SECTION II: COMMITTEE REPORTS

Reports with Recommendations

Innovations in Education Regulation Committee .................................................. 53
   Attachment A: Full Report of Innovations in Education Regulation Committee ........................................ 55
   Attachment B: Recommendations for Boards of Nursing for Fostering Innovations in Education ............. 61
   Attachment C: Tips for Planning Nursing Education Innovative Approaches .................................... 65
   Attachment D: Model Rules for Innovative Approaches in Nursing Education Programs ..................... 67

Report of the NCLEX® Examination Committee .................................................. 71
   Attachment A: Proposed 2010 NCLEX-RN® Test Plan-Strikethrough Copy ........................................... 80
   Attachment B: Proposed 2010 NCLEX-RN® Test Plan-Clean Copy ....................................................... 88
   Attachment C: Timeline for Implementation of the 2010 NCLEX-RN® Test Plan ................................... 96
   Attachment D: Annual Report of Pearson VUE for the NCLEX® ......................................................... 97

Informational Reports

Report of the APRN Committee ................................................................. 111
   Attachment A: Legislative Fact Sheet ....................................................................................................... 113

Report of the Awards Committee ................................................................. 115
   Attachment A: Past NCSBN Award Recipients ....................................................................................... 117
   Attachment B: Awards Brochure/Awards Criteria .................................................................................. 119

Report of the Chemical Dependency Committee ........................................ 129

Report of the Continued Competence Committee ......................................... 131
   Attachment A: NCSBN Guiding Principles and Regulatory Model for Continued Competence ........... 133
   Attachment B: Advantages and Challenges of the Regulatory Model ................................................. 138

Report of the Commitment to Ongoing Regulatory Excellence (CORE) Committee ................................ 139
Report of the Disciplinary Resources Committee.................................................................141
Attachment A: Advantages and Disadvantages of Alternative Early Intervention Programs for Substandard Practice,....................................................144
Report of the Finance Committee.........................................................................................151
Attachment B: Report of the Independent Auditors FY08....................................................155
Report of the Institute of Regulatory Excellence Committee................................................165
Report of the National Nurse Aide Assessment Program (NNAAP™) and the Medication Aide Certification Examination (MACE™).........................................................169
Attachment A: 2010 NNAAP™ Written (Oral) Examination Content Outline......................173
Report of the TERCAP® Committee....................................................................................175
Attachment A: TERCAP® Overview..................................................................................177
Attachment B: TERCAP® Research Criteria......................................................................179
Report of Transition to Practice Committee....................................................................181
Attachment A: Model Act and Rules for Transition to Practice.............................................184
Attachment B: Transition to Practice: Promoting Public Safety..........................................186
Attachment C: Description of Transition to Practice Model................................................188
Attachment D: NCSBN's Transition to Practice Model: Frequently Asked Questions........190
Attachment E: Transition to Practice Committee Dashboard..............................................192
Attachment F: Goals of NCSBN's Transition to Practice Model...........................................194
Attachment G: Transition to Practice Verification Form....................................................195
Attachment H: Transition to Practice Article....................................................................196
Attachment I: Transition Evidence Grid............................................................................197
Innovations in Education Regulation Committee

Recommendation to the Delegate Assembly

1. **Adopt the proposed revisions to the Education Model Rules.**

   **Rationale:**
   One of the charges to the Innovations in Education Regulation Committee was to develop a regulatory model for innovative education proposals. In meeting this charge, the committee reviewed the literature and received feedback from Member Boards and educators. Because of today's complexities in health care delivery, nursing and health care leaders agree that there is a need to transform how we educate nurses. In their mission of public protection, boards of nursing (BONs) approve nursing programs across the U.S. and its territories. The committee concluded that this is the ideal time for the NCSBN Model Education Rules to be revised to include language that would foster innovative approaches to nursing education when the proposed strategy departs from the current rule structure. BONs are in an excellent position to create a favorable climate for innovative educational approaches and champion new strategies to educate nurses while remaining diligent in regulating core education standards.

**Background**

Because of the complexities in nursing and health care delivery, and a national focus on patient safety, there has been a call across nursing and health care organizations for more innovation in nursing and health care education. Therefore, on March 25, 2008, NCSBN hosted an invitational roundtable where leaders in nursing gathered to discuss the implications of implementing innovations in nursing education. The next day, March 26, 2008, NCSBN hosted a national conference where the regulatory implications of nursing education innovations were presented. To continue with this endeavor to foster nursing education innovation, the Board of Directors (BOD) established the Innovations in Education Regulation Committee. A more comprehensive report can be found in Attachment A.

The BOD charged the committee with:

1. Identify real and perceived regulatory barriers to innovations in education.

   As a foundation for this work, members of the committee reviewed the literature and developed definitions and premises. They also hosted a collaborative call with the following organizations to gain their input about perceived regulatory barriers:

   - American Association of Colleges of Nursing (AACN);
   - Commission on Collegiate Nursing Education (CCNE);
   - National Association for Practical Nurse Education and Service (NAPNES);
   - National League for Nursing (NLN); and
   - National League for Nursing Accrediting Commission (NLNAC). (They were not able to attend.)

   The members of the committee then developed a conceptual model to visualize the regulatory influences (processes, rules/law and communication) on nursing education innovations (Attachment A). They also developed flyers for the BONs (Attachments B and C). Attachment B describes the real and perceived regulatory barriers and makes some recommendations to BONs for creating a favorable environment for innovative education approaches. Another flyer (Attachment C) was designed for BONs to distribute to educators who are contemplating an innovative approach in nursing education. This handout will provide an opportunity for faculty and BONs to dialogue about innovations in nursing education.
2. Develop a regulatory model for innovative education proposals.

The members of the Innovations in Education Regulation Committee decided that developing model rules (see Attachment D) would be an excellent way to foster innovation in education. These would provide BONs with regulatory language to allow for innovative approaches to nursing education that are outside the current rule structure. This language would be particularly effective for those BONs that don’t have a lot of flexibility in their practice act or rules. As with any model rules, BONs can adapt the language for their particular jurisdictions.

**Highlights of FY09 Activities**

Besides reviewing the literature and holding conference calls with nursing education organizations, committee members dialogued with the membership at NCSBN’s Midyear Meeting and through e-mail, conducted a survey on regulatory simulation limitations, and reviewed the Member Board Profiles. With that background, the committee developed a conceptual model for describing the influences of regulatory parameters on innovation. It is, however, clear that other hindrances exist as well. Educational institutions, practice administrators and the students themselves can all set up barriers for implementing innovative educational approaches.

The committee also developed model rule language for BONs to adopt that will allow educators to develop innovations outside the current rule structure. If a jurisdiction adopts the model rules on innovations, evaluation data on the innovative approaches will be reported to the BON and these data will provide the nursing community with evidence for nursing education innovations.

Specific highlights from this year’s committee include:

- Sought input from our membership on the model rules that foster innovative approaches to nursing education and on perceived or real regulatory barriers.
- Hosted a collaborative conference call with five nursing education organizations to gain insight on their perceptions of regulatory barriers.
- Developed model rules that foster innovations in nursing education.
- Developed a conceptual model that describes the three major regulatory influences on innovative approaches in nursing education: laws/rules, processes and communication.
- Conducted an online survey on the use of simulation in BONs.
- Designed a flyer for BONs that makes recommendations for creating a favorable environment for innovative education approaches.
- Designed a flyer for BONs to distribute to nursing education programs that provides some tips on what to think about before developing an innovative approach.

**Future Activities**

- NCSBN will create a Web site to serve as a clearinghouse for those innovative education approaches that BONs approve.
- If the model rules are adopted at the 2009 Delegate Assembly, NCSBN will disseminate that information in NCSBN’s new journal, Leader to Leader and Council Connector, for the purpose of encouraging innovative approaches.
- NCSBN will establish a plan to evaluate whether BONs have adopted the innovation model rules and if they have been effective in fostering innovations in nursing education.

**Attachments**

A. Full Report of Innovations in Education Regulation Committee
B. Recommendations for Boards of Nursing for Fostering Innovations in Education
C. Tips for Planning Nursing Education Innovative Approaches
D. Model Rules for Innovative Approaches in Nursing Education Programs
Attachment A

Full Report of Innovations in Education Regulation Committee

April 6, 2009

To supplement the work done by the Innovations in Education Regulation Committee, a history of the committee, the definitions and premises for their recommendations, a synopsis of the literature, a full report from the collaborative call held with education leaders, and a discussion of the influences that affect regulation, particularly regulatory influences, are presented below.

Background

Because of the complexities in nursing and health care delivery, and a national focus on patient safety, there has been a call across nursing organizations and health care organizations for more innovation in nursing and health care education (Greiner and Knebel, 2003; IHI, 2003; NLN, 2003; NCSBN, 2005; AACN, 2008). Therefore, NCSBN held an invitational roundtable on March 25, 2008, where leaders in education, practice and regulation gathered to discuss how nursing can collaborate to innovatively enhance nursing education for the next generation of nurses. This meeting was facilitated by NCSBN staff and included representatives from seven organizations related to nursing education, three boards of nursing (BONs), the American Nurses Association, and the Robert Wood Johnson Foundation. The group discussed the meaning and implications of innovation in nursing education. Perceived barriers to educational innovations were discussed; not only those related to regulation, but also the barriers set up by education systems, practice environments and the students themselves. A vision for the future was presented, which focused on improved communication and forming partnerships between education, regulation and practice.

The following day, March 26, 2008, NCSBN’s Faculty Qualifications Committee hosted a conference on the faculty shortage that attracted educators, practitioners and regulators from around the country, as well as internationally. At this meeting, some exemplar innovations were presented and nurse regulators discussed how these could be implemented in their jurisdictions.

In May 2008 the NCSBN Board of Directors established a new committee for 2008-2009 to continue with this endeavor of fostering innovation in education, the Innovations in Education Regulation Committee, which was charged with:

- Identifying real and perceived regulatory barriers to education innovations; and
- Developing a regulatory model for innovative education proposals.

Definitions and Premises

Committee members began by developing the following definitions and premises as a foundation to their work. When devising the definition for innovation, the group recognized that the etymology of the word derives from the Latin word “innovare,” which means “to renew or change” (Online Etymology Dictionary, 2001). Therefore, while an innovation is something very new and different, it doesn’t necessarily mean that an innovation is better. Oftentimes, that nuance is not understood.

- Definitions
  - Innovation - a dynamic, systematic process that envisions new approaches to nursing education.
  - Regulatory barrier - real or perceived regulatory parameters that hinder innovation in nursing education.

- Premises
  - The mission of BONs is public protection.
Factors other than BON regulations may constrain innovation and therefore limit the scope of this report.

As knowledge and complexity in health care increase exponentially, newer models of nursing education are necessary.

Collaboration and partnerships often are required for innovation in nursing education.

Innovation can occur at all levels of nursing education.

Nursing regulation recognizes the value of evidence based innovation in meeting nursing education program outcomes.

Quality can be maintained amidst innovative changes.

The ultimate responsibility and accountability of any innovation rests with the nursing program.

Advances in technology may influence innovation in nursing education.

Nursing is a practice discipline requiring supervised clinical instruction.

Regulation criteria for nursing programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection.

Selected Literature Review
The members of the committee reviewed the literature, with an emphasis on reports related to regulatory issues and concerns. Please see Appendix C for a list of suggested references.

The literature clearly calls for more innovation in nursing education (Bellack, 2008; Benner, Sutphen, Leonard-Kahn & Day, 2008; Coonan, 2008; Dreher, 2008; Gabrud-Howe and Schoessler, 2008; Tanner, 2008; Unterscheutz, Hughes, Nienhauser, Weberg and Jackson, 2008), even though Ironside and Valiga (2007) found that 77 percent of their survey respondents reported that faculty in their program have made a commitment to implementing innovative, evidence based approaches to teaching and learning. Further, Clarke and Cheung (2008), in reporting workforce statistics in nursing, predict that faculty shortages will stay high and that there will be “heavy pressure” (p. 24) for innovations in nursing education to increase the numbers of new graduates. For nursing to advance through the 21st century, education, practice and regulation will all need to work together to foster innovative approaches in the education of nurses.

There are myriad examples of innovations reported in the nursing literature. The Journal of Nursing Education has a section in each issue reporting on innovations. Some examples of innovative approaches to nursing education include a recent report using the Schumacher Model to recruit and groom new faculty (Schumacher, Risco & Conway, 2008). Given the current faculty shortage, this model shows promise. Moscato, Miller, Logsdon, Weinberg and Chorpenning (2007) report on the University of Portland’s very positive experience with the innovative dedicated education unit approach to clinical education. Brown, Kirkpatrick, Mangum and Avery (2008) report on their work with transforming traditional nursing education by implementing the emerging narrative pedagogy approach. With this approach, the student becomes a more self-directed, participative learner and the faculty role shifts from being teacher-dominated to being more learner-centered. Goodin and Stein (2008) discuss the implication of the deliberate discussion teaching strategy in nursing. This method has been used in other disciplines for more than 25 years and offers some real benefits to nursing. These innovations are just a few examples of what is available in the literature.

Yet sometimes there are barriers that prevent these innovations from being implemented. Higher education itself, with its time-consuming curriculum committees and administrative hierarchies, can get in the way of innovators (Bellack, 2008; Coonan, 2008). Coonan (2008) says two barriers cited by educators are not having enough time and not having enough money. However, he disputes these reasons as being shortsighted. Coonan particularly suggests that when educators partner with practice, there are potential benefits.
Similarly, practice can be a barrier to innovation, partly because the power is so centralized, and there is often linear thinking and vertical hierarchies in health care organizations (Unterschuetz et al., 2008). Coonan (2008) asserts that state and federal policy makers have failed to support innovation in nursing education as a priority, thereby setting up barriers. Regulation, including national nursing accreditors and BONs, have also been cited as barriers to innovation (Bellack, 2008; Coonan, 2008; Dreher, 2008). Dreher (2008) states that the regulatory entities are not in the position to drive innovation as they must ensure adherence to standards. While the Innovations in Education Regulation Committee agrees with this, they also think that regulators can champion innovative approaches in education and can act as a conduit for them.

Hargreaves (2008) presents an interesting perspective in innovation for regulators. She discusses the importance of balancing the risk with the expected outcome. She also presents an excellent decision tree for thinking through the consequences of the innovation, as well as looking at whether the innovation will make a difference. Please see Attachment C for more detail on Hargreaves’ decision tree.

