
<th>Degree Program</th>
<th>NCLEX® Codes</th>
<th>Accreditation</th>
<th>% Accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NLNAC</td>
<td>CCNE</td>
</tr>
<tr>
<td>Baccalaureate</td>
<td>740</td>
<td>230</td>
<td>540</td>
</tr>
<tr>
<td>Associate</td>
<td>1246</td>
<td>671</td>
<td>-</td>
</tr>
<tr>
<td>Diploma</td>
<td>68</td>
<td>53</td>
<td>-</td>
</tr>
<tr>
<td>Practical</td>
<td>1722</td>
<td>163</td>
<td>-</td>
</tr>
</tbody>
</table>
Attachment B

Survey on Prelicensure Nursing Education Program Approval

EXECUTIVE SUMMARY

Of the 59 boards of nursing (BONs) that approve prelicensure registered nurse (RN) and licensed practical/vocational nurse (LPN/VN) programs, 51 completed a survey in February 2011. The survey was sent to NCSBN’s listserv for 59 education consultants, which includes all jurisdictions. It should be noted that while the survey asked for the BON’s perspective, the education consultants, in most cases, did not take the survey to the BON and replied as to what they thought their BONs’ perspectives were.

There were seven different approval processes identified and the BONs were asked which one best describes their current approval process:

- 51 percent (27 BONs) approve programs separately from accreditors.
- 32 percent (17 BONs) have shared responsibilities with accreditors, by making joint visits with them, accepting accreditation as meeting approval standards or both.
- 11 percent (six BONs) require accreditation or will be requiring it shortly.
- Four percent (two BONs) do not have authority to approve nursing education programs; that is done by another state agency.
- Two percent (one BON) only initially approves programs that are not nationally accredited and this approval is done under specific statutory requirements.

When asked about their “preferred future” in program approval, fewer BONs preferred the separate approval process (37 percent), while the majority preferred a collaborative model (61 percent). This finding suggests BONs are interested in evaluating additional models as they move into the future. Yet, they report that they were satisfied with their current initial and continuing approval processes, 67 percent and 84 percent, respectively. This finding indicates that it’s their perception that their current approval model is accomplishing their mission of public protection. 100 percent of the respondents (n=50) reported that they require initial approval of nursing programs.

Staffing is the biggest barrier to a BON’s current approval process. The BONs estimated that they spend, on average, $2,000 for their initial approval processes and $1,800 for their continuing approval processes, though this amount varied widely. Yet, a majority of BONs do not charge fees for initial program approval (42 percent of the 49 responses) and only 12 (26 percent) charge fees for continuing program approval.

Overwhelmingly, BONs reported that joint visits with accreditors were satisfactory or better (92 percent). When asked whether national nursing accreditors adequately meet BON requirements, the BONs were divided (45 percent agreed, while 56 percent did not). Some of the differences included statutory authority over nursing programs, assessment of faculty qualifications/roles, and their mission. When asked for possible unintended consequences of their BONs requiring national nursing accreditation, the most frequently mentioned factors included programs needing increased resources to accomplish this, programs not being able to meet faculty qualifications requirements, and no one would have legal authority over the programs.

These results indicate that BONs are ready to move to a different approval model, though they think the jurisdiction should retain its legal authority over programs. They acknowledged that while they would suggest some changes, they would also like to retain parts of their current processes.

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1 53 BONs are listed because NCSBN staff identified two states’ processes from their online regulations.
2 One of these six BONs may remove the required accreditation from its rules because the faculty qualifications are too hard for their programs to meet.
SURVEY RESULTS

Q1 – What is the BON’s approval process? (N=51)

Currently, more than 50 percent of the respondents (27) approve programs separately from the accreditors, while five collaborate with the accreditors; four accept accreditation as meeting approval standards; seven accept accreditation as meeting approval standards with further documentation; seven require, or will soon require, national nursing accreditation; one initially approves nonaccredited programs and under statutory requirements; and two have no authority over nursing programs as the Board of Higher Education approves nursing programs in that state.

Themes from comments:
- Clarity around collaborative visits (7);
- BON is updating their education rules and regulations (2); and
- BON requires the national nursing accreditation report (1).

Q2 – What is your preferred future? (N=49)

This question showed that BONs are not entirely satisfied with the status quo. Few chose to approve programs separately from accreditors (18), while more chose to collaborate with accreditors (19) or to require accreditation (9).

Q3 – Could your BON’s preferred future be standardized? (N=46)

YES: 31
NO: 12

Themes from comments:
- Each state is different and rules/regulations are inconsistent (16);
- Final authority should be with the BON (5);
- Sharing between regulators and accreditors is beneficial (3);
- Legislation would be needed (3);
- Funding issues prevent standardization (2);
- There is nothing specific about our state (1);
- No interest in changing (1);
- Accreditors do not review regulations (1);
- Cannot accept accreditation in lieu of approval (1); and
- Checks and balances (1).

Q4 – Requirement of current approval process? (N=51)

- Feasibility study (34)
- Self study (35)
- Annual report (42)
- Site visits (45)
- Other (18)

Themes of “other” include:
- NCLEX® (3);
- No site visits if accredited (3);
Qualified faculty (2); Clinical site visits (1); Waive site visits (1); Monitor (1); LPN site visit only (1); Complaints (1); Regulatory compliance (1); and Curriculum (1).

Q5 – Program outcomes assessed? (N=51)

NCLEX (50); Student satisfaction (29); Employment (16); Systematic plan for evaluation (43); Employer satisfaction (21); and Other (21).

Themes of “other” include:

- Attrition and graduation rates (5);
- Faculty qualifications (3);
- Resources (4);
- Compliance with regulations (2);
- Competencies (2);
- Governance (2);
- Curriculum (2);
- Transition to practice (1);
- Admission rates (1);
- Clinical agencies (1); and
- Administration (1).