There is also literature about implementing innovations. Murray (2007) presents an excellent review of how to make choices in adopting trends in nursing education using the diffusion theory of innovation (Rogers, 2003). She also discusses the adopter categories from the diffusion theory, which includes innovators, early adopters, early majority, late majority and laggards. The tipping point occurs, she says, when the early majority adopts the innovation. Van Achterberg, Schoonhoven & Grol (2008) provide some evidence based guidelines for implementing innovations, though they acknowledge that further research is needed in implementation science, particularly in nursing.

Tanner (2008) suggests that our next generation of innovations in nursing education will be pedagogies of integration where students will learn through experience and evidence based practice. Similarly, Benner et al. (2008), in their Carnegie study of nursing education, propose that educators should shift from using curricular threads and competencies to the integration of cognitive knowledge, practice know-how and ethical formation. Benner et al., found in their study that clinical and classroom study in nursing education was often separate and distinct, and they’d like to see clinical and classroom teaching integrated into a “seamless whole” (p. 475). It is likely the Carnegie study, when published, will stimulate innovative pedagogies integrating clinical and didactic approaches to nursing education.

Collaborative Conference Call with Educators
At their January meeting, Innovations in Education Regulation Committee members held a collaborative call with nursing education organizations to learn their perspectives about some of the regulatory barriers that BONs have in place that hinder innovation in nursing education. Committee members had sent representatives from the organizations their definitions, premises and some objectives for the meeting. The following were the themes from that call:

- There are issues about specialization of faculty. In some states, programs are required to have content specialists.
- Educators are wondering about how much simulation can be used to replace clinical experiences.
- There are concerns about full-time/part-time percentages of faculty.
- There was a concern that BONs are monitoring distance learning programs more than other programs, though the guests did understand that all programs are regulated equally.
- The faculty shortage is a problem for BON rules on faculty qualifications. Similarly, the use of preceptors is sometimes limited by BONs, causing barriers.

1American Association of Colleges of Nursing (AACN); Commission on Collegiate Nursing Education (CCNE); National Association for Practical Nurse Education and Service (NAPNES); and National League for Nursing (NLN). The National League for Nursing Accrediting Commission (NLNAC) was invited, but no one from that organization was able to participate at that time.
The education organizations would like to see more piloting of innovations and might encourage more partnering with BONs.

NCLEX® first-time pass rates are barriers, as discussed by NLN.

The dedicated education unit (DEU) is an excellent way to work with the faculty shortage, though some BONs might have difficulty incorporating them in their rules.

Educators need access to the data. For example, it is believed that some states don’t inform programs about which students have failed the NCLEX.

There was discussion about disseminating the committee’s findings, including bundling with brochures; Webinars; YouTube videoclips; Leader to Leader, and appearances at each others’ conferences and conference calls. Getting the word out about the model rules fostering innovations would be particularly important.

One participant said that the BON is often feared by educators. The group talked about developing relationships between the BON and educators in each jurisdiction. Suggestions included the BON sending a representative to the deans’ and directors’ meetings.

The group suggested that BONs need to communicate which innovations are working and which ones are not. State Web sites could report this, as is done in Texas.

Outcomes are very important in measuring the strength of a program and they should include more than just the NCLEX pass rates.

One of the committee members reminded the group about the NCLEX program reports and how valuable they can be for the programs.

The group expressed willingness to review model rules that the committee is developing. Generally, participants on the collaborative call were very grateful that NCSBN had asked for their input and were eager to continue the dialogue about how to foster innovation in nursing education.

**Fostering Innovation**

After reviewing the literature and listening to input from educators and BONs, the Innovations in Education Regulation Committee decided that developing model rules (see Attachment D) would be an excellent way to foster innovation in education. These would provide BONs with regulatory language to allow for innovative approaches to nursing education that are outside the current rule structure. This language would be particularly effective for those BONs that don’t have a lot of flexibility in their practice act or rules. As with any model rules, BONs can adapt the language for their particular jurisdictions.

Related to regulatory influences that prevent innovation, the committee devised the following model to describe these influences:
The laws/rules, processes in the BONs and communication with educators are all regulatory processes that can hinder innovation. When the three regulatory influences overlap, the barrier might be even harder to overcome. Please see Attachment B for an identification of possible regulatory barriers and for recommendations to BONs for promoting a favorable climate for innovation. Attachment C will be available to BONs to provide to educators who are interested in implementing innovations. This document gives the educators tips to consider when planning an innovation and also contains a suggested reading list.

**Works Cited**


index.php?search=innovate&searchmode=none


and excellence in nursing and for recruiting and grooming new faculty. J Nurs Educ, 
7(12), 571-75.

integration. J Nurs Educ, 47(8), 335-36.

innovation and caring for the innovator. Nurs Adm Q, 32(2), 133-41.

evidence based nursing requires evidence based implementation. J Nurs Scholarsh, 
40(4), 302-10.
Innovations in Education Regulation Committee

Recommendations for Boards of Nursing for Fostering Innovations in Education

Because of today’s complexities in health care delivery, there is a need to transform how we educate nurses (AACN, 2008; Greiner & Knebel, 2003; NLN, 2003). Some of these complexities include increasing technologies, the need for systems thinking, a more diverse population that is living longer with multiple chronic illnesses, and a national focus on patient safety and preventing errors. Therefore, the NCSBN Board of Directors asked the Innovations in Education Regulation Committee to identify ways for Boards to foster innovation in nursing education. In their mission of public protection, Boards of Nursing approve nursing programs across the U.S. and its territories and are in an excellent position to act as a conduit for innovative educational approaches. However, as Boards of Nursing champion innovative approaches in nursing education, they must also assure that the approaches conform to the core education criteria as established by the individual Boards. A full report of this committee work can be found on the NCSBN Web site.

Through their research of reviewing the literature, dialoging with the NCSBN membership at NCSBN’s Midyear meeting and through e-mail, conducting a survey, and holding a conference call with the educational organizations, NCSBN’s Innovations in Education Regulation Committee members developed the following conceptual model for describing the influences of regulatory parameters on innovation. It is, however, clear that other hindrances exist as well. The educational institutions can set up barriers for innovations, for example with institutional hierarchies or lengthy committee processes to approve curricular changes (Bellack, 2008; Coonan, 2008). Practice similarly can set up barriers with its centralized power bases and linear thinking (Unterschuetz et al. 2008). Students even may set up barriers because they desire the comfort of traditional teaching methodologies.

The model below describes three major regulatory influences on innovative approaches in nursing education: laws/rules, communication, and process. The barriers may be real, though many perceived regulatory barriers also exist. That is, while educators think the rules are too prescriptive to allow their innovative strategy, oftentimes they are not. A barrier to innovation could exist independently in any of these areas but may be more likely where there is an overlap of the regulatory influences.

---

1 Innovation is defined by the Innovations in Education Regulation Committee as a dynamic, systematic process that envisions new approaches to nursing education.
2 On March 27, 2009, a Web survey request was sent to all Education Consultants on their rules and regulations with simulation.
3 This conference call was held on January 29, 2009, and participants were from the following organizations: American Association of Colleges of Nursing, Commission on Collegiate Nursing Education, National Association for Practical Nurse Education and Service, and National League for Nursing. The National League for Nursing Accrediting Commission was invited but no one from that organization was able to participate at that time.
4 The Innovations in Education Regulation Committee defines a regulatory barrier as a real or perceived regulatory parameter that hinders innovation in nursing education.
Communication
Much of the feedback obtained from educators and regulators indicated that lack of communication between the two groups affects the implementation of innovative approaches in nursing education. For example, the NCSBN Member Boards reported that most innovations can be implemented through the current laws/rules and Board processes, but that the educators, often mistakenly, perceive the rules to be too prescriptive. Before embarking on an innovative approach, educators should first review the Practice Act and administrative rules, which are available online in most jurisdictions. If the proposed innovation is outside the rules and regulations, the faculty should then contact the Board of Nursing and consult with the education consultant about the possibility of carrying out the innovation. Of the states with rules that specifically address education innovations, most of the innovative approaches were allowed under the current rules and didn’t need a specific application or rule exemption.

Some educators report that they are fearful to go before their Boards to request permission for an innovative approach because their program will be watched more carefully. They would rather stay as “part of the crowd.” This again demonstrates the need for communication between educators and the Boards of Nursing. By working together, education and regulation can facilitate the transformation of nursing education that must take place in nursing.

Process
The Boards of Nursing and educators both cited the regulatory process as sometimes limiting how quickly innovation can take place in nursing education. For example, some Boards report that it can take up to two years just to change rules, though in most Boards this process takes up to a year. Faculty members report that Board timelines create a lengthy and difficult process when they attempt to make curricular changes.

Laws/Rules
The education practice acts and rules vary somewhat across jurisdictions, though there are some core standards such as the requirement in prelicensure programs for supervised clinical experiences with actual patients (NCSBN, 2005). NCSBN also has published a model education practice act and rules for the Boards of Nursing to use as guidelines (NCSBN, 2008), and many Boards have adopted those guidelines.

Table 1 contains a list of the regulatory barriers perceived by the educators, along with the realities (NCSBN, 2007). For example, while faculty members often identify simulation limitations as a barrier for implementing innovations, a 2009 survey of the Member Boards (48/59 prelicensure Boards of Nursing have responded) found that only five Boards limit simulation to non-clinical courses. Most Boards of Nursing are waiting for more research in order to determine how simulation might be used to complement clinical experiences. Similarly, oftentimes faculty members report that Boards of Nursing have stricter regulations for online programs than for traditional programs, but the Boards have the same laws and rules for traditional and online programs.
### Table 1. Myths and Realities about Perceived Regulatory Barriers Related to Rules

<table>
<thead>
<tr>
<th>Perceived Regulatory Barriers</th>
<th>Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific number of clinical hours are mandated</td>
<td>Required in:</td>
</tr>
<tr>
<td></td>
<td>PN programs (certificate/diploma) – 17 Boards</td>
</tr>
<tr>
<td></td>
<td>PN programs (associate degree) – 8 Boards</td>
</tr>
<tr>
<td></td>
<td>RN diploma – 3 Boards</td>
</tr>
<tr>
<td></td>
<td>RN ADN – 8 Boards</td>
</tr>
<tr>
<td></td>
<td>RN BSN – 7 Boards</td>
</tr>
<tr>
<td>Specific number of didactic hours are mandated</td>
<td>Required in:</td>
</tr>
<tr>
<td></td>
<td>PN programs (certificate/diploma) – 19 Boards</td>
</tr>
<tr>
<td></td>
<td>PN programs (Associate degree) – 9 Boards</td>
</tr>
<tr>
<td></td>
<td>RN diploma – 6 Boards</td>
</tr>
<tr>
<td></td>
<td>RN ADN – 8 Boards</td>
</tr>
<tr>
<td></td>
<td>RN BSN – 7 Boards</td>
</tr>
<tr>
<td>Distance learning nursing programs are approved differently from traditional programs</td>
<td>All Boards approve distance/online programs using the same approval criteria as with traditional programs.</td>
</tr>
<tr>
<td>Faculty-student ratios</td>
<td>Required in 46 Boards</td>
</tr>
<tr>
<td></td>
<td>(ranging from 1:4 to 1:15)</td>
</tr>
<tr>
<td>Full and part-time ratios of faculty</td>
<td>Required in 9 Boards</td>
</tr>
<tr>
<td></td>
<td>(ranging from 1:2 to 1:10)</td>
</tr>
<tr>
<td>Simulation limitations</td>
<td>• 5 Boards limit simulation to non-clinical courses.</td>
</tr>
<tr>
<td></td>
<td>• Most Boards don’t have simulation specified in their rules and/or are awaiting further research on the use of simulation.</td>
</tr>
</tbody>
</table>

5 Based on 59 prelicensure Boards of Nursing, which include the Boards of Nursing in the 50 states, the District of Columbia, four LPN/VN Boards (Louisiana, Georgia, California, and West Virginia), and four territories (Guam, Northern Mariana Islands, Virgin Islands and American Samoa).
Recommendations to Boards of Nursing

One of the cautions from experts in nursing education innovations is that not all educators are innovators and it is not expected that all faculty or all nursing programs will implement innovations. However, the Boards of Nursing can create a favorable climate for innovation for those programs that are ready for it. The following are some recommendations for Boards of Nursing that might promote innovations:

- Boards of Nursing might consider critically analyzing their education rules, particularly related to those listed in Table 1, with an eye toward fostering innovation in education.
- Boards of Nursing may contemplate evaluating their approval processes for the purpose of streamlining them.
- Related to communication, Boards of Nursing could think about:
  - Representing the Board of Nursing at deans and director meetings.
  - Convening education advisory committees including representation from educators, employers, and consumers.
  - Developing Power Point presentations for faculty related to the role of the Board’s education consultant.
  - Developing online orientation courses for deans and directors.
  - Sending out regular e-mails and/or newsletters to programs.
  - Informally communicating with faculty.
  - Developing an innovations Web site 6 to serve as a statewide clearinghouse for innovations in nursing education.
  - Hosting conferences with educators on regulatory issues and providing question and answer sessions.
  - Posting a frequently asked questions (FAQ) handout on the Web site.

References Cited


---

6 See this example from the Texas Board of Nursing: http://www.bon.state.tx.us/nursingeducation/innovative.html
Health care delivery in the U.S. is becoming increasingly complex, requiring the use of sophisticated technologies and the need for systems thinking in order for nurses to practice safely. Further, more than ever before nurses are caring for sicker, older, and more diverse patients with myriad chronic conditions. In order to keep up with this these changes, innovative approaches in nursing education are being encouraged. However, before educators begin to plan innovative approaches to nursing education, they might consider the following:

Hargreaves (2008) suggests that it is important to think about consequences (intended and unintended) before beginning to plan an innovative instructional strategy. Answering questions such as those listed below will provide guidelines as decisions are made:

- What are the likely outcomes of a given learning and teaching strategy?
- Will it work for all students/staff/the institution?
- What is the intention?
- What is the worst possible outcome?
- What is the best possible outcome?
- On balance, how great is the likelihood that positive consequences will outweigh negative ones?

When the consequences are identified, then think about:

- Would greater support make a difference?
- Which assessment tasks ensure students can complete the course/education without being compromised by uncertain outcomes?

If the decision is made to go ahead with the innovative strategy, review your jurisdiction’s nurse practice act and administrative rules. If your innovation constitutes a significant departure from the way a nursing education program currently functions under the rule structure, contact your Board of Nursing about implementing an innovative approach. Early consultation with your Board is highly recommended.

Suggested References


Texas Board of Nursing's Innovation in Nursing Education Web site. Retrieved April 1, 2009, from: http://www.bon.state.tx.us/nursingeducation/innovative.html


Developed by: NCSBN's Innovations in Education Regulation Committee
Contact information: Nancy Spector, PhD, RN (nspector@ncsbn.org)
Attachment D

Model Rules for Innovative Approaches in Nursing Education Programs

Latest revision: 3/30/09

Model Rules for Innovative Approaches in Nursing Education Programs

Placement:
(Left side – Act: Language for Boards that will need to change the Act) Article IX. Section 3. Provision for innovative approaches in nursing education programs.

The Board shall, by administrative rule, identify the process for implementing innovative approaches in nursing education programs.

(Current Section 3 will change to Section 4 and the current Section 4 will change to Section 5)

Definitions – Chapter 3

Innovative approach – A creative nursing education strategy that departs from the current rule structure and requires Board approval for implementation.

(Right side – Rules)

9.3. Innovative approaches in nursing education programs

A nursing education program may apply to implement an innovative approach by complying with the provisions of this section. Nursing education programs approved to implement innovative approaches shall continue to provide quality nursing education that prepares graduates to practice safely, competently, and ethically within the scope of practice as defined in <jurisdiction’s> statutes.

9.3.1. Purposes

a. To foster innovative models of nursing education to address the changing needs in health care.

b. To assure that innovative approaches are conducted in a manner consistent with the Board’s role of protecting the public.

c. To assure that innovative approaches conform to the quality outcome standards and core education criteria established by the Board.

9.3.2. Eligibility

a. The nursing education program shall hold full Board approval without conditions.

b. There are no substantiated complaints in the past 2 years.

c. There are no rule violations in the past 2 years.

9.3.3. Application

The following information (no longer than < > pages with a 1-page executive summary) shall be provided to the Board at least <> days prior to a Board meeting:

a. Identifying information (name of nursing program, address, responsible party and contact information).

b. A brief description of the current program, including accreditation and Board approval status.

c. Identification of the regulation(s) affected by the proposed innovative approach.

d. Length of time for which the innovative approach is requested.
e. Description of the innovative approach, including objective(s).

f. Brief explanation of why you want to implement an innovative approach at this time.

g. Explanation of how the proposed innovation differs from approaches in the current program.

h. Rationale with available evidence supporting the innovative approach.
i. Identification of resources that support the proposed innovative approach.
j. Expected impact innovative approach will have on the program, including administration, students, faculty, and other program resources.
k. Plan for implementation, including timeline.
l. Plan for evaluation of the proposed innovation, including measurable criteria/outcomes, method of evaluation, and frequency of evaluation.
m. Additional application information as requested by the Board.

9.3.4. Standards for approval

a. Eligibility criteria in 9.3.2. and application criteria in 9.3.3. are met.
b. The innovative approach will not compromise the quality of education or safe practice of students.
c. Resources are sufficient to support the innovative approach.
d. Rationale with available evidence supports the implementation of the innovative approach.
e. Implementation plan is reasonable to achieve the desired outcomes of the innovative approach.
f. Timeline provides for a sufficient period to implement and evaluate the innovative approach.
g. Plan for periodic evaluation is comprehensive and supported by appropriate methodology.

9.3.5. Review of application and board action

a. Annually the Board may establish the number of innovative approach applications it will accept, based on available Board resources.
b. The Board shall evaluate all applications to determine if they meet the eligibility criteria in 9.3.2 and the standards established in section 9.3.4.
c. The Board shall inform the education program of the approval process timeline within <> days of the receipt of the application.
d. If the application meets the standards, the Board may:
   1) Approve the application, or
   2) Approve the application with modifications as agreed between the Board and the nursing education program.

e. If the submitted application does not meet the criteria in 9.3.2 and 9.3.4., the Board may deny approval or request additional information.
f. The Board may rescind the approval or require the program to make modifications if:
   1) The Board receives substantiated evidence indicating adverse impact.
2) The nursing program fails to implement the innovative approach as presented and approved.

9.3.6. Periodic Evaluation

a. The education program shall submit progress reports conforming to the evaluation plan annually or as requested by the Board.

b. The final evaluation report shall conform to the evaluation plan, detailing and analyzing the outcomes data.

c. If any report indicates that students were adversely impacted by the innovation, the nursing program shall provide documentation of corrective measures and their effectiveness.

d. Nursing education program maintains eligibility criteria in 9.3.2.

9.3.7. Requesting continuation of the innovative approach

a. If the innovative approach has achieved the desired outcomes and the final evaluation has been submitted, the program may request that the innovative approach be continued.

b. Request for the innovative approach to become an ongoing part of the education program must be submitted < > days prior to a regularly scheduled Board meeting.

c. The Board may grant the request to continue approval if the innovative approach has achieved desired outcomes, has not compromised public protection, and is consistent with core nursing education criteria.
Report of the NCLEX® Examination Committee

Recommendation to the Delegate Assembly

1. Adopt the proposed 2010 NCLEX-RN® Test Plan.

Rationale:
The NCLEX® Examination Committee (NEC) reviewed and accepted the Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice (NCSBN, 2009) as the basis for recommending revisions to the 2007 NCLEX-RN® Test Plan to the Delegate Assembly. Empirical evidence from the practice analysis, feedback from Member Boards and the professional judgment of the NEC provide support for the recommendation to the Delegate Assembly to adopt the 2010 NCLEX-RN® Test Plan.

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

Highlights of FY09 Activities

ENTRY LEVEL NURSE COMPETENCE ASSESSED

2010 NCLEX-RN® Test Plan
At the October 2008 meeting, the NEC reviewed the results of the Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice. Empirical data from the 2008 registered nurse (RN) practice analysis was used to evaluate the 2007 NCLEX-RN® Test Plan to determine if changes were needed. After in-depth discussion and careful deliberation, the committee decided to retain the client needs framework. Based on data from the practice analysis and psychometric considerations, the percentage of test items allocated to the subcategory of “Management of Care” was increased from 13-19 percent to 16-22 percent, and the subcategory of “Reduction of Risk Potential” was reduced from 13-19 percent to 10-16 percent. Minor revisions were made in the document to provide clarity.

A draft of the proposed 2010 NCLEX-RN® Test Plan was sent to all Member Boards in November 2008 for feedback on these changes. During its April 2009 business meeting, the committee discussed all comments from the Member Boards and approved a final draft of the proposed 2010 NCLEX-RN® Test Plan as noted in Attachments A and B, as well as approved the timeline for implementation (Attachment C).
IMPROVEMENTS TO THE DEVELOPMENT AND ADMINISTRATION OF THE NCLEX® EXAMINATIONS

2009 Licensed Practical/Vocational Nurse (LPN/VN) Practice Analysis

An LPN/VN panel of subject matter experts (SMEs) was selected to develop a comprehensive list of nursing activity statements that will be used to inform the test plan. At the January 2009 meeting, the committee reviewed and approved the list of LPN/VN activity statements and the survey form that will be used for the 2009 LPN/VN practice analysis. The practice analysis is anticipated to be completed in August 2009.

2009 LPN/VN Knowledge Survey

A second LPN/VN panel of SMEs created a comprehensive list of knowledge statements to survey new graduates, faculty and supervisors. The knowledge survey, which will be completed in July 2009, will be used to inform item development.

Joint Research Committee (JRC)

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

Several new pieces of research have either been completed or are near the final draft stage. Examples include: an investigation into the cognitive processing and memorability of various innovative item types; the comparability of item quality indices from sparse data matrices that result from computerized adaptive tests; the effects of item position on response time and the probability of a correct response; stability of item parameters over time; estimation of item difficulty of pretest items; establishing pretest statistical criteria specific for alternate item types; and developing item variants and the impact of item compromise on the probability of passing the NCLEX.

The JRC has also approved, in some cases tentatively, research to be conducted on an optimal item pool design; the effect of sample sizes on differential item functioning analyses; the feasibility of various approaches to situated tasks as a format for new item types; and an analysis of how candidates interact with alternate item types.

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 could reduce the amount of time it takes to place new items into operational usage. Security could also be enhanced by reducing the window of availability for any given operational item pool. Moving toward these goals, the JRC has approved a study to investigate the optimal item pool design for quarterly deployments.

Revise Performance Benchmarks for Test of English as a Foreign Language – internet-Based Test (TOEFL-iBT)

TOEFL is a test of English proficiency commonly used by boards of nursing (BONs) as one of the requirements for obtaining licensure to practice. The current NCSBN-endorsed TOEFL standard was set in 2004 with TOEFL Computer Based Test (TOEFL-CBT). As of 2006, Educational Testing Service (ETS), owner and developer of the TOEFL, has discontinued the use of TOEFL-CBT and replaced it with TOEFL-iBT, which includes a speaking component. Unlike the CBT, the iBT is made up of four sections: reading, listening, speaking and writing. As a result of changes in test format from CBT to iBT, the committee has been working to establish an empirically based passing standard for the TOEFL-iBT. This standard is intended to reflect the minimum level of English proficiency required in the U.S. to practice nursing safely at the entry level.

On Nov. 10-12, 2008, a panel of 22 SMEs met in Chicago to participate in a criterion-referenced standard setting exercise for TOEFL-iBT. ETS staff members, Susan Nissan, assessment director,
and Eileen Tyson, director of client relations, facilitated the panel. Using retired TOEFL-iBT items, the panel made preliminary recommendations for performance benchmarks on the examination. Results from this criterion-referenced standard setting exercise were presented to the NEC for consideration. Using the score interpretation guide published by ETS, the expert panel recommended a fair to intermediate mastery as the minimum level of English needed to practice entry level nursing safely and effectively for the four exam components.

After reviewing the standard setting process and recommendations from the standard setting panel, historical data from the 2004 TOEFL passing standard and other available evidence, such as comparability and impact data, the committee recommended that a total score of 84 and a minimum score of 26 be required for the speaking component on the TOEFL-iBT in order to demonstrate the minimum degree of English proficiency necessary to be a safe and effective entry level nurse. Making this legally defensible standard available to Member Boards will be beneficial. In addition to being legally defensible, the use of this passing standard by Member Boards would allow TOEFL scores to be portable across jurisdictions. However, the final decision of whether to adopt the recommended passing standard rests on each individual BON. Each BON should carefully consider the applicability of the recommended standard to circumstances unique to their jurisdiction. This recommendation regarding the TOEFL-iBT passing standard will be communicated to Member Boards, as well as other stakeholders. Additional information regarding the TOEFL-iBT standard setting will be made available on the NCSBN Web site.

As part of the NCSBN initiative to establish standards for minimally acceptable English language proficiency for entry level nurses, the committee anticipates continuing similar criterion-referenced standard setting exercises in FY10 with the Pearson Test of English (PTE). The standard setting workshop will be followed by a recommended passing standard of English proficiency that can be used by Member Boards.

**NCLEX® Alternate Item Types**

The committee consistently reviews the present and future of the NCLEX examinations with an eye towards innovations that would maintain the examination’s premier status in licensure. In keeping with this plan, the NCLEX 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® Administration Enhancements**

Pearson VUE has implemented a user interface on the NCLEX® Administration Web site that gives Member Boards the ability to select an option on the printed score reports and Education Program Summary, to either show or conceal the candidate’s Social Security Number (SSN) and date of birth (DOB). This change was initiated by Member Boards’ requests to ensure the privacy of candidate information.

Beginning Jan. 1, 2009, candidates were able to register for the NCLEX examination online and pay by check (cashiers/certified) or money order. This option was introduced to assist those candidates or candidate sponsors that are unable to utilize the credit card option.

Pearson VUE has begun to phase-in palm vein technology at test centers. This technology is very accurate and allows NCSBN to more accurately identify people trying to take the NCLEX under assumed testers’ identities. By preventing proxy testers, the technology helps NCSBN maintain the integrity of the NCLEX examination. NCSBN will potentially start using the palm vein device in FY10. The palm vein device would serve as a second level of security; it would not be replacing fingerprinting for the NCLEX program.

Additionally, the NEC has approved the use of an optional reader service from Pearson VUE’s subcontractor for NCLEX candidates seeking a reader accommodation. The criteria and procedures for the optional Pearson VUE reader service will remain the same and there is no charge to Member Boards for this service.
Pearson VUE will be opening 10 new Pearson Professional Centers (PPCs) and expanding seating capacity at 13 other centers during 2009. Member Boards are notified of these PPC changes prior to implementation. Information on PPC updates are featured in NCSBN’s Council Connector newsletter.

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

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

**MONITORED ALL 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 committee continue to chair subcommittee meetings. The committee and the subcommittee: (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, the subcommittee and staff currently evaluate 100 percent of all validations for pretest items and 100 percent of all validations of master pool items scheduled for review.

Assistance from the subcommittee continues to reduce the committee’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 14, with representation from all four NCSBN geographic areas. Orientation to the subcommittee 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 has been made available to Member Boards and candidates in the NCLEX® Candidate Bulletin, candidate tutorial and on the NCSBN Web site.