Q6 – Cost of initial approval (N=46)

- 0-$500 (8)
- $501-$750 (1)
- $751-$1000 (3)
- $1001-$1500 (7)
- $1501-$2000 (4)
- $2001-$2500 (7)
- $2501-$3000 (4)
- $3001-$4000 (4)
Q7 – Cost of continuing approval (N=45)
- $4001-$5000 (1)
- >$5001 (7)

Approximate mean = $2000

Q8 – Charge an initial fee? (N=49)
- YES: 21
- NO: 28

Fees charged ranged from $50 - $10,000. Fees varied.

Q9 – Charge a fee for continuing approval? (N=49)
- YES: 12
- NO: 35

Fees ranged from $150 to $1,300. One BON stated that it will charge $3,000 if the program is out of compliance and is trying to comply with the rules and regulations.

Q10 – Does your BON accept accreditation in lieu of initial approval? (N=50)
- NO: 50 (100 percent)

Q11 – Does your BON accept accreditation in lieu of continuing approval? (N=50)
- YES: 15
- NO: 35

Themes from comments:
- NCLEX pass rates monitored (2);
- High attrition, faculty turnover and NCLEX pass rates do not rise to the same level for the accreditors as they do for the BON (3);
- Are attempting to eliminate site visits in favor of accreditation (1); and
- BON reviews regulatory requirements (1).
Q12 – Rate experience of joint site visits (N=23)

- Excellent: 5
- Very Good: 8
- Satisfactory: 9
- Disappointing: 2

Themes from comments:
- Review was separate, though visit was joint (1);
- Lack of consistency with site visitors (1);
- Clearly different standards are evaluated (1);
- Saves time and resources (1);
- Focus on the accreditation visit (1);
- More communication needed between BON and accreditors (1); and
- Problems obtaining documents (1).

Q13 – Do national nursing accreditation standards meet your requirements to protect the public? (N=42)

- YES: 19
- NO: 23

Themes from comments:
- BON statutory authority (8);
- Faculty qualifications/role evaluated differently (7);
- Missions are different (4);
- Clinical experiences (3);
- Curricular elements (3);
- More emphasis by BONs on NCLEX (2);
- No enforcement by accreditors (2);
- Different emphasis (1);
- Issue is how they are evaluating the elements (1);
- Accreditation is more general (1);
- Accreditation is not updated as often (1); and
- Accreditation is not measureable (1).

Q14 – What are the barriers, if any, to successful implementation of your education rules/regulations? (Could select more than one barrier) (N=48)

- Staffing (17)
- Funding (9)
- Legislature (9)
- None (22)
46 percent of the BONs reported having no barriers to implementing their education rules/regulations. Comments included:

- Political with for-profits (3);
- Legislation not focused on public safety, but other issues (1);
- Education not given priority (1); and
- Increasing number of programs (1).

Q15 – Is your BON currently satisfied with its initial approval process? (N=49)

- YES: 33
- NO: 16

A majority of the BONs are satisfied with their initial approval processes. Comments included:

- Overwhelmed by new programs (particularly proprietary) (9);
- Need a fee (2);
- Hard to evaluate quality without site visits (1);
- Regulation education rules are static, not dynamic (1);
- Availability of clinical sites is a problem (local issues) (1);
- Defer initial site visit (1); and
- Need more efficiency (1).

Q16 – Is your BON satisfied with its current continuing approval process? (N=50)

- YES: 42
- NO: 8

BONs are even more satisfied with their continuing approval process. Some comments included:

- Would like national accreditation to be required (2);
- Would like to see some changes if they increase efficiency and save resources (1);
- Are in the process of deleting the national accreditation requirement (1);
- Key is asking the right questions (1);
- Regulation education rules are static, not dynamic (1);
- Eliminate site visits (1);
- Need a fee (1); and
- Would like the programs to share their national accreditation reports (1).

Q17 – What would be the unintended consequences of requiring national nursing accreditation? (N=44)

Overwhelmingly the BONs worried about additional costs and resources, particularly for the LPN/VN BONs. Comments included:

- Lack of resources (fiscal and personnel) (15);
- Faculty qualification requirements (9);
- No one would have legal authority over the programs (5);
- None (4);
- None as long as BON collaborates (1);
- Differences in standards (4);
- Monitoring issues (length of time between accreditation visits) (3);
- Political pressure to accredit programs (2);
- Local issues not addressed (such as clinical experiences) (2);
- Patient safety would not be enhanced by requiring accreditation (1); and
- PN high school programs would discontinue (1).

**Q18 – Are there differences between BON approval processes for LPN/VN programs versus RN programs? (N=47)**

- YES: 10
- NO: 37

Generally, the approval process is the same across programs. Comments included:

- Separate BONs or regulations (6);
- Process same, but different requirements (2); and
- LPN/VN programs have hour requirements (1).

**Q19 – Other information you would like to share with us? (N=21)**

There were 21 general comments that were categorized into the following themes:

- Shared site visits are important (2);
- Requesting approval conference for general and consistent guidelines (2);
- Concerns about length of time between accreditation visits (1);
- Considering requiring regional accreditation (1);
- BON advantage is they frequently monitor programs (1);
- Need to reduce duplication (1);
- Requiring accreditation for ADN’s and LPN/VNs would be burdensome (1);
- Missions of accreditation/regulation are different (1); and
- Outcome data not available for new programs, and yet they get accredited (1).
**Report of the TERCAP® Committee**

**Background**

Begun in 1999, the Taxonomy of Error, Root Cause Analysis and Practice-Responsibility (TERCAP®) project grew out of the emerging need to learn more about medical errors and their root causes. The original goal of this project, which continues in 2011, is to learn from the experience of nurses who have had episodes of practice breakdown (defined as the absence of “good practice”) and discover characteristics of nurses at risk.