**NCSBN Item Development Sessions Held at Pearson VUE**

<table>
<thead>
<tr>
<th>Table 1. RN Item Development Productivity Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year</strong></td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>April 02 – March 03</td>
</tr>
<tr>
<td>April 03 – March 04</td>
</tr>
<tr>
<td>April 04 – March 05</td>
</tr>
<tr>
<td>April 05 – March 06</td>
</tr>
<tr>
<td>April 06 – March 07</td>
</tr>
<tr>
<td>April 07 – March 08</td>
</tr>
<tr>
<td>April 08 – March 09</td>
</tr>
</tbody>
</table>
Table 2. PN Item Development Productivity Comparison

<table>
<thead>
<tr>
<th>Year</th>
<th>Writing Sessions</th>
<th>Item Writers</th>
<th>Items Written</th>
<th>Review Sessions</th>
<th>Items Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 02 – March 03</td>
<td>3</td>
<td>33</td>
<td>1476</td>
<td>6</td>
<td>1547</td>
</tr>
<tr>
<td>April 03 – March 04</td>
<td>2</td>
<td>24</td>
<td>968</td>
<td>5</td>
<td>1611</td>
</tr>
<tr>
<td>April 04 – March 05</td>
<td>1</td>
<td>11</td>
<td>430</td>
<td>3</td>
<td>2124</td>
</tr>
<tr>
<td>April 05 – March 06</td>
<td>4</td>
<td>50</td>
<td>1938</td>
<td>5</td>
<td>3682</td>
</tr>
<tr>
<td>April 06 – March 07</td>
<td>3</td>
<td>45</td>
<td>2453</td>
<td>4</td>
<td>1661</td>
</tr>
<tr>
<td>April 07 – March 08</td>
<td>3</td>
<td>48</td>
<td>2378</td>
<td>6</td>
<td>3304</td>
</tr>
<tr>
<td>April 08 – March 09</td>
<td>1</td>
<td>16</td>
<td>551</td>
<td>6</td>
<td>2829</td>
</tr>
</tbody>
</table>

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

**Monitored Item Sensitivity Review**

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

**Evaluated Item Development Process and Progress**

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

**Monitored the Development of Operational NCLEX® Item Pools**

The NEC monitored the configuration of RN and PN operational item pools. The process of configuring operational item pools involves only a few critical variables; however, the quality control checks performed afterward are based upon both nursing content and psychometric variables. The resulting operational item pools were evaluated extensively with regard to these variables and were found to be within operational specifications. To ensure that operational item pools and the item selection algorithm were functioning together as expected, simulated examinations were evaluated. Using these simulated examinations, the functioning of the algorithm was scrutinized with regard to the distribution of items by test plan content area; it was concluded that the operational item pools and the item selection algorithm were acting in concert to produce exams that were within NCSBN specifications and were comparable to 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 items twice a year and items are referred to the NEC. No items from the April 2008 Member Board Review were referred to the committee. In April 2009, the committee reviewed the items referred from the October 2008 Member Board Review. BONs referred items to the NEC for one of the following reasons: not entry level practice, not consistent with the nurse practice act or for other reasons. The committee provided direction on the resolution of each Member Board item and staff gave Member Boards feedback on the committee’s decisions on all referred items. The NEC encourages each Member Board to take advantage of the semi-annual opportunities to review NCLEX items.
Item Related Incident Reports (IRs)
Electronically filed IRs may be submitted at PPCs when candidates question item content. Pearson VUE and NCSBN staff investigates each incident and reports their findings to the NEC for decisions related to retention of the item.

Americans with Disabilities Act (ADA) Implications of Alternate Item Formats
The NEC reviewed information from NCSBN's psychometrician regarding the psychometric impact of adding alternate items. NCSBN's legal counsel offered a legal opinion and questions for the committee regarding alternate items and the ADA. In particular, legal counsel noted that the introduction of new item types that require hand/eye coordination and visual or auditory acuity will likely lead to additional requests for ADA accommodations and for different types of accommodations, including the use of assistive devices. After a thorough discussion and deliberation, the committee determined that such alternate items are measuring essential psychomotor, audio or visual abilities identified in the practice analysis as part of the nursing competencies being measured by NCLEX. The committee directed staff to continue to investigate new item types.

MONITOR EXAMINATION ADMINISTRATION

Monitored Procedures for Candidate Tracking: Candidate Matching Algorithm
The committee continued to monitor the status and effectiveness of the candidate-matching algorithm. On a semi-annual basis, Pearson VUE conducts a check for duplicate candidate records on all candidates that have tested within the last six months. The most recent check covered the period from January 2008 through June 2008 and compared over 173,000 candidate records. The result of that check revealed that there were no duplicate candidate records and that no repeat candidate records were treated by the system as separate individuals.

Monitored the Security of the NCLEX® Examination Administrations and Item Pools
In the last year, the NEC has continued to approach security proactively. It has worked to develop formal procedures to describe how certain categories of security-related investigations and actions are executed.

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

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, 2008, to Dec. 31, 2008, all candidates were able to be tested in compliance. A dedicated department at Pearson VUE 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 committee and the NCSBN NCLEX® Examinations Department 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
ADA Amendment
An amendment to the ADA was approved by the U.S. legislature and enacted in January 2009. The new ADA language includes a broader definition of a disability with the addition of “inability to think and concentrate” labeled as disabilities. The committee reviewed a staff report on the ADA amendment and noted that this amendment may increase the number of requests for accommodations from Member Boards. Pearson VUE has been alerted to this issue and is proactively making plans for this potential.

NCSBN staff consulted with NCSBN legal counsel who did not anticipate that any significant programmatic changes in the NCLEX will be needed as a result of the new ADA amendment, nor will changes to policies and procedures be necessary.

ADMINISTER NCLEX® AT INTERNATIONAL SITES
The international test centers meet the same security specifications and follow the same administration procedures as the professional centers located in Member Board jurisdictions. Please see Attachment D of this report for the 2008 candidate volumes and pass rates for the international testing centers.

EDUCATE STAKEHOLDERS
NCLEX® Research Presentations
At the 2008 American Educational Research Association (AERA) annual meeting, a paper, “Development and Evaluation of Innovative Test Items for a Computerized Nursing Licensure Exam,” was presented. AERA is an internationally recognized professional organization with the primary goal of advancing educational research and its practical application. In collaboration with test service, two papers, “Limiting Item Exposure for Key-difficulty Ranges in a High-stakes CAT” and “Developing Item Variants: An Empirical Study,” have been selected for presentation at the 2009 Graduate Management Admission Council (GMAC®) Conference on Computerized Adaptive Testing (CAT). The GMAC Conference on CAT provides a venue where researchers and practitioners come together to improve practice and advance the field of CAT. Acceptance in these programs not only helps NCSBN share expertise on best testing practices worldwide, but also allows NCSBN to move ahead in psychometric testing solutions through the collective strength of internal and external stakeholders. Furthermore, collaborating on psychometric testing issues with external communities allows NCSBN to remain at the forefront of the testing industry.

Presentations and Publications
NCSBN NCLEX® Examinations Department staff conducted numerous NCLEX informational presentations, Webinars and workshops. This included a presentation entitled, “Filipino Nurses and the NCLEX Examination: Trends and Test Performance,” at the 2008 First Philippine Nursing Competitiveness Conference in Manila, Philippines. In order to ensure NCSBN membership was kept current on the NCLEX program, the NCLEX® Examinations Department hosted three informational Webinars for Member Boards.

Additionally, as part of the departments outreach activities, content staff conducted two BON sponsored NCLEX® Regional Workshops. Regional workshops are presented for the purpose of providing information to educators preparing students to take the NCLEX examination. The BONs that hosted a regional workshop were Kansas and Wyoming. These opportunities assist NCSBN’s NCLEX® Examinations Department with educating stakeholders about the examination, as well as recruiting for NCSBN item development panels.

The committee continues to oversee development of various publications that accurately reflect the NCLEX examination process. This year the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice and the 2008 Knowledge of Newly Licensed Registered Nurses Survey
were published, distributed to Member Boards and made available to the public at no charge on the NCSBN Web site.

Eight other articles were written and accepted for publication by NCSBN staff:

- “Readability of licensure examinations,” CLEAR Exam Review, 20(1);
- “Memorability of innovative items,” CLEAR Exam Review, 20(1);
- “NCLEX fairness and sensitivity review,” Nurse Educ, September/October 2009;
- “Evaluating innovative items for the NCLEX: Part I,” Nurse Educ, 34(2);
- “Evaluating innovative items for the NCLEX: Part II,” Nurse Educ, 34(3);
- “NCLEX pass rates: An investigation into the effect of lag time and retake attempts,” JONAS Healthc Law Ethics Regul, 11(1);
- “Alternate item types: Continuing the quest for authentic testing,” J Nurs Educ, 48(3);
- “Setting a passing standard for English proficiency on the Internet-based Test of English as a Foreign Language (TOEFL®-iBT),” JONAS Healthc Law Ethics Regul.

**NCLEX® Member Board Manual**

NCSBN updates the NCLEX® Member Board Manual on a quarterly basis. Changes included updates on the notification process for test center changes; the process to request a new test center in a Member Board jurisdiction; option to mask a candidate’s SSN and DOB; the online pay by check registration option; instructions on how to order additional candidate bulletins; correcting program code errors; expanded definition of a ADA disability; the new optional reader process and NCSBN’s process for handling candidates suspected of violating NCLEX rules.

**NCLEX® Invitational**

Historically, the NCLEX® Examinations Department 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 2008 NCLEX® Invitational was held in San Diego, on Sept. 8, 2008, with approximately 200 participants. The 2009 NCLEX® Invitational is scheduled for Sept. 21, 2009, at the Hyatt Regency in Chicago.

**NCLEX® Program Reports**

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

**NCLEX® Unofficial Quick Results Service**

BONs, through NCSBN, offer candidates the opportunity to learn their unofficial results (official results are only available from 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, 46 BONs participate in offering this service to their candidates. In 2008, approximately 152,000 candidates utilized this service.

**Future Activities**

- Conduct a continuous online RN practice analysis.
- Evaluate the NCLEX-PN test plan.
- Conduct a PN Standard Setting Workshop.
- Continue to monitor all administrative, test development and psychometric aspects of the NCLEX examination program.
- Evaluate all aspects of the NCLEX program and initiate additional quality assurance processes as needed.
- Evaluate NCLEX informational initiatives such as the NCLEX® Invitational, NCLEX® Regional Workshops and other presentations.
- Evaluate ongoing international testing.
- Host the 2010 NCLEX® Invitational.
- Introduce additional alternate format item types, which may include multimedia, such as sound and video for the NCLEX examinations.
- Explore additional item writing strategies for the NCLEX.
- Conduct a study of U.S. nursing education competencies using an international nursing survey.
- Recommend a passing standard to Member Boards for the Pearson Test of English (PTE).
- Conduct practice analysis comparability studies with British Columbia and Ontario.

**Attachments**
A. Proposed 2010 NCLEX-RN® Test Plan-Strikethrough Copy
B. Proposed 2010 NCLEX-RN® Test Plan-Clean Copy
C. Timeline for Implementation of the 2010 NCLEX-RN® Test Plan
D. Annual Report of Pearson VUE for the NCLEX
Comparison of 2007 to the proposed 2010 NCLEX-RN® Test Plan

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

National Council Licensure Examination for Registered Nurses

(NCLEX-RN® EXAMINATION)

Introduction

Entry into the practice of nursing is regulated by the licensing authorities within each of the National Council of State Boards of Nursing (NCSBN®) member board jurisdictions (state, commonwealth, and territorial boards of nursing). To ensure public protection, each jurisdiction requires candidates for licensure to pass an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level registered nurse. NCSBN develops a licensure examination, the National Council Licensure Examination for Registered Nurses (NCLEX-RN®), which is used by member board jurisdictions to assist in making licensure decisions.

Several steps occur in the development of the NCLEX-RN® Test Plan. The first step is conducting a practice analysis that is used to collect data on the current practice of the entry-level nurse (Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice, NCSBN, 2009). Twelve thousand newly licensed registered nurses are asked about the frequency and importance of performing 155 nursing care activities. Nursing care activities are analyzed in relation to the frequency of performance, impact on maintaining client safety and client care settings where the activities are performed. This analysis guides the development of a framework for entry-level nursing practice that incorporates specific client needs as well as processes fundamental to the practice of nursing. The second step is the development of the NCLEX-RN® Test Plan, which guides the selection of content and behaviors to be tested.

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

Beliefs

Beliefs about people and nursing underlie the NCLEX-RN® Test Plan. People are finite beings with varying capacities to function in society. They are unique individuals who have defined systems of daily living reflecting their values, motives and lifestyles. Additionally, people have the right to make decisions regarding their health care needs and to participate in meeting those needs.

Nursing is both an art and a science, founded on a professional body of knowledge that integrates...
concepts from the liberal arts and the biological, physical, psychological and social sciences. It is a learned profession based on an understanding of the human condition across the life span and the relationships of an individual with others and within the environment. Nursing is a dynamic, continually evolving discipline that employs critical thinking to integrate increasingly complex knowledge, skills, technologies, and client care activities into evidence-based nursing practice. The goal of nursing for client care in any setting is preventing illness; alleviating suffering; protecting, promoting and restoring health; and promoting dignity in dying. The registered nurse provides a unique, comprehensive assessment of the health status of the client (individual, family or group), and then develops and implements an explicit plan of care. The nurse assists clients in the promotion of health, in coping with health problems, in adapting to and/or recovering from the effects of disease or injury, and in supporting the right to a dignified death. The registered nurse is accountable for abiding by all applicable jurisdiction statutes related to nursing practice.

Classification of Cognitive Levels

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

Test Plan Structure

The framework of Client Needs was selected for the examination because it provides a universal structure for defining nursing actions and competencies, and focuses on clients in all settings.

Client Needs

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

Safe and Effective Care Environment
  - Management of Care
  - Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

Physiological Integrity
  - Basic Care and Comfort
  - Pharmacological and Parenteral Therapies
  - Reduction of Risk Potential
  - Physiological Adaptation

Integrated Processes

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

- Nursing Process – a scientific, clinical reasoning, approach to client care that includes assessment, analysis, planning, implementation and evaluation.
- Caring – interaction of the nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the nurse provides encouragement, hope, support and
compassion to help achieve desired outcomes.

- Communication and Documentation – verbal and nonverbal interactions between the nurse and the client, the client’s significant others and the other members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.

- Teaching/Learning – facilitation of the acquisition of knowledge, skills and attitudes promoting a change in behavior.

Distribution of Content

The percentage of test questions assigned to each Client Needs category and subcategory of the NCLEX-RN® Test Plan is based on the results of the Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice (NCSBN, 2009), and expert judgment provided by members of the NCSBN Examination Committee.

<table>
<thead>
<tr>
<th>Client Needs Category/Subcategory</th>
<th>Percentage of Items From Each Category/Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe and Effective Care Environment</td>
<td>Management of Care</td>
</tr>
<tr>
<td>Safety and Infection Control</td>
<td>8-14%</td>
</tr>
<tr>
<td>Health Promotion And Maintenance</td>
<td>6-12%</td>
</tr>
<tr>
<td>Psychosocial Integrity</td>
<td>6-12%</td>
</tr>
<tr>
<td>Physiological Integrity</td>
<td>Basic Care and Comfort</td>
</tr>
<tr>
<td>Pharmacological and Parenteral Therapies</td>
<td>13-19%</td>
</tr>
<tr>
<td>Reduction of Risk Potential</td>
<td>40-16%</td>
</tr>
<tr>
<td>Physiological Adaptation</td>
<td>11-17%</td>
</tr>
</tbody>
</table>
Overview of Content

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

Safe and Effective Care Environment

The nurse promotes achievement of client outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect clients, family/significant others and other health care personnel.

- Management of Care – providing and directing nursing care that enhances the care delivery setting to protect clients, family/significant others and health care personnel.

Related content includes but is not limited to:

- Advance Directives
- Advocacy
- Case Management
- Client Rights
- Collaboration with Interdisciplinary Team
- Concepts of Management
- Confidentiality/Information Security
- Consultation
- Continuity of Care
- Delegation
- Establishing Priorities
- Ethical Practice
- Informed Consent
- Information Technology
- Legal Rights and Responsibilities
- Performance Improvement (Quality Improvement)
- Referrals
- Supervision
- Resource Management
- Staff Education
116  ■ Safety and Infection Control – protecting clients, family/significant others and health care
personnel from health and environmental hazards.

119  ■ Accident/Injury Prevention
■ Emergency Response Plan
■ Ergonomic Principles
■ Error Prevention
■ Handling Hazardous and Infectious Materials
■ Home Safety

119  ■ Reporting of Incident/Event/Irregular Occurrence/Variance
■ Safe Use of Equipment
■ Security Plan
■ Standard Precautions/Transmission-Based Precautions/Surgical Asepsis
■ Use of Restraints/Safety Devices

120  Health Promotion and Maintenance
121  The nurse provides and directs nursing care of the client, and family/significant other that incorporates
122  the knowledge of expected growth and development principles; prevention and/or early detection of
123  health problems, and strategies to achieve optimal health.

124  ■ Aging Process
■ Ante/Intra/Postpartum and Newborn Care
■ Developmental Stages and Transitions
■ Health and Wellness
■ Self-Care
■ Techniques of Physical Assessment

125  Psychosocial Integrity
126  The nurse provides and directs nursing care that promotes and supports the emotional, mental and social
127  well-being of the client and family/significant others experiencing stressful events, as well as clients with
128  acute or chronic mental illness.

129  ■ Abuse/Neglect
■ Behavioral Interventions
■ Chemical and Other Dependencies
■ Coping Mechanisms
■ Crisis Intervention
■ Cultural Diversity
■ End of Life Care
■ Family Dynamics
■ Grief and Loss
■ Mental Health Concepts

130  Physiological Integrity
The nurse promotes physical health and wellness by providing care and comfort, reducing client risk potential and managing health alterations.

- **Basic Care and Comfort** - providing comfort and assistance in the performance of activities of daily living.

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

- **Pharmacological and Parenteral Therapies** - providing care related to the administration of medications and parenteral therapies.

  Related content includes but is **not limited** to:
  - Adverse Effects/Contraindications /Side Effects/Interactions
  - Blood and Blood Products
  - Central Venous Access Devices
  - Dosage Calculation
  - Expected Actions/Outcomes
  - Medication Administration
  - Parenteral/Intravenous Therapies
  - Pharmacological Pain Management
  - Total Parenteral Nutrition

- **Reduction of Risk Potential** - reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatments or procedures.

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

- **Physiological Adaptation** - managing and providing care for clients with acute, chronic or life threatening physical health conditions.

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

  - **Deleted: Complementary and Alternative Therapies**
  - **Deleted: Palliative/Comfort Care**
  - **Deleted: Pharmacological Agents/Actions**
  - **Deleted: Pharmacological Interactions**
  - **Deleted: Pharmacological Pain Management**
  - **Deleted: Total Parenteral Nutrition**
  - **Deleted: Monitoring Conscious Sedation**
  - **Deleted: Radiation Therapy**
  - **Deleted: Infectious Diseases**
Administration of the NCLEX-RN® Examination

The NCLEX-RN® examination is administered to the candidate by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. Items go through an extensive review process before they can be used as items on the examination. In addition to multiple choice items, candidates may be administered items written in alternate formats. These formats may include but are not limited to multiple response, fill-in-the-blank, drag and drop, and/or hot spots. All item types may include multimedia such as charts, tables, graphics, sound and video.

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

All registered nurse candidates must answer a minimum of 75 items. The maximum number of items that the candidate may answer is 265 during the allotted six-hour time period. Examination instructions and all rest breaks are included in the measurement of the time allowed for a candidate to complete the examination.

Candidates should be aware and understand that the disclosure of any examination materials including the nature or content of examination items, before, during or after the examination is a violation of law. Violations of confidentiality and/or candidates’ rules can result in criminal prosecution or civil liability and/or disciplinary actions by the licensing agency including the denial of licensure.

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


Report of the NCLEX® Examination Committee - Attachment A: Proposed 2010 NCLEX-RN® Test Plan-Strikethrough Copy
Proposed 2010 NCLEX-RN® Test Plan

National Council Licensure Examination for Registered Nurses

(NCLEX-RN® EXAMINATION)

Introduction
Entry into the practice of nursing is regulated by the licensing authorities within each of the National Council of State Boards of Nursing (NCSBN®) member board jurisdictions (state, commonwealth, and territorial boards of nursing). To ensure public protection, each jurisdiction requires candidates for licensure to pass an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level registered nurse. NCSBN develops a licensure examination, the National Council Licensure Examination for Registered Nurses (NCLEX-RN®), which is used by member board jurisdictions to assist in making licensure decisions.

Several steps occur in the development of the NCLEX-RN® Test Plan. The first step is conducting a practice analysis that is used to collect data on the current practice of the entry-level nurse (Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice, NCSBN, 2009). Twelve thousand newly licensed registered nurses are asked about the frequency and importance of performing 155 nursing care activities. Nursing care activities are analyzed in relation to the frequency of performance, impact on maintaining client safety and client care settings where the activities are performed. This analysis guides the development of a framework for entry-level nursing practice that incorporates specific client needs as well as processes fundamental to the practice of nursing. The second step is the development of the NCLEX-RN® Test Plan, which guides the selection of content and behaviors to be tested.

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

Beliefs
Beliefs about people and nursing underlie the NCLEX-RN® Test Plan. People are finite beings with varying capacities to function in society. They are unique individuals who have defined systems of daily living reflecting their values, motives and lifestyles. Additionally, people have the right to make decisions regarding their health care needs and to participate in meeting those needs.

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

The registered nurse provides a unique, comprehensive assessment of the health status of the client (individual, family or group), and then develops and implements an explicit plan of care. The nurse assists clients in the promotion of health, in coping with health problems, in adapting to and/or recovering from the effects of disease or injury, and in supporting the right to a dignified death. The registered nurse is accountable for abiding by all applicable member board jurisdiction statutes related to nursing practice.

Classification of Cognitive Levels
Bloom’s taxonomy for the cognitive domain is used as a basis for writing and coding items for the examination (Bloom, et al., 1956; Anderson & Krathwohl, 2001). Since the practice of nursing requires application of knowledge, skills and abilities, the majority of items are written at the application or higher levels of cognitive ability, which requires more complex thought processing.

Test Plan Structure
The framework of Client Needs was selected for the examination because it provides a universal structure for defining nursing actions and competencies, and focuses on clients in all settings.

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

- **Safe and Effective Care Environment**
  - Management of Care
  - Safety and Infection Control

- **Health Promotion and Maintenance**

- **Psychosocial Integrity**

- **Physiological Integrity**
  - Basic Care and Comfort
  - Pharmacological and Parenteral Therapies
  - Reduction of Risk Potential
  - Physiological Adaptation
Integrated Processes

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

- **Nursing Process** – a scientific, clinical reasoning approach to client care that includes assessment, analysis, planning, implementation and evaluation.
- **Caring** – interaction of the nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the nurse provides encouragement, hope, support and compassion to help achieve desired outcomes.
- **Communication and Documentation** – verbal and nonverbal interactions between the nurse and the client, the client’s significant others and the other members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.
- **Teaching/Learning** – facilitation of the acquisition of knowledge, skills and attitudes promoting a change in behavior.

Distribution of Content

The percentage of test questions assigned to each Client Needs category and subcategory of the NCLEX-RN® Test Plan is based on the results of the Report of Findings from the 2008 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice (NCSBN, 2009), and expert judgment provided by members of the NCSBN Examination Committee.

<table>
<thead>
<tr>
<th>Client Needs</th>
<th>Percentage of Items From Each Category/Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe and Effective Care Environment</td>
<td></td>
</tr>
<tr>
<td>Management of Care</td>
<td>16-22%</td>
</tr>
<tr>
<td>Safety and Infection Control</td>
<td>8-14%</td>
</tr>
<tr>
<td>Health Promotion And Maintenance</td>
<td>6-12%</td>
</tr>
<tr>
<td>Psychosocial Integrity</td>
<td>6-12%</td>
</tr>
<tr>
<td>Physiological Integrity</td>
<td></td>
</tr>
<tr>
<td>Basic Care and Comfort</td>
<td>6-12%</td>
</tr>
<tr>
<td>Pharmacological and Parenteral Therapies</td>
<td>13-19%</td>
</tr>
<tr>
<td>Reduction of Risk Potential</td>
<td>10-16%</td>
</tr>
<tr>
<td>Physiological Adaptation</td>
<td>11-17%</td>
</tr>
</tbody>
</table>
Overview of Content
All content categories and subcategories reflect client needs across the life span in a variety of settings.

Safe and Effective Care Environment
The nurse promotes achievement of client outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect clients, family/significant others and other health care personnel.

- **Management of Care** - providing and directing nursing care that enhances the care delivery setting to protect clients, family/significant others and health care personnel.

Related content includes but is not limited to:

- Advance Directives
- Advocacy
- Case Management
- Client Rights
- Collaboration with Interdisciplinary Team
- Concepts of Management
- Confidentiality/Information Security
- Consultation
- Continuity of Care
- Delegation
- Establishing Priorities
- Ethical Practice
- Informed Consent
- Information Technology
- Legal Rights and Responsibilities
- Performance Improvement (Quality Improvement)
- Referrals
- Supervision
- **Safety and Infection Control** – protecting clients, family/significant others and health care personnel from health and environmental hazards.

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

**Health Promotion and Maintenance**

The nurse provides and directs nursing care of the client and family/significant others that incorporates the knowledge of expected growth and development principles; prevention and/or early detection of health problems, and strategies to achieve optimal health.

Related content includes but is **not limited** to:
- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Developmental Stages and Transitions
- Health and Wellness
- Health Promotion/Disease Prevention
- Health Screening
- High Risk Behaviors
- Lifestyle Choices
- Principles of Teaching/Learning
- Self-Care
- Techniques of Physical Assessment

**Psychosocial Integrity**

The nurse provides and directs nursing care that promotes and supports the emotional, mental and social well-being of the client and family/significant others experiencing stressful events, as well as clients with acute or chronic mental illness.

Related content includes but is **not limited** to:
- Abuse/Neglect
- Behavioral Interventions
- Chemical and Other Dependencies
- Coping Mechanisms
- Crisis Intervention
- Cultural Diversity
- End of Life Care
- Family Dynamics
- Grief and Loss
- Mental Health Concepts
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Stress Management
- Support Systems
- Therapeutic Communication
- Therapeutic Environment
Physiological Integrity

The nurse promotes physical health and wellness by providing care and comfort, reducing client risk potential and managing health alterations.

- Basic Care and Comfort - providing comfort and assistance in the performance of activities of daily living.
  
  Related content includes but is **not limited** to:
  
  - Assistive Devices
  - Elimination
  - Mobility/Immobility
  - Non-Pharmacological Comfort Interventions
  - Nutrition and Oral Hydration
  - Personal Hygiene
  - Rest and Sleep

- Pharmacological and Parenteral Therapies - providing care related to the administration of medications and parenteral therapies.
  
  Related content includes but is **not limited** to:
  
  - Adverse Effects/Contraindications /Side Effects/Interactions
  - Blood and Blood Products
  - Central Venous Access Devices
  - Dosage Calculation
  - Expected Actions/Outcomes
  - Medication Administration
  - Parenteral/Intravenous Therapies
  - Pharmacological Pain Management
  - Total Parenteral Nutrition

- Reduction of Risk Potential - reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatments or procedures.
  
  Related content includes but is not limited to:
  
  - Changes/Abnormalities in Vital Signs
  - Diagnostic Tests
  - Laboratory Values
  - Potential for Alterations in Body Systems
  - Potential for Complications of Diagnostic Tests/Treatments/Procedures
  - Potential for Complications from Surgical Procedures and Health Alterations
  - System Specific Assessments
  - Therapeutic Procedures

- Physiological Adaptation - managing and providing care for clients with acute, chronic or life threatening physical health conditions.
  
  Related content includes but is not limited to:
  
  - Alterations in Body Systems
  - Fluid and Electrolyte Imbalances
  - Hemodynamics
  - Illness Management
  - Medical Emergencies
  - Pathophysiology
  - Unexpected Response to Therapies
Administration of the NCLEX-RN® Examination

The NCLEX-RN® examination is administered to the candidate by Computerized Adaptive Testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. Items go through an extensive review process before they can be used as items on the examination.

In addition to multiple choice items, candidates may be administered items written in alternate formats. These formats may include but are not limited to multiple response, fill-in-the-blank, drag and drop, and/or hot spots. All item types may include multimedia such as charts, tables, graphics, sound and video.

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

All registered nurse candidates must answer a minimum of 75 items. The maximum number of items that the candidate may answer is 265 during the allotted six-hour time period. Examination instructions and all rest breaks are included in the measurement of the time allowed for a candidate to complete the examination.

Candidates should be aware and understand that the disclosure of any examination materials including the nature or content of examination items, before, during or after the examination is a violation of law. Violations of confidentiality and/or candidates’ rules can result in criminal prosecution or civil liability and/or disciplinary actions by the licensing agency including the denial of licensure.

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


### Proposed Timeline for Implementation of the 2010 NCLEX-RN® Test Plan

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2008</td>
<td>NCLEX® Examination Committee reviews RN practice analysis results and makes recommendations for the test plan.</td>
</tr>
<tr>
<td>November 2008</td>
<td>Proposed test plan is sent to Member Boards for feedback.</td>
</tr>
<tr>
<td>March 2009</td>
<td>NCLEX® Examination Committee may present the proposed test plan at the NCSBN Midyear Meeting.</td>
</tr>
<tr>
<td>April 2009</td>
<td>NCLEX® Examination Committee reviews feedback on the test plan and submits recommendations to the Delegate Assembly.</td>
</tr>
<tr>
<td>August 2009</td>
<td>Delegate Assembly action is provided.</td>
</tr>
<tr>
<td>September 2009</td>
<td>RN test plan is published and placed on the NCSBN Web site.</td>
</tr>
<tr>
<td>October 2009</td>
<td>The panel of judges meets to recommend the passing standard.</td>
</tr>
<tr>
<td>December 2009</td>
<td>NCSBN Board of Directors evaluates the passing standard.</td>
</tr>
<tr>
<td>April 2010</td>
<td>Implement the test plan and passing standard.</td>
</tr>
</tbody>
</table>
Attachment D  

Annual Report of Pearson VUE for the NCLEX®

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

Pearson VUE Organizational Changes

In April 2008, Dr. Betty Bergstrom assumed the role of vice president of testing services, which includes working with the NCLEX program. Dr. Bergstrom has over 16 years experience with large scale, computer-based testing and has research expertise in the areas of item response theory (IRT), equating, standard setting, computerized testing and adaptive testing. She has authored numerous articles and publications relating to computer-based testing. Dr. Bergstrom earned her MS and PhD in measurement, evaluation and statistical analysis from the University of Chicago.