Over the last decade, the TERCAP® Committee (formerly the Practice Breakdown Advisory Panel) was charged with various aspects of the development of the TERCAP data collection tool. The uniqueness of TERCAP is that it attempts to capture the human causes of error and at the same time, allow for the analysis of complex system-related issues that often occur within the health care environment. The TERCAP tool, which attempts to capture detailed data regarding practice breakdown, has undergone many reiterations. Most recently in 2011, after the TERCAP® Committee analyzed data collected from the tool, the committee realized certain questions could be eliminated to make the tool shorter and easier to use. It was also noted that some questions required clarification in order to elicit accurate answers. These changes were made to the newest version, TERCAP® 2011, which is currently in use.

While TERCAP was originally developed as a research study, during the spring of 2010 the committee made a decision to change TERCAP’s focus from that of a research project to one of an adverse events reporting database. This continues to allow for the determination of the root cause of practice breakdown, but eliminates concerns about case selection bias and the need for a high number of cases for statistical analysis. In addition, most research projects have a finite point in which data collection ends and analysis begins. Since TERCAP was envisioned to be an ongoing project, it seemed more appropriate to classify it as an adverse events reporting database. These types of databases are ongoing data collection systems and allow for the calculation of frequencies and analysis of trends. In addition, it provides increased flexibility. Adverse events databases do not require the same precision in case selection and fastidious attention to methodology as research projects require. This decision was discussed with Patricia Benner, PhD, RN, FAAN (one of the developers of the TERCAP tool), and was approved by the NCSBN Board of Directors (BOD) in 2010.

Data collection using the TERCAP tool began in 2008. Currently, there are 21 boards of nursing (BONs) that have entered cases into the database. Arkansas is the newest TERCAP participant. New York has begun entering cases as well. As of March 2011, there were a total of 1,282 cases submitted into the database with 953 of these completed.

**Highlights of FY11 Activities**

- Development of a shorter more precise TERCAP tool.
- Report of the analysis of 861 TERCAP cases.
- Update of TERCAP protocol, policies and teaching materials.
- Development of a TERCAP toolkit.
- Plan to roll out the newly revised TERCAP® 2011 tool and a recruitment strategy for more participants.

**Accomplishments:**

1. Review trends and determine implications of TERCAP data.

Data from 861 cases entered into the TERCAP database have been analyzed. See Attachment A for a full report, including the trends and implications of the data.
2. Advise staff on implementation and evaluation of changes to the TERCAP project.

The focus of the TERCAP® Committee has been on data analysis and tool revision. Based on feedback from TERCAP users and input from Benner, the TERCAP tool has been streamlined to make it shorter and easier to enter data. After evaluating the data, the committee noted that there were possible discrepancies in the answers selected by users. This may have been caused by a lack of clarity of certain questions or overlapping categories within the answer choices, among other issues. These concerns have been addressed and modifications were made to the revised tool. The committee removed 16 questions from the main body of the tool; however, they have been placed in an optional section at the end of the tool and BONs wishing to answer them can still do so.

After completion of the tool changes and the analysis of the 861 cases, the committee developed an implementation plan. The first step was to introduce the tool changes to the TERCAP® Users Group (designated individuals from BONs who are participating in the TERCAP project). This was done via a webinar and the purpose was not only to introduce the changes made to the tool, it was also to gather input and allow for some preliminary evaluation of the changes. The TERCAP® Users Group had excellent suggestions and these were incorporated into the final phase of tool modifications. They gave very positive feedback about the 2011 TERCAP tool. TERCAP® 2011 went live on April 1, 2011.

In order to accommodate data entry into the new tool, the committee also worked on modifications to the TERCAP protocol. In addition, all TERCAP policies and procedures were revised to coincide with the newly revised tool. TERCAP training will also be updated to accommodate these changes and new users will be asked to use the tool during investigations and submit all eligible cases into the database.

As part of the implementation plan a TERCAP toolkit has been developed by the committee. This includes a reference file, a PowerPoint presentation for education purposes, a training file with case studies, a flow chart for helping analyze cases, FAQs, and the TERCAP policies, protocol, tool and user sign-up form. The plan is also to have an edited video that can be used for instructional purposes. All of these have been made available online.

The TERCAP tool and the results from the data analysis (with the BOD’s approval) will be presented at the Annual Meeting as part of the implementation plan roll-out. The focus will be on reintroducing TERCAP as a shorter, more concise tool. In addition, by sharing TERCAP data with the members, the committee hopes that more BONs will become interested in participating in the project. As part of the implementation plan, the committee plans on giving a formal presentation, having an exhibit booth with demonstrations of the new tool, presenting participants with TERCAP give-a-ways and having committee members available in area meetings to answer questions.

TERCAP training took place in June for the Washington and Oregon State Boards of Nursing, both of which wish to become TERCAP participants.

Future Activities
1. Devise a method for measuring the efficiency and cost-effectiveness of participating in TERCAP and using the TERCAP tool.
2. Develop more stringent criteria for participation in TERCAP, a recognition ladder to identify levels of commitment and identify barriers to participation.
3. Share data by submitting an article to the Journal of Nursing Administration.

Attachment
A. TERCAP® Report: Analysis of Nurse Practice Breakdown Cases in 20 States
Attachment A

TERCAP® Report: Analysis of Nurse Practice Breakdown Cases in 20 States

April 4, 2011

ABSTRACT

Objective: The ultimate goal of the establishment of the TERCAP® (Taxonomy of Error, Root Cause Analysis and Practice-Responsibility) adverse event reporting database is to identify factors that contribute to practice breakdown.