In June 2008, Bob Bailey assumed the role of interim director of test development for the NCLEX program. Mr. Bailey has been working exclusively in the testing industry for the past 10 years and has worked in the development and delivery of innovative item types, such as scenario-based items. Bob has worked predominantly with high-stakes, high-volume national programs.

In August 2008, Jerry Gorham joined Pearson VUE as psychometric manager for the NCLEX program and is responsible for managing the NCLEX psychometrics and research program. Dr. Gorham’s work focuses on applied psychometrics in the area of high-stakes licensure examinations and his areas of expertise include licensure tests, computerized adaptive testing (CAT) examinations, item pool development, constructed-response items, IRT and non-parametric statistical methods.

In November 2008, Kathleen Spaltro joined Pearson VUE as a senior content editor for the NCLEX program. Kathleen brings five years of experience as a medical writer and editor for a physicians’ professional association and a teaching hospital, in addition to eight years as managing editor of two quarterly publications for a librarians’ professional association and 13 years of teaching professional writing at graduate schools of clinical psychology. After she earned a doctorate in English from Northwestern University, she also engaged in more than 25 years of freelance writing, editing, indexing, and proofreading for publishers, businesses, and nonprofit entities.

Special Reports

During the April 1, 2008, pool deployment, Pearson VUE standard operating procedures were not followed with regard to deploying the masking file (a file that turns off specific items). After careful review, Pearson VUE and NCSBN determined that all original candidate results should be retained. In May, Pearson VUE submitted a detailed report on the findings and recommendations to NCSBN.

Pearson VUE developed a series of new procedures and quality control checks to mitigate such incidents. In addition to the new procedures, a cross-functional team meeting is held approximately one week prior to the deployment of a new pool. Together with NCSBN, each quality control procedure and significant operational step is audibly confirmed and recorded, thus assuring that all quality control steps have been met.

Test Development

In 2008, psychometric and statistical analyses of the NCLEX data were conducted and documented as required. Pearson VUE developed multiple-choice items and items in alternate formats, including multiple-response, drag-and-drop, ordered response and chart/exhibit items. The focus was on producing high-quality traditional and alternate-format items at targeted difficulty levels in sufficient quantities to meet contract requirements. Pearson VUE conducted other test development activities, including coding and referencing of items. Pearson VUE facilitated Item Writing, Item Review, Master Pool Review, Sensitivity and Differential Item Functioning (DIF)
panels with subject matter experts (SMEs) and attended NCLEX® Examination Committee (NEC) and NCLEX® Item Review Subcommittee (NIRSC) meetings per the contractual agreement. Each quarter, Pearson VUE produced reports for the NEC on these activities.

**NCLEX® Examinations Operations**

In addition to Pearson VUE delivering the NCLEX examinations in the U.S., NCSBN has approved Pearson VUE to deliver the NCLEX examinations at 18 international Pearson Professional Centers (PPCs) in 11 countries. NCLEX examinations are currently being administered in Australia, Canada, Germany, Hong Kong, India, Japan, Mexico, the Philippines, Puerto Rico, Taiwan and the United Kingdom. These additions raise the number of PPCs delivering NCLEX examinations to a current total of 227 locations globally.

**Pearson VUE visits to NCSBN**

- Jan. 22-24, 2008, NCLEX® Examination Committee Meeting
- March 3-5, 2008, Midyear Meeting
- April 15-17, 2008, NCLEX® Examination Committee Meeting
- April 18, 2008, Pearson VUE Business Review Meeting
- May 7, 2008, Board of Directors Meeting
- June 12, 2008, NCLEX® Development Group Meeting
- July 7, 2008, Contract Evaluation Meeting
- July 22-23, 2008, NCLEX® Examination Committee Meeting
- Aug. 4-8, 2008, Delegate Assembly
- Oct. 21-23, 2008, NCLEX® Examination Committee Meeting
- Nov. 14, 2008, Pearson VUE Business Review Meeting

**Monthly Meetings/Conference Calls:**

- Weekly conference calls with NCSBN, test development and operations, psychometrics and administration
- Monthly administration conference call with Pearson VUE and NCSBN
- Conference calls with Pearson VUE and NCSBN content staff held periodically as needed
- Other visits and conference calls conducted as needed
- Cross-functional meetings are held a week before each scheduled pool deployment

**Summary of NCLEX® Examination Results for the 2007 Calendar Year**

Longitudinal summary statistics are provided in Tables 1 to 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 2007, the overall candidate volumes were higher for both the NCLEX-RN® (about +4.8 percent) and NCLEX-PN® (about +3.9 percent) examinations. The registered nurse (RN) passing rate for the overall group was 0.4 percentage points higher for 2008 than for 2007 and the passing rate for the reference group was 1.3 percentage points higher for this period compared to 2007. The PN overall passing rate was lower by 2.3 percentage points from 2007 and the practical nurse (PN) reference group passing rate was 1.7 percentage points lower than in 2007.

1Figures presented in this section may be slightly discrepant to those published in the 2008 NCLEX® Fact Sheet and NCLEX® Examination Pass Rates, as some candidates’ results were on hold at the time of publication for the fact sheet and pass rates documents. Figures shown here reflect the most current information in the NCLEX examination database, with all result holds reconciled.
The slight decrease in the PN overall and reference group passing rates may be a result of the increase in the PN passing standard that went into effect on April 1, 2008. Generally, however, RN and PN passing rates are consistent with expected variations in annual passing rates. Passing rates are also typically 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 2008 testing year for the NCLEX-RN examination:

- Overall, 209,769 NCLEX-RN examination candidates tested during 2008, as compared to 200,215 during the 2007 testing year. This represents an increase of approximately 4.8 percent.

- The candidate population reflected 129,121 first-time, U.S.-educated candidates who tested during 2008, as compared to 119,574 for the 2007 testing year, representing an 8.0 percent increase.

- The overall passing rate was 69.8 percent in 2008 compared to 69.4 percent in 2007. The passing rate for the reference group was 86.7 percent in 2008 and 85.4 percent in 2007.

- Approximately 50.6 percent of the total group and 54.1 percent of the reference group ended their tests after a minimum of 75 items were administered. This is slightly higher than the 2007 testing year, in which 48.6 percent of the total group and 50.9 percent of the reference group took minimum-length exams.

- The percentage of maximum-length test takers was 14.3 percent for the total group and 12.8 percent for the reference group. This is slightly lower than last year’s figures (15.4 percent for the total group and 14.5 percent for the reference group).

- The average time needed to take the NCLEX-RN examination during the 2008 testing period was 2.55 hours for the overall group and 2.28 hours for the reference group (approximately the same as last year’s average times of 2.54 hours and 2.26 hours, respectively).

- A total of 59.4 percent of the candidates chose to take a break during their examinations (compared to 59.0 percent last year).

- Overall, 2.2 percent of the total group and 1.1 percent of the reference group ran out of time before completing the test. These percentages of candidates timing out were comparable to the corresponding percentages for candidates during the 2007 testing year (2.1 percent and 1.0 percent, respectively).

- In general, the NCLEX-RN examination summary statistics for the 2008 testing period indicated patterns that were similar to those observed for the 2007 testing period. These results provide continued evidence that the administration of the NCLEX-RN examination is psychometrically sound.

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

- Overall 77,835 PN candidates tested in 2008, as compared to 74,933 PN candidates tested during 2007. This represents an increase of approximately 3.9 percent.

- The candidate population reflected 61,773 first-time, U.S.-educated candidates who tested in 2008, as compared to 60,235 for the 2007 testing year (an increase of approximately 2.6 percent).

- The overall passing rate was 76.2 percent in 2008 compared to 78.5 percent in 2007, and the reference group passing rate was 85.6 percent in 2008 compared to 87.3 percent in 2007.

- There were 54.4 percent of the total group and 58.8 percent of the reference group who ended their tests after a minimum of 85 items were administered. These figures are slightly lower than those from the 2007 testing year in which 55.1 percent of the total group and
59.9 percent of the reference group took minimum-length exams.

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

- The average time needed to take the NCLEX-PN examination during the 2008 testing period was 2.22 hours for the overall group, and 2.05 hours for the reference group (very similar to last year’s times of 2.21 and 2.04 hours, respectively).

- Overall, 1.8 percent of the total group and 0.9 percent of the reference group ran out of time before completing the test (equivalent to last year’s figures of 1.8 percent and 0.9 percent, respectively).

- In general, the NCLEX-PN examination summary statistics for the 2008 testing period indicated patterns that were similar to those observed for the 2007 testing period. These results provide continued evidence that the administration of the NCLEX-PN examination is psychometrically sound.

<table>
<thead>
<tr>
<th>Table 1: Longitudinal Technical Summary for the NCLEX-RN Examination: Group Statistics for 2008 Testing Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 08 - Mar 08</td>
</tr>
<tr>
<td>Overall</td>
</tr>
<tr>
<td>Number Testing</td>
</tr>
<tr>
<td>Percent Passing</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
</tr>
<tr>
<td>Ave. Test Time</td>
</tr>
<tr>
<td>% Taking Break</td>
</tr>
<tr>
<td>% Timing Out</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2: Longitudinal Technical Summary for the NCLEX-RN Examination: Group Statistics for 2007 Testing Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 07 - Mar 07</td>
</tr>
<tr>
<td>Overall</td>
</tr>
<tr>
<td>Number Testing</td>
</tr>
<tr>
<td>% Passing</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
</tr>
<tr>
<td>Ave. Test Time</td>
</tr>
<tr>
<td>% Taking Break</td>
</tr>
<tr>
<td>% Timing Out</td>
</tr>
</tbody>
</table>
### Table 3: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2008 Testing Year

<table>
<thead>
<tr>
<th>Operational Item Statistics</th>
<th>Jan 08 - Mar 08</th>
<th>Apr 08 - Jun 08</th>
<th>Jul 08 - Sep 08</th>
<th>Oct 08 - Dec 08</th>
<th>Cumulative 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>0.20</td>
<td>0.20</td>
<td>0.20</td>
<td>0.20</td>
<td>0.19</td>
</tr>
<tr>
<td>Std. Dev.</td>
<td>0.08</td>
<td>0.08</td>
<td>0.08</td>
<td>0.08</td>
<td>0.07</td>
</tr>
<tr>
<td>Ave. Item Time (secs)</td>
<td>72.7</td>
<td>24.1</td>
<td>74.0</td>
<td>32.3</td>
<td>72.9</td>
</tr>
<tr>
<td>Pretest Item Statistics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Items</td>
<td>890</td>
<td>851</td>
<td>1,322</td>
<td>245</td>
<td>3,308</td>
</tr>
<tr>
<td>Ave. Sample Size</td>
<td>496</td>
<td>571</td>
<td>513</td>
<td>653</td>
<td>534</td>
</tr>
<tr>
<td>Mean Point-Biserial</td>
<td>0.10</td>
<td>0.09</td>
<td>0.08</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td>Mean P+</td>
<td>0.57</td>
<td>0.52</td>
<td>0.56</td>
<td>0.57</td>
<td>0.55</td>
</tr>
<tr>
<td>Mean B-Value</td>
<td>-0.13</td>
<td>0.23</td>
<td>-0.09</td>
<td>-0.19</td>
<td>-0.03</td>
</tr>
<tr>
<td>SD B-Value</td>
<td>1.63</td>
<td>1.76</td>
<td>1.63</td>
<td>1.61</td>
<td>1.67</td>
</tr>
<tr>
<td>Total Number Flagged</td>
<td>295</td>
<td>345</td>
<td>604</td>
<td>96</td>
<td>1,340</td>
</tr>
<tr>
<td>% Items Flagged</td>
<td>33.1</td>
<td>40.5</td>
<td>45.7</td>
<td>39.2</td>
<td>40.5</td>
</tr>
</tbody>
</table>

### Table 4: Longitudinal Technical Summary for the NCLEX-RN® Examination: Item Statistics for 2007 Testing Year

<table>
<thead>
<tr>
<th>Operational Item Statistics</th>
<th>Jan 07 - Mar 07</th>
<th>Apr 07 - Jun 07</th>
<th>Jul 07 - Sep 07</th>
<th>Oct 07 - Dec 07</th>
<th>Cumulative 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>0.20</td>
<td>0.20</td>
<td>0.20</td>
<td>0.20</td>
<td>0.19</td>
</tr>
<tr>
<td>Std. Dev.</td>
<td>0.08</td>
<td>0.08</td>
<td>0.08</td>
<td>0.07</td>
<td>0.07</td>
</tr>
<tr>
<td>Ave. Item Time (secs)</td>
<td>73.7</td>
<td>28.9</td>
<td>70.8</td>
<td>23.7</td>
<td>70.1</td>
</tr>
<tr>
<td>Pretest Item Statistics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Items</td>
<td>489</td>
<td>519</td>
<td>1,289</td>
<td>217</td>
<td>2,514</td>
</tr>
<tr>
<td>Ave. Sample Size</td>
<td>821</td>
<td>900</td>
<td>596</td>
<td>678</td>
<td>710</td>
</tr>
<tr>
<td>Mean Point-Biserial</td>
<td>0.07</td>
<td>0.07</td>
<td>0.07</td>
<td>0.10</td>
<td>0.07</td>
</tr>
<tr>
<td>Mean P+</td>
<td>0.56</td>
<td>0.56</td>
<td>0.55</td>
<td>0.53</td>
<td>0.55</td>
</tr>
<tr>
<td>Mean B-Value</td>
<td>-0.17</td>
<td>-0.06</td>
<td>-0.04</td>
<td>0.02</td>
<td>-0.05</td>
</tr>
<tr>
<td>SD B-Value</td>
<td>1.43</td>
<td>1.46</td>
<td>1.62</td>
<td>1.58</td>
<td>1.55</td>
</tr>
<tr>
<td>Total Number Flagged</td>
<td>215</td>
<td>237</td>
<td>583</td>
<td>73</td>
<td>1,108</td>
</tr>
<tr>
<td>% Items Flagged</td>
<td>44.0</td>
<td>45.7</td>
<td>45.2</td>
<td>33.6</td>
<td>44.1</td>
</tr>
</tbody>
</table>