Methods: A 60-item online instrument was developed and used to investigate the records of registered nurses (RNs), licensed practical nurses/vocational nurses (LPNs/VNs) and advanced practice registered nurses (APRNs) who were reported to the boards of nursing (BONs) for practice breakdown. The cases were submitted by 20 BONs to NCSBN's TERCAP database between February 2008 and December 2010. The submission of the practice breakdown cases to the TERCAP database is voluntary and confidential.

Main Findings: Overall, 72 percent of the cases were unintentional human errors. Among the nurses who were reported to BONs for committing practice breakdown, 60 percent were RNs, 37 percent were LPNs/VNs, one percent were APRNs and three percent held multiple licenses. A significant association between the nurses’ employment history (discipline and termination by employers) and the practice breakdown was found.

The complete employment history on a nurse’s previous discipline and termination by their employers for practice issues was available for 725 (84 percent) of the 861 nurses. Among the 725 nurses, 60 percent (n=437) had been disciplined and/or terminated by their employers previously. Furthermore, our data indicate that 55 percent (n=476) of practice breakdowns occurred when a nurse worked in a patient care position for two years or less, whereas 73 percent (n=348) of these nurses had been licensed for two years or longer. Among the 348 nurses, 36 percent (n=125) had been disciplined by their employers before and 38 percent (n=131) had their employment terminated by their previous employers.

The current data show that a disproportionally higher percentage of male nurses and LPNs/VNs committed a practice breakdown over the percentage in the nursing workforce. Additionally, LPNs/VNs had committed similar types of practice breakdown. The current data set does not reveal significant association between the system factors that we have assessed and any types of practice breakdowns.

Conclusions: A statistically significant link between the employment history and the risk of committing additional practice breakdown is established by the current analysis. This finding indicates that the nurses’ employment history can serve as a useful tool to identify a small group of nurses with a high risk of committing violations. We were not able to identify sufficient association between system factors and the practice breakdown, possibly due to constraints in sample size.

BACKGROUND

Begun in 1999, the TERCAP project grew out of emerging needs to learn more about medical errors and their root causes. The original goal of this project, which continues in 2011, is to learn from the experience of nurses who have had episodes of practice breakdown (defined as the absence of “good practice”) and discover characteristics of nurses at risk. The TERCAP project meets the recommendation made in the Institute of Medicine’s (IOM) report Keeping Patients Safe, Transforming the Work Environment of Nurses (Page, 2003). The TERCAP instrument is designed to collect the practice breakdown data from BONs to identify the root causes of nursing practice breakdown from systems and individual perspectives. This approach will facilitate the development of strategic interventions to minimize the risk factors that may endanger patient safety.
Objectives
The current report addresses the following questions:
1. What is the nature of the practice breakdown committed by nurses?
2. How are personal characteristics associated with practice breakdown?
3. Do system factors contribute to practice breakdown?

METHODS
Survey instrument development
The TERCAP® 2008 online survey instrument was released in February 2008 and consisted of 60 questions including: (1) patient profile; (2) patient outcome; (3) work setting; (4) system issues; (5) health care team; (6) nurse profile; (7) intentional misconduct or criminal behavior; and (8) types of practice breakdown. The TERCAP instrument was developed by various NCSBN committees and external consultants, including Patricia Benner, PhD, RN, FAAN, and Marie Ferrell, PhD, RN, FAAN.

Case selection criteria
Cases that met the following criteria were used for data analysis: (1) a nurse was involved in the practice breakdown; (2) one or more identifiable patients were involved; and (3) the case was not fully dismissed by the BON (i.e., the BON took disciplinary or nondisciplinary action, the nurse enrolled in an alternative program, or the BON issued a letter of concern). These criteria were established for the TERCAP project in 2007.

Confidentiality
A unique number was assigned to each case by the TERCAP users from the BONs using a standardized coding system. The database does not contain any information which may lead to the individual’s identity; therefore, neither individual patient nor the nurse can be identified.

Participating BONs and data collection
The number of BONs submitting cases to the TERCAP database has increased 67 percent, from 12 to 20 since 2008. The 20 BONs who have submitted cases are: (1) Texas Board of Nursing; (2) North Carolina Board of Nursing; (3) Arizona State Board of Nursing; (4) North Dakota Board of Nursing; (5) Idaho Board of Nursing; (6) Minnesota Board of Nursing; (7) Kentucky Board of Nursing; (8) Oklahoma Board of Nursing; (9) Ohio Board of Nursing; (10) Alaska Board of Nursing; (11) Nevada State Board of Nursing; (12) New Hampshire Board of Nursing; (13) New Jersey Board of Nursing; (14) Maine State Board of Nursing; (15) Mississippi Board of Nursing; (16) Virginia Board of Nursing; (17) New Mexico Board of Nursing; (18) West Virginia Board of Examiners for Registered Professional Nurses; (19) Louisiana State Board of Practical Nurse Examiners; and (20) West Virginia State Board of Examiners for Licensed Practical Nurses.

These participating BONs voluntarily submit practice breakdown cases to the TERCAP database. It is not explicitly required that all practice breakdown cases reported to the BONs need to be submitted to the TERCAP database. As of Dec. 1, 2010, the total number of cases submitted to the TERCAP database was 884. There were two BONs (the Arkansas State Board of Nursing and the New York State Board of Nursing) that started to submit practice breakdown cases to NCSBN after Dec. 1, 2010.

The number of cases that have been submitted by each individual board vary from one to 240. The majority of cases (68 percent) came from Texas, North Carolina and Arizona.