### Table 5: Longitudinal Technical Summary for the NCLEX-PN Group Statistics for 2008 Testing Year

<table>
<thead>
<tr>
<th>Overall</th>
<th>1st Time U.S. ED</th>
<th>Overall</th>
<th>1st Time U.S. ED</th>
<th>Overall</th>
<th>1st Time U.S. ED</th>
<th>Overall</th>
<th>1st Time U.S. ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Testing</td>
<td>18,047</td>
<td>15,452</td>
<td>11,378</td>
<td>26,497</td>
<td>22,506</td>
<td>17,839</td>
<td>13,460</td>
</tr>
<tr>
<td>% Passing</td>
<td>76.8</td>
<td>85.4</td>
<td>82.0</td>
<td>80.8</td>
<td>83.3</td>
<td>72.2</td>
<td>82.6</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>115.1</td>
<td>110.7</td>
<td>119.4</td>
<td>114.6</td>
<td>114.5</td>
<td>111.1</td>
<td>119.2</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>56.1</td>
<td>60.8</td>
<td>57.6</td>
<td>56.7</td>
<td>60.1</td>
<td>51.8</td>
<td>56.0</td>
</tr>
<tr>
<td>Ave. Test Time</td>
<td>2.22</td>
<td>2.04</td>
<td>2.09</td>
<td>2.12</td>
<td>1.98</td>
<td>2.31</td>
<td>2.13</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>52.9</td>
<td>46.1</td>
<td>48.2</td>
<td>49.6</td>
<td>44.1</td>
<td>57.5</td>
<td>50.3</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>2.1</td>
<td>1.2</td>
<td>0.8</td>
<td>1.4</td>
<td>0.7</td>
<td>1.9</td>
<td>0.9</td>
</tr>
</tbody>
</table>
### Table 6: Longitudinal Technical Summary for the NCLEX-PN Group Statistics for 2007 Testing Year

<table>
<thead>
<tr>
<th></th>
<th>Jan 07 - Mar 07</th>
<th>Apr 07 - Jun 07</th>
<th>Jul 07 - Sep 07</th>
<th>Oct 07 - Dec 07</th>
<th>Cumulative 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Testing</td>
<td>Overall</td>
<td>1st Time</td>
<td>Overall</td>
<td>1st Time</td>
<td>Overall</td>
</tr>
<tr>
<td>Overall</td>
<td>16,500</td>
<td>13,123</td>
<td>15,566</td>
<td>11,741</td>
<td>26,184</td>
</tr>
<tr>
<td>% Passing</td>
<td>77.9</td>
<td>87.0</td>
<td>74.9</td>
<td>86.1</td>
<td>83.3</td>
</tr>
<tr>
<td>Ave. # Items Taken</td>
<td>117.3</td>
<td>112.5</td>
<td>118.6</td>
<td>112.9</td>
<td>113.0</td>
</tr>
<tr>
<td>% Taking Min # Items</td>
<td>53.6</td>
<td>58.2</td>
<td>52.7</td>
<td>58.4</td>
<td>58.2</td>
</tr>
<tr>
<td>% Taking Max # Items</td>
<td>17.7</td>
<td>14.8</td>
<td>18.4</td>
<td>15.0</td>
<td>15.1</td>
</tr>
<tr>
<td>Ave. Test Time</td>
<td>2.15</td>
<td>1.97</td>
<td>2.30</td>
<td>2.09</td>
<td>2.11</td>
</tr>
<tr>
<td>% Taking Break</td>
<td>51.3</td>
<td>44.2</td>
<td>57.2</td>
<td>49.3</td>
<td>48.9</td>
</tr>
<tr>
<td>% Timing Out</td>
<td>1.5</td>
<td>0.8</td>
<td>2.1</td>
<td>1.1</td>
<td>1.4</td>
</tr>
</tbody>
</table>

### Table 7: Longitudinal Technical Summary for the NCLEX-PN Examination: Item Statistics for 2008 Testing Year

#### Operational Item Statistics

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

#### Pretest Item Statistics

- # of Items: 582
- Ave. Sample Size: 620
- Mean Point-Biserial: 0.13
- Mean P+: 0.53
- Mean B-Value: -0.03
- SD B-Value: 1.66
- Total Number Flagged: 157
- % Items Flagged: 27.0

### Table 8: Longitudinal Technical Summary for the NCLEX-PN Examination: Item Statistics for 2007 Testing Year

#### Operational Item Statistics

<table>
<thead>
<tr>
<th></th>
<th>Jan 07 - Mar 07</th>
<th>Apr 07 - Jun 07</th>
<th>Jul 07 - Sep 07</th>
<th>Oct 07 - Dec 07</th>
<th>Cumulative 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point-Biserial</td>
<td>Mean</td>
<td>0.20</td>
<td>0.20</td>
<td>0.20</td>
<td>0.20</td>
</tr>
<tr>
<td>Ave. Item Time (secs)</td>
<td>64.0</td>
<td>17.5</td>
<td>67.1</td>
<td>19.9</td>
<td>63.4</td>
</tr>
</tbody>
</table>

#### Pretest Item Statistics

- # of Items: 488
- Ave. Sample Size: 631
- Mean Point-Biserial: 0.10
- Mean P+: 0.53
- Mean B-Value: -0.08
- SD B-Value: 1.33
- Total Number Flagged: 167
- % Items Flagged: 34.2
International Testing Update

Pearson VUE has a total of 209 PPCs in the U.S. and 18 PPCs internationally in Australia, Canada, Germany, Hong Kong, India, Japan, Mexico, the Philippines, Puerto Rico, Taiwan and the United Kingdom, for a total of 227 test centers globally.

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

### Table 1: NCLEX International Test Center Volume by Member Board* Jan. 1 – Dec. 31, 2008

<table>
<thead>
<tr>
<th>Member Board</th>
<th>Total</th>
<th>Sydney, Australia</th>
<th>Burnaby, Canada</th>
<th>Montreal, Canada</th>
<th>Toronto, Canada</th>
<th>Frankfurt, Germany</th>
<th>Hong Kong, Hong Kong</th>
<th>Bangalore, India</th>
<th>Chennai, India</th>
<th>Hyderabad, India</th>
<th>Mumbai, India</th>
<th>New Delhi, India</th>
<th>Chiyoda-ku (Tokyo), Japan</th>
<th>Yokohama City, Japan</th>
<th>Mexico City, Mexico</th>
<th>Manila, Philippines</th>
<th>San Juan, Puerto Rico</th>
<th>Taipei, Taiwan</th>
<th>London, United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Alaska</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Arizona</td>
<td>177</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>15</td>
<td>15</td>
<td>17</td>
<td>4</td>
<td>37</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>78</td>
<td>0</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Arkansas</td>
<td>38</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>California - RN</td>
<td>12351</td>
<td>42</td>
<td>68</td>
<td>18</td>
<td>118</td>
<td>38</td>
<td>591</td>
<td>46</td>
<td>47</td>
<td>13</td>
<td>45</td>
<td>158</td>
<td>28</td>
<td>5</td>
<td>2</td>
<td>10230</td>
<td>1</td>
<td>274</td>
<td>627</td>
</tr>
<tr>
<td>California - VN</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Colorado</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Connecticut</td>
<td>48</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>39</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>19</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Florida</td>
<td>221</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>28</td>
<td>13</td>
<td>4</td>
<td>7</td>
<td>12</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>110</td>
<td>1</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Georgia - RN</td>
<td>22</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>64</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Hawaii</td>
<td>24</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>13</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Idaho</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Illinois</td>
<td>615</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>14</td>
<td>5</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>565</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Indiana</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Iowa</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Kentucky</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maryland</td>
<td>87</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>66</td>
<td>0</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>56</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>16</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Michigan</td>
<td>184</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>13</td>
<td>11</td>
<td>2</td>
<td>11</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>117</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Minnesota</td>
<td>278</td>
<td>0</td>
<td>74</td>
<td>31</td>
<td>135</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>31</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Mississippi</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Missouri</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nebraska</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nevada</td>
<td>89</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>79</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
## Table 1: NCLEX International Test Center Volume by Member Board* Jan. 1 – Dec. 31, 2008

<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>Hong Kong, Hong Kong</th>
<th>Bangalore, India</th>
<th>Chennai, India</th>
<th>Hyderabad, India</th>
<th>Mumbai, India</th>
<th>New Delhi, India</th>
<th>Chiyoda, Tokyo, Japan</th>
<th>Yokohama City, Japan</th>
<th>Mexico City, Mexico</th>
<th>Manila, Philippines</th>
<th>San Juan, Puerto Rico</th>
<th>Taipei, Taiwan</th>
<th>London, United Kingdom</th>
<th>Wyoming</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Hampshire</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Jersey</td>
<td>140</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Mexico</td>
<td>2774</td>
<td>23</td>
<td>8</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td>211</td>
<td>70</td>
<td>85</td>
<td>24</td>
<td>70</td>
<td>26</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>2008</td>
<td>3</td>
<td>3</td>
<td>229</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>New York</td>
<td>2798</td>
<td>25</td>
<td>11</td>
<td>7</td>
<td>43</td>
<td>11</td>
<td>345</td>
<td>52</td>
<td>23</td>
<td>8</td>
<td>13</td>
<td>21</td>
<td>85</td>
<td>7</td>
<td>0</td>
<td>724</td>
<td>3</td>
<td>546</td>
<td>102</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>North Carolina</td>
<td>70</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>10</td>
<td>7</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>28</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>North Dakota</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Northern Mariana Islands</td>
<td>495</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ohio</td>
<td>17</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Oregon</td>
<td>18</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>68</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>28</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>South Carolina</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>South Dakota</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tennessee</td>
<td>38</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>34</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Texas</td>
<td>303</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>226</td>
<td>0</td>
<td>226</td>
<td>0</td>
<td>36</td>
<td>0</td>
<td>226</td>
</tr>
<tr>
<td>Vermont</td>
<td>4693</td>
<td>18</td>
<td>3</td>
<td>4</td>
<td>15</td>
<td>7</td>
<td>72</td>
<td>597</td>
<td>434</td>
<td>65</td>
<td>187</td>
<td>387</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>2417</td>
<td>0</td>
<td>0</td>
<td>482</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Virginia</td>
<td>40</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>11</td>
<td>7</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Washington</td>
<td>25</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>West Virginia - PN</td>
<td>26</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>West Virginia - RN</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>67</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>47</td>
<td>17</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>25871</td>
<td>126</td>
<td>204</td>
<td>67</td>
<td>374</td>
<td>94</td>
<td>1268</td>
<td>892</td>
<td>679</td>
<td>132</td>
<td>362</td>
<td>689</td>
<td>893</td>
<td>18</td>
<td>12</td>
<td>17582</td>
<td>35</td>
<td>826</td>
<td>1618</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Only Member Boards with international test center candidate data are represented.*
### Table 2: NCLEX International Test Center Volume by Country of Education Jan. 1 – Dec. 31, 2008

<table>
<thead>
<tr>
<th>Member Board</th>
<th>Total</th>
<th>Sydney, Australia</th>
<th>Burnaby, Canada</th>
<th>Montreal, Canada</th>
<th>Toronto, Canada</th>
<th>Frankfurt, Germany</th>
<th>Hong Kong, Hong Kong</th>
<th>Bangalore, India</th>
<th>Chennai, India</th>
<th>Hyderabad, India</th>
<th>Mumbai, India</th>
<th>New Delhi, India</th>
<th>Chiyoda-ku Tokyo, Japan</th>
<th>Yokohama City, Japan</th>
<th>Mexico City, Mexico</th>
<th>Manila, Philippines</th>
<th>San Juan, Puerto Rico</th>
<th>Taipei, Taiwan</th>
<th>London, United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Algeria</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Argentina</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Australia</td>
<td>18</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Barbados</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Belarus</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Belgium</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Botswana</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Brazil</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cambodia</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cameroon</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Canada</td>
<td>306</td>
<td>0</td>
<td>88</td>
<td>43</td>
<td>174</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>China</td>
<td>261</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>221</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Cuba</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dominica</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Eritrea</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Finland</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>France</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gambia</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Germany</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ghana</td>
<td>17</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Greece</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Guyana</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hungary</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Iceland</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