RESULTS
The key findings of the analysis are presented in the following sections: (1) overview of practice breakdown cases; (2) characteristics of nurses that committed a practice breakdown; (3) system factors; and (4) factors that may contribute to the practice breakdown.
Overview of practice breakdown cases
Among the 884 cases submitted to the TERCAP database, 23 failed to meet the case selection criteria: 14 of them were dismissed by the BONs and nine cases did not involve patients. Therefore, these cases were excluded from the analysis. The current analysis was based on 861 cases.

Practice breakdown is defined broadly as the disruption or absence of any of the aspects of good practice. The eight categories of nursing practice breakdown are listed in Table 1. Lack of professional responsibility (77 percent of the cases), lack of clinical reasoning (51 percent of the cases) and lack of intervention (50 percent of the cases) are the most frequently selected practice breakdown categories; 89 percent (n=766) of the cases were classified in more than one practice breakdown category (Table 2) indicating the complexity of error commission. For those cases that were classified in more than one practice breakdown category, TERCAP users were asked to pick the category that was primary to the practice breakdown event. Lack of professional responsibility (28 percent, n=212) and lack of clinical reasoning (23 percent, n=177) were listed as the most significant categories.

<table>
<thead>
<tr>
<th>Practice Breakdown Category</th>
<th>Number of Cases in the Practice Breakdown Category/Percent of Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Professional Responsibility</td>
<td>665 (77.24)</td>
</tr>
<tr>
<td>Lack of Clinical Reasoning</td>
<td>441 (51.22)</td>
</tr>
<tr>
<td>Lack of Intervention</td>
<td>434 (50.41)</td>
</tr>
<tr>
<td>Documentation Error</td>
<td>380 (44.13)</td>
</tr>
<tr>
<td>Lack of Interpretation</td>
<td>343 (39.84)</td>
</tr>
<tr>
<td>Medication Error</td>
<td>278 (32.29)</td>
</tr>
<tr>
<td>Lack of Attentiveness</td>
<td>219 (25.44)</td>
</tr>
<tr>
<td>Lack of Prevention</td>
<td>208 (24.16)</td>
</tr>
</tbody>
</table>

* The total number of cases in the practice breakdown categories exceeds 861 since some cases were classified in more than one category.

<table>
<thead>
<tr>
<th>Total Number of Practice Breakdown Categories</th>
<th>Total Number of Cases/Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 category</td>
<td>92 (10.69)</td>
</tr>
<tr>
<td>2 categories</td>
<td>158 (18.35)</td>
</tr>
<tr>
<td>3 categories</td>
<td>205 (23.81)</td>
</tr>
<tr>
<td>4 categories</td>
<td>196 (22.76)</td>
</tr>
<tr>
<td>5 categories</td>
<td>120 (13.94)</td>
</tr>
<tr>
<td>6 categories</td>
<td>56 (6.50)</td>
</tr>
<tr>
<td>7 categories</td>
<td>23 (2.67)</td>
</tr>
<tr>
<td>8 categories</td>
<td>8 (0.93)</td>
</tr>
<tr>
<td>Missing</td>
<td>3 (0.35)</td>
</tr>
<tr>
<td>Total</td>
<td>861 (100)</td>
</tr>
</tbody>
</table>
Following the IOM recommendations, users were also asked to identify those cases that involved intentional misconduct or criminal behavior. In summary, 72 percent of the cases (n=618) involved unintentional human errors, while 27 percent of the cases (n=234) involved intentional misconduct or criminal behavior. This information was reported unknown in nine (one percent) cases. More than half of the practice breakdown cases (52 percent, n=446) did not cause any harm to patients. Of the cases investigated (n=508), 59 percent resulted in disciplinary actions and 23 percent (n=200) of the cases were sanctioned nondisciplinary actions. In 18 percent (n=151) of the cases, the nurses were given the opportunity to participate in an alternative program.

**Characteristics of the nurses that committed a practice breakdown**

The majority of the nurses involved in a practice breakdown are U.S. educated (93 percent, n=804) and English is their primary language (90 percent, n=776).

**Distribution of gender and age**

Of those involved in the practice breakdown 83 percent of the nurses (n=716) were female and 17 percent (n=143) were male. Gender data are missing in two cases. The proportion of male nurses who committed a practice breakdown is about two times higher than the national composition of the nursing workforce, that is, since 2000, 9.6 percent of the nursing population were male in the U.S. (NCSBN, 2010). This finding is consistent with the reports from previous studies indicating that male nurses are more vulnerable to practice breakdown (Green, Crisman, Waddill, & Fitzpatrick, 1995; Zhong, Kenward, Sheets, Doherty, & Gross, 2009; NCSBN, 2009).

The average age of the nurses was 46.2 years (SD=11.6, n=834), ranging from 21 to 77. The demographic characteristics of the nurses involved in practice breakdown are in line with previous NCSBN reports (Zhong at al., 2009; NCSBN, 2009).

**Types of license**

Approximately 60 percent of nurses held RN licenses, while 37 percent held LPN/VN licenses (Table 3), and 1 percent held an APRN license. The NCSBN Licensure Statistics show that in 2009, 22 percent of the nurses practicing in the 20 states held LPN/VN licenses and 73 percent held RN licenses (Kenward, Woo, Gross, & Liu, 2010). Therefore, the proportion of LPNs/VNs who committed practice breakdown is higher than the proportion of LPNs/VNs in the workforce.

<table>
<thead>
<tr>
<th>Type of License</th>
<th>Total Number of Cases/Percent of Total (n=861)*</th>
<th>Total Number of Licensees/Percent of Total (n=1,543,871)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>513 (59.58)</td>
<td>1,134,574 (73.49)</td>
</tr>
<tr>
<td>LPN/VN</td>
<td>319 (37.05)</td>
<td>345,575 (22.38)</td>
</tr>
<tr>
<td>APRN</td>
<td>5 (0.58)</td>
<td>63,722 (4.13)</td>
</tr>
</tbody>
</table>

*24 (three percent) nurses who committed a practice breakdown held multiple licenses (RN, LPN/VN and/or APRN licenses).

**Employment settings**

About 38 percent of the practice breakdowns occurred in hospitals, 32 percent in long-term care facilities/assisted living, 17 percent in outpatient settings and three percent in behavioral health.
Table 4. Employment Setting When Practice Breakdown Occurred

<table>
<thead>
<tr>
<th>Employment Setting</th>
<th>Total Number of Cases/ Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>322 (37.40)</td>
</tr>
<tr>
<td>Long-term Care</td>
<td>250 (29.04)</td>
</tr>
<tr>
<td>Home Care</td>
<td>102 (11.85)</td>
</tr>
<tr>
<td>Physician/Provider Office or Clinic</td>
<td>33 (3.83)</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>27 (3.14)</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>27 (3.14)</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>11 (1.28)</td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td>9 (1.05)</td>
</tr>
<tr>
<td>Office-based Surgery</td>
<td>1 (0.12)</td>
</tr>
<tr>
<td>Other</td>
<td>79 (9.18)</td>
</tr>
<tr>
<td>Total</td>
<td>861 (100)</td>
</tr>
</tbody>
</table>

At the time when the practice breakdown occurred, 56 percent of LPNs/VNs (n=177) and 14 percent of RNs (n=69) worked in long-term care facilities. The high proportion of LPNs/VNs working in long-term care facilities was also reported in the NCSBN remediation study (Zhong et al., 2009).

Length of licensure

At the time when the practice breakdown occurred, these nurses had been licensed for an average length of 14.3 years (SD=11.1, n=708), ranging from the minimum of less than one year to a maximum of 54 years. The length of licensure was reported unknown for 153 nurses (Table 5).

Table 5. Length of Licensure When the Practice Breakdown Occurred

<table>
<thead>
<tr>
<th>Length of Licensure</th>
<th>Total Number of Cases/ Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5 years</td>
<td>171 (19.86)</td>
</tr>
<tr>
<td>5 to 10 years</td>
<td>148 (17.19)</td>
</tr>
<tr>
<td>11 to 20 years</td>
<td>191 (22.18)</td>
</tr>
<tr>
<td>21 to 30 years</td>
<td>126 (14.63)</td>
</tr>
<tr>
<td>More than 30 years</td>
<td>72 (8.36)</td>
</tr>
<tr>
<td>Missing</td>
<td>153 (17.77)</td>
</tr>
<tr>
<td>Total</td>
<td>861 (100)</td>
</tr>
</tbody>
</table>

Employment history

A review of the nurses’ employment history shows that 37 percent (n=319) of nurses were disciplined by their employers for practice issues in the past and 39 percent (n=334) were terminated by their employers (Tables 6 and 7). Among the 334 nurses who were terminated by their previous employers, 49 percent (n=162) were also disciplined by their current or previous employers. The previous discipline history was unknown for 13 (four percent) cases. According to these data, nurses who had a violation history were more likely to recidivate, which is consistent with findings reported in NCSBN’s remediation study (Zhong et al., 2009).
Table 6. Discipline by Employers for All Involved Nurses

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Total Number of Cases/ Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>319 (37.05)</td>
</tr>
<tr>
<td>No</td>
<td>481 (55.87)</td>
</tr>
<tr>
<td>Unknown</td>
<td>61 (7.08)</td>
</tr>
<tr>
<td>Total</td>
<td>861 (100)</td>
</tr>
</tbody>
</table>

Table 7. Termination by Previous Employers

<table>
<thead>
<tr>
<th>Termination</th>
<th>Total Number of Cases/ Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>334 (38.79)</td>
</tr>
<tr>
<td>No</td>
<td>417 (48.43)</td>
</tr>
<tr>
<td>Unknown</td>
<td>110 (12.78)</td>
</tr>
<tr>
<td>Total</td>
<td>861 (100)</td>
</tr>
</tbody>
</table>

A review of the 725 cases with known employment history for discipline and termination information shows that 60 percent of the nurses involved in practice breakdown were either disciplined by their employers for practice related issues in the past and/or terminated by their previous employers (Figure 1).

We also examined the employment outcomes of these nurses after they had been reported to the BONs for the practice breakdown. As a result of the current investigation, 56 percent (n=479) of the nurses were terminated by their employers and seven percent (n=56) resigned in lieu of termination. Only 28 percent of the nurses involved (n=237) were retained by their employers.

System factors

In the current database, TERCAP users were also asked to identify the system factors that may have contributed to the practice breakdown. Health team members was reported as a contributing factor for the practice breakdown by 65 percent of the cases (n=556) (Table 8). Over 51 percent of these (286 of 556) cited a staff nurse as being a contributing cause to the practice breakdown.

Communication was the second most frequently reported contributing factor to the practice breakdown, cited in 42 percent (n=359) of cases. This is in line with a previous study on medication errors (Hughes & Blegen, 2008). Of the 359 cases that reported communication as a contributing factor, 39 percent (n=140) cited interdepartmental breakdown/conflict as being the main cause; 31 percent (n=110) cited lack of ongoing education or inadequate orientation/training; and 25
percent (n=88) attributed a shift change to the practice breakdown.

Less than 30 percent of the practice breakdowns claimed staffing, environment, or backup and support as contributing factors. Further analysis shows that over 53 percent (n=456) of the practice breakdowns were identified as having more than one contributing factor (Table 9).

### Table 8. Contributing Factors to Practice Breakdown

<table>
<thead>
<tr>
<th>Contributing Factor</th>
<th>Total Number of Cases/Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health team members</td>
<td>556 (64.58)</td>
</tr>
<tr>
<td>Communication</td>
<td>359 (41.70)</td>
</tr>
<tr>
<td>Leadership</td>
<td>287 (33.33)</td>
</tr>
<tr>
<td>Staffing</td>
<td>204 (23.69)</td>
</tr>
<tr>
<td>Environment</td>
<td>195 (22.65)</td>
</tr>
<tr>
<td>Backup and support</td>
<td>178 (20.67)</td>
</tr>
</tbody>
</table>

### Table 9. Total Number of Contributing Factors

<table>
<thead>
<tr>
<th>Total Number of Factors Involved</th>
<th>Total Number of Cases/Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 contributing factor</td>
<td>256 (29.73)</td>
</tr>
<tr>
<td>2 contributing factors</td>
<td>162 (18.82)</td>
</tr>
<tr>
<td>3 contributing factors</td>
<td>108 (12.54)</td>
</tr>
<tr>
<td>4 contributing factors</td>
<td>88 (10.22)</td>
</tr>
<tr>
<td>5 contributing factors</td>
<td>65 (7.55)</td>
</tr>
<tr>
<td>6 contributing factors</td>
<td>33 (3.83)</td>
</tr>
<tr>
<td>Missing</td>
<td>149 (17.31)</td>
</tr>
<tr>
<td>Total</td>
<td>861 (100)</td>
</tr>
</tbody>
</table>

### Factors that may be associated with practice breakdown

**Previous employment history**

It was reported that more than half (55 percent, n=476) of the practice breakdowns occurred when a nurse had worked in a patient care location for two years or less. This information was unknown in 10 percent (n=89) of the cases. Interestingly, a further review shows that even though the 476 nurses committed a practice breakdown in the location they had worked for two years or less, 73 percent (n=348) of them had been licensed for two years or longer. This information was not available in 17 percent (n=82) of the cases (Figure 2).
On the other hand, among the 348 nurses who had been licensed for two years or longer, 36 percent of them were disciplined by their current or previous employers for practice related issues and 38 percent of them were terminated by their previous employers (Table 10). This trend is in line with the previous findings from the nurses who committed practice breakdown in general (Tables 6 and 7).

### Table 10. Employment History of Nurses Who Committed Practice Breakdown When Working in a Location for Two Years or Less But Had Been Licensed for Two Years or Longer

<table>
<thead>
<tr>
<th>Employment History (n=348)</th>
<th>Yes # of Cases/Percentage</th>
<th>No # of Cases/Percentage</th>
<th>Unknown # of Cases/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discipline</td>
<td>125 (35.9)</td>
<td>200 (57.5)</td>
<td>23 (6.6)</td>
</tr>
<tr>
<td>Termination</td>
<td>131 (37.6)</td>
<td>174 (50.0)</td>
<td>43 (12.4)</td>
</tr>
</tbody>
</table>

System factors contributing to practice breakdown

We were not able to identify significant associations between any contributing factors and certain types of practice breakdowns. Health team members is the most dominant contributing factor involved in all types of practice breakdown categories (Table 11). A further review of the subcategories of the health team members shows that staff nurse, supervisory nurse/personnel, and unlicensed assistive personnel were claimed as having been involved in all types of practice breakdown categories.

### Table 11. Involvement of Different Factors in Practice Breakdown Categories

<table>
<thead>
<tr>
<th>Factor</th>
<th>Communication</th>
<th>Leadership</th>
<th>Environment</th>
<th>Backup and Support</th>
<th>Health Team Members</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Professional Responsibility (n=665)</td>
<td>42.0%</td>
<td>34.0%</td>
<td>22.1%</td>
<td>21.2%</td>
<td>68.1%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Lack of Clinical Reasoning (n=441)</td>
<td>48.5%</td>
<td>42.2%</td>
<td>24.9%</td>
<td>26.3%</td>
<td>73.7%</td>
<td>28.8%</td>
</tr>
<tr>
<td>Lack of Intervention (n=434)</td>
<td>46.8%</td>
<td>38.0%</td>
<td>26.5%</td>
<td>24.2%</td>
<td>73.0%</td>
<td>29.5%</td>
</tr>
<tr>
<td>Documentation Error (n=380)</td>
<td>40.8%</td>
<td>34.2%</td>
<td>24.7%</td>
<td>19.2%</td>
<td>61.8%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Lack of Interpretation (n=343)</td>
<td>46.6%</td>
<td>37.9%</td>
<td>26.2%</td>
<td>27.4%</td>
<td>63.3%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Medication Error (n=278)</td>
<td>45.6%</td>
<td>36.0%</td>
<td>25.9%</td>
<td>24.8%</td>
<td>61.5%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Lack of Attentiveness (n=219)</td>
<td>43.8%</td>
<td>36.1%</td>
<td>25.1%</td>
<td>23.3%</td>
<td>70.3%</td>
<td>25.6%</td>
</tr>
<tr>
<td>Lack of Prevention (n=208)</td>
<td>0.0%</td>
<td>40.0%</td>
<td>26.4%</td>
<td>27.4%</td>
<td>67.8%</td>
<td>25.5%</td>
</tr>
</tbody>
</table>

Other miscellaneous factors

Gender

Even though about 17 percent of nurses involved in a practice breakdown were male, which is two times higher than the proportion of male nurses in the national nursing workforce, the current data did not reveal any significant particular patterns of violations committed by male nurses in the practice (data not shown due to the constraints in the case number). For example, 85 percent (121 of 143) of male nurses versus 76 percent (544 of 716) of female nurses committed a lack of professional responsibility practice breakdown; 51 percent of male (73 of 143) and female (368 of 716) nurses committed violations of a lack of clinical reasoning, respectively, while 27 percent of male (39 of 143) and female nurses (195 of 716) were involved in intentional misconduct.
respectively. Furthermore, there is no difference in the consequences of practice breakdown caused by male and female nurses; 55 percent (79 of 143) of male nurses versus 51 percent (366 of 716) of female nurses did not cause any harm to patients. A previous study shows that male nurses are more likely to work in critical and acute care settings and the intense nature of this work may put them at higher risk for committing violations (Carruth & Booth, 1999).

Type of licensure

Even though the data show that there were a higher percentage of LPNs/VNs (37 percent) reported to BONs for committing a practice breakdown than the proportion of nurses who held LPN/VN licenses (22 percent) in the work force in the 20 states that submitted data, a further review shows that the types of practice breakdowns committed by LPNs/VNs are similar to those committed by RNs. Approximately 79 percent (251 of 319) of LPN/VNs committed errors related to a lack of professional responsibility, whereas 76 percent (390 of 513) of RNs committed the same type of error, and 52 percent (167 of 319) of LPNs/VNs and 50 percent (254 of 513) of RNs committed errors related to a lack of clinical reasoning. A previous NCSBN study shows that the higher discipline rate of LPNs/VNs was associated with the fact that the majority of LPNs/VNs worked in long-term care facilities where the reporting of violations of state or federal regulations is strictly required (NCSBN, 2009).

Shifts and employment status

A review of the current data shows that there is no sufficient association between the types of breakdowns and the types of shifts the nurses worked (eight-hour versus 12-hour). A lack of professional responsibility is the most frequently reported error that occurred on both the eight-hour shifts (79 percent, 281 of 356) and 12-hour shifts (77 percent, 234 of 303). Additionally, no difference could be identified regarding what happened to the patients on the different shifts. For the nurses on eight-hour shifts, 12 percent (43 of 356) provided wrong treatment to patients, while this rate was 11 percent (32 of 303) during the 12-hour shifts.

We also examined if there were any differences in the types of errors committed by temporary and permanent nurses. The data show no significant difference regarding the types of practice breakdowns committed by the temporary and the permanent nurses: 70 percent (77 of 110) of the temporary nurses versus 78 percent (581 of 742) of permanent nurses committed errors relating to a lack of professional responsibility. There is no sufficient data to elucidate the consequences of the practice breakdowns committed by temporary and permanent nurses.

Limitations

This analysis was based on the available data from 20 BONs who voluntarily submitted their data to the TERCAP database. The case number is not sufficient for detailed analysis of each subcategory. Additionally, missing data and incomplete records in the current database may have a negative impact on the significance of the findings. By design, the TERCAP adverse event reporting database only focused on the factors associated with practice breakdown. No direct comparison of the characteristics between the nurses who committed practice breakdown and the nurses who met the safe practice standard can be carried out. In some circumstances, lack of control group data restrained our ability to draw definitive conclusions.

DISCUSSION

This report indicates that previous employment history is associated with a nurse’s future practice, i.e., nurses who had been disciplined or even terminated by their employers for practice issues tended to commit additional violation(s); 60 percent of the nurses who were reported as having committed a practice breakdown in the current database were either disciplined and/or terminated by their current or previous employers for practice related issues. This report also indicates that the causality of practice breakdown is a complicated issue; 89 percent of the cases involved had more than one type of practice breakdown category and over 53 percent of the cases were identified as having more than one contributing factor.
Currently, there are no published studies that specifically address the relationship between the risk of committing practice breakdown and having discipline or termination history by nursing employers. The current data show that employment history could be useful for BONs and nursing employers to identify nurses who are at a higher risk of committing violations and provide proactive intervention to prevent or reduce additional harm to the public.

The data show that more than half of the practice breakdowns occurred by those nurses who worked at a location two years or less and that 73 percent had been licensed for two years or longer. Among those who had been licensed for two years or longer, 36 percent were known to have been disciplined by their current or previous employers for practice issues before and 38 percent were terminated by their previous employers.

Current data show that after being reported to the BONs for committing a practice breakdown, about 56 percent of the nurses were terminated by their employers. This data suggest a potentially high risk of these nurses engaging in practice breakdown that is reportable to the BON. The public, including employers, should be aware of any practice breakdown that results in a board action. For instance, in the state of Texas, all nursing employers are mandated to report any nurse who was terminated for nursing practice issues and the BON evaluates these nurses to determine if a violation of the BON’s rules occurred. In this way, if a nurse is fired from one job and seeks another, the new employers would be aware of the violation and could provide proper support and supervision for the nurse.

Current data do not reveal any meaningful associations between system factors and types of practice breakdown. It is possible that health care facilities have already corrected system errors that obviously caused practice breakdown due to the feedback report they received from the BONs or other healthcare regulators. The multi-faceted nature of contributing factors and involvement of multiple practice breakdown categories could have made it more difficult to capture the system factors for practice breakdown from the current limited data set. Those cases that involved purely system issues could be dismissed by the BONs, and therefore, were not reported/analyzed. It is possible that the individual factors rather than the system factors predominantly contributed to the practice breakdown, as suggested by a previous study on medication errors (Hughes & Blegen, 2008).

Current data show that the majority (72 percent) of the cases investigated involved unintentional human errors and LPNs/VNs committed similar practice breakdown. Additionally, male nurses and LPNs/VNs were over-represented in the groups of nurses who committed a practice breakdown. Whether these resulted from work setting and the reporting requirements as suggested by previous NCSBN studies remains elusive because they are out of the current scope of the TERCAP database (Zhong et al., 2009; NCSBN, 2009).

We are currently in the early stages of an exploratory analysis and a more detailed and comprehensive analysis can be expected with an increase in the case numbers.

REFERENCES