| Member Board | Total | Sydney, Australia | Burnaby, Canada | Montreal, Canada | Toronto, Canada | Frankfurt, Germany | Hong Kong, Hong Kong | Bangalore, India | Chennai, India | Hyderabad, India | Mumbai, India | New Delhi, India | Chiyoda, Tokyo, Japan | Yokohama, City, Japan | Tokyo, Japan | Mexico City, Mexico | Mexico, Philippines | San Juan, Puerto Rico | Taipei, Taiwan | London, United Kingdom | Naples | Italy | Jordan | Kenya | Korea, North | Korea, South | Latvia | Lebanon | Macedonia | Malaysia | Mexico | Moldova | Myanmar | Nepal | Netherlands | New Zealand | Nigeria | Norway | Pakistan | Peru | Philippines | Pitcairn | Poland |
|--------------|-------|------------------|----------------|-----------------|-----------------|------------------|---------------------|---------------------|-----------------|-----------------|-------------|----------------|----------------------|---------------------|----------|-------------------|----------------|----------------|---------------|----------------|----------|-------------|--------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
| India        | 2908  | 15               | 5              | 0               | 26              | 2                | 1                  | 862                 | 667             | 122            | 277           | 628          | 0                  | 0                   | 0                   | 2                  | 0                | 0               | 301             |
| Indonesia    | 4     | 0                | 0              | 0               | 0               | 1                | 0                  | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 3                  | 0               | 0               | 0               |
| Iran         | 15    | 0                | 0              | 0               | 4               | 0                | 0                  | 0                   | 0               | 1              | 2            | 5            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 3               |
| Ireland      | 1     | 0                | 0              | 0               | 0               | 0                | 0                  | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 1               |
| Israel       | 51    | 0                | 0              | 0               | 3               | 24               | 0                  | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 24              |
| Italy        | 1     | 0                | 0              | 0               | 0               | 0                | 0                  | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 1               |
| Jamaica      | 17    | 0                | 0              | 0               | 1               | 0                | 0                  | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 16              |
| Japan        | 41    | 0                | 0              | 0               | 0               | 1                | 0                  | 0                   | 0               | 0              | 0            | 0            | 36                  | 0                   | 0                   | 0                  | 1               | 0               |
| Jordan       | 2     | 0                | 0              | 0               | 0               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 0               |
| Kenya        | 55    | 0                | 0              | 0               | 0               | 0                | 0                   | 3                   | 1               | 10             | 42           | 2            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 0               |
| Korea, North | 2     | 0                | 0              | 0               | 0               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 0               |
| Korea, South | 1763  | 15               | 10             | 0               | 8               | 1                | 309                 | 0                   | 0               | 0              | 0            | 1            | 846                 | 6                   | 0                   | 50                 | 0               | 515             |
| Latvia       | 1     | 0                | 0              | 0               | 0               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 0               |
| Lebanon      | 10    | 0                | 0              | 0               | 1               | 1                | 0                   | 0                   | 0               | 0              | 0            | 6            | 0                  | 0                   | 0                   | 1                  | 0               | 0               |
| Macedonia    | 1     | 0                | 0              | 0               | 0               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 0               |
| Malaysia     | 6     | 1                | 0              | 0               | 0               | 0                | 3                   | 1                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 1                  | 0               | 0               |
| Mexico       | 5     | 0                | 0              | 0               | 0               | 0                | 0                   | 0                   | 0               | 0              | 0            | 5            | 0                  | 0                   | 0                   | 0                  | 0               | 0               |
| Moldova      | 1     | 0                | 0              | 0               | 1               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 0               |
| Myanmar      | 3     | 0                | 0              | 0               | 0               | 0               | 0                   | 1                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 1                  | 0                  | 0               | 0               |
| Nepal        | 24    | 0                | 0              | 0               | 2               | 1                | 1                   | 0                   | 2               | 0              | 12           | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 6               |
| Netherlands  | 3     | 0                | 0              | 0               | 2               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 0               |
| New Zealand  | 18    | 15               | 0              | 0               | 1               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 2               |
| Nigeria      | 49    | 1                | 0              | 1               | 5               | 5                | 0                   | 3                   | 0               | 0              | 2            | 2            | 0                  | 0                   | 0                   | 4                  | 0               | 0               | 26              |
| Norway       | 1     | 0                | 0              | 0               | 0               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 0               |
| Pakistan     | 22    | 0                | 1              | 0               | 0               | 0               | 18                  | 0                   | 1               | 0              | 0            | 1            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 1               |
| Peru         | 2     | 0                | 0              | 0               | 0               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 0               |
| Philippines  | 19398 | 49               | 66             | 20              | 126            | 16               | 590                 | 12                   | 4               | 5              | 31           | 22           | 6                  | 5                   | 0                   | 17496              | 0              | 13              | 937             |
| Pitcairn     | 1     | 0                | 0              | 0               | 0               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 1                  | 0               | 0               |
| Poland       | 2     | 0                | 0              | 0               | 0               | 0                | 0                   | 0                   | 0               | 0              | 0            | 0            | 0                  | 0                   | 0                   | 0                  | 0               | 0               | 2               |
### Table 2: NCLEX International Test Center Volume by Country of Education Jan. 1 – Dec. 31, 2008

<table>
<thead>
<tr>
<th>Member Board</th>
<th>Portugal</th>
<th>Puerto Rico</th>
<th>Romania</th>
<th>Russian Federation</th>
<th>Saudi Arabia</th>
<th>Sierra Leone</th>
<th>Singapore</th>
<th>Slovakia</th>
<th>South Africa</th>
<th>Spain</th>
<th>Sri Lanka</th>
<th>St. Vincent and Grenadines</th>
<th>Sudan</th>
<th>Taiwan</th>
<th>Thailand</th>
<th>Trinidad and Tobago</th>
<th>Uganda</th>
<th>Ukraine</th>
<th>United Arab Emirates</th>
<th>United Kingdom</th>
<th>United States</th>
<th>Zambia</th>
<th>Zimbabwe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5</td>
<td>32</td>
<td>8</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>14</td>
<td>1</td>
<td>19</td>
<td>2</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>297</td>
<td>106</td>
<td>1</td>
<td>1</td>
<td>16</td>
<td>3</td>
<td>154</td>
<td>111</td>
<td>5</td>
<td>4</td>
<td>25871</td>
</tr>
<tr>
<td>Sydney, Australia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burnaby, Canada</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montreal, Canada</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toronto, Canada</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frankfurt, Germany</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hong Kong, Hong Kong</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangalore, India</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chennai, India</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyderabad, India</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumbai, India</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Delhi, India</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiyoda-ku (Tokyo), Japan</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yokohama City, Japan</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mexico City, Mexico</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manila, Philippines</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Juan, Puerto Rico</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taipei, Taiwan</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>London, United Kingdom</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>111</td>
<td>20</td>
<td>1</td>
<td>16</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>19</td>
<td>17</td>
<td>0</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25871</td>
<td>126</td>
<td>204</td>
<td>67</td>
<td>374</td>
<td>94</td>
<td>1268</td>
<td>892</td>
<td>679</td>
<td>132</td>
<td>362</td>
<td>689</td>
<td>893</td>
<td>18</td>
<td>12</td>
<td>17582</td>
<td>35</td>
<td>826</td>
<td>1618</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 3: NCLEX International Volume by Testing Center Jan. 1 – Dec. 31, 2008

<table>
<thead>
<tr>
<th>Site ID</th>
<th>City</th>
<th>Country</th>
<th>Total</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>50482</td>
<td>Sydney</td>
<td>Australia</td>
<td>126</td>
<td>8</td>
<td>14</td>
<td>15</td>
<td>11</td>
<td>7</td>
<td>13</td>
<td>9</td>
<td>13</td>
<td>8</td>
<td>6</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>50486</td>
<td>Burnaby</td>
<td>Canada</td>
<td>204</td>
<td>15</td>
<td>23</td>
<td>13</td>
<td>12</td>
<td>11</td>
<td>25</td>
<td>25</td>
<td>20</td>
<td>17</td>
<td>18</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>50485</td>
<td>Montreal</td>
<td>Canada</td>
<td>67</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>10</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>50484</td>
<td>Toronto</td>
<td>Canada</td>
<td>374</td>
<td>39</td>
<td>19</td>
<td>30</td>
<td>38</td>
<td>33</td>
<td>26</td>
<td>40</td>
<td>33</td>
<td>42</td>
<td>26</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>50491</td>
<td>Frankfurt</td>
<td>Germany</td>
<td>94</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>10</td>
<td>7</td>
<td>8</td>
<td>10</td>
<td>1</td>
<td>12</td>
<td>6</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>50493</td>
<td>Hong Kong</td>
<td>Hong Kong</td>
<td>1268</td>
<td>98</td>
<td>74</td>
<td>83</td>
<td>134</td>
<td>127</td>
<td>110</td>
<td>131</td>
<td>112</td>
<td>75</td>
<td>122</td>
<td>96</td>
<td>106</td>
</tr>
<tr>
<td>50497</td>
<td>Bangalore</td>
<td>India</td>
<td>892</td>
<td>131</td>
<td>101</td>
<td>99</td>
<td>94</td>
<td>87</td>
<td>56</td>
<td>83</td>
<td>38</td>
<td>47</td>
<td>68</td>
<td>34</td>
<td>54</td>
</tr>
<tr>
<td>50498</td>
<td>Chennai</td>
<td>India</td>
<td>679</td>
<td>89</td>
<td>69</td>
<td>54</td>
<td>77</td>
<td>55</td>
<td>62</td>
<td>67</td>
<td>50</td>
<td>51</td>
<td>33</td>
<td>29</td>
<td>43</td>
</tr>
<tr>
<td>50496</td>
<td>Hyderabad</td>
<td>India</td>
<td>132</td>
<td>26</td>
<td>10</td>
<td>7</td>
<td>19</td>
<td>14</td>
<td>17</td>
<td>14</td>
<td>11</td>
<td>10</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>50494</td>
<td>Mumbai</td>
<td>India</td>
<td>362</td>
<td>33</td>
<td>36</td>
<td>23</td>
<td>38</td>
<td>41</td>
<td>27</td>
<td>38</td>
<td>33</td>
<td>27</td>
<td>28</td>
<td>6</td>
<td>32</td>
</tr>
<tr>
<td>50495</td>
<td>New Delhi</td>
<td>India</td>
<td>689</td>
<td>81</td>
<td>64</td>
<td>44</td>
<td>44</td>
<td>68</td>
<td>54</td>
<td>64</td>
<td>61</td>
<td>43</td>
<td>63</td>
<td>26</td>
<td>77</td>
</tr>
<tr>
<td>50500</td>
<td>Chiyoda-ku</td>
<td>Japan</td>
<td>893</td>
<td>72</td>
<td>100</td>
<td>90</td>
<td>73</td>
<td>91</td>
<td>74</td>
<td>61</td>
<td>65</td>
<td>75</td>
<td>65</td>
<td>63</td>
<td>64</td>
</tr>
<tr>
<td>50501</td>
<td>Yokohama City</td>
<td>Japan</td>
<td>18</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>50503</td>
<td>Mexico City</td>
<td>Mexico</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>50555</td>
<td>Manila</td>
<td>Philippines</td>
<td>17582</td>
<td>1351</td>
<td>1134</td>
<td>1396</td>
<td>1506</td>
<td>1444</td>
<td>1448</td>
<td>1551</td>
<td>1397</td>
<td>1639</td>
<td>1705</td>
<td>1429</td>
<td>1582</td>
</tr>
<tr>
<td>47108</td>
<td>San Juan</td>
<td>Puerto Rico</td>
<td>35</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>50506</td>
<td>Taipei</td>
<td>Taiwan</td>
<td>826</td>
<td>94</td>
<td>55</td>
<td>116</td>
<td>88</td>
<td>83</td>
<td>65</td>
<td>64</td>
<td>38</td>
<td>67</td>
<td>52</td>
<td>48</td>
<td>56</td>
</tr>
<tr>
<td>50140</td>
<td>London</td>
<td>United Kingdom</td>
<td>1618</td>
<td>188</td>
<td>154</td>
<td>91</td>
<td>175</td>
<td>169</td>
<td>133</td>
<td>143</td>
<td>128</td>
<td>128</td>
<td>109</td>
<td>95</td>
<td>105</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>25871</td>
<td>2247</td>
<td>1868</td>
<td>2075</td>
<td>2327</td>
<td>2249</td>
<td>2124</td>
<td>2310</td>
<td>2006</td>
<td>2256</td>
<td>2312</td>
<td>1895</td>
<td>2202</td>
</tr>
</tbody>
</table>
Table 4: NCLEX International Volume – by Pass/Fail Rate Jan. 1 – Dec. 31, 2008

<table>
<thead>
<tr>
<th>Site ID</th>
<th>City</th>
<th>Country</th>
<th>Total Taken</th>
<th>Total Passed</th>
<th>Jan (%)</th>
<th>Feb (%)</th>
<th>Mar (%)</th>
<th>Apr (%)</th>
<th>May (%)</th>
<th>Jun (%)</th>
<th>Jul (%)</th>
<th>Aug (%)</th>
<th>Sep (%)</th>
<th>Oct (%)</th>
<th>Nov (%)</th>
<th>Dec (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50482</td>
<td>Sydney</td>
<td>Australia</td>
<td>126</td>
<td>57</td>
<td>25.00</td>
<td>21.43</td>
<td>60.00</td>
<td>36.36</td>
<td>71.43</td>
<td>38.46</td>
<td>33.33</td>
<td>38.46</td>
<td>62.50</td>
<td>33.33</td>
<td>57.14</td>
<td>66.67</td>
</tr>
<tr>
<td>50486</td>
<td>Burnaby</td>
<td>Canada</td>
<td>204</td>
<td>98</td>
<td>53.33</td>
<td>30.43</td>
<td>69.23</td>
<td>41.67</td>
<td>54.55</td>
<td>52.00</td>
<td>64.00</td>
<td>60.00</td>
<td>29.41</td>
<td>38.89</td>
<td>33.33</td>
<td>43.75</td>
</tr>
<tr>
<td>50485</td>
<td>Montreal</td>
<td>Canada</td>
<td>67</td>
<td>17</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>50.00</td>
<td>0.00</td>
<td>40.00</td>
<td>25.00</td>
<td>0.00</td>
<td>33.33</td>
<td>60.00</td>
<td>42.86</td>
<td>14.29</td>
</tr>
<tr>
<td>50484</td>
<td>Toronto</td>
<td>Canada</td>
<td>374</td>
<td>142</td>
<td>30.77</td>
<td>47.37</td>
<td>36.67</td>
<td>39.47</td>
<td>24.24</td>
<td>38.46</td>
<td>42.50</td>
<td>33.33</td>
<td>35.71</td>
<td>46.15</td>
<td>41.67</td>
<td>50.00</td>
</tr>
<tr>
<td>50491</td>
<td>Frankfurt</td>
<td>Germany</td>
<td>94</td>
<td>54</td>
<td>44.44</td>
<td>100.00</td>
<td>50.00</td>
<td>80.00</td>
<td>71.43</td>
<td>50.00</td>
<td>50.00</td>
<td>100.00</td>
<td>75.00</td>
<td>33.33</td>
<td>22.22</td>
<td>44.44</td>
</tr>
<tr>
<td>50493</td>
<td>Hong Kong</td>
<td>Hong Kong</td>
<td>1268</td>
<td>575</td>
<td>36.73</td>
<td>40.54</td>
<td>36.14</td>
<td>45.52</td>
<td>48.82</td>
<td>50.00</td>
<td>46.56</td>
<td>44.64</td>
<td>49.33</td>
<td>49.18</td>
<td>45.83</td>
<td>46.23</td>
</tr>
<tr>
<td>50497</td>
<td>Bangalore</td>
<td>India</td>
<td>892</td>
<td>532</td>
<td>73.28</td>
<td>63.37</td>
<td>72.73</td>
<td>56.38</td>
<td>54.02</td>
<td>50.00</td>
<td>51.81</td>
<td>63.16</td>
<td>55.32</td>
<td>51.47</td>
<td>50.00</td>
<td>50.00</td>
</tr>
<tr>
<td>50498</td>
<td>Chennai</td>
<td>India</td>
<td>679</td>
<td>380</td>
<td>67.42</td>
<td>55.07</td>
<td>57.41</td>
<td>53.25</td>
<td>47.27</td>
<td>38.71</td>
<td>53.73</td>
<td>62.00</td>
<td>58.82</td>
<td>60.61</td>
<td>62.07</td>
<td>58.14</td>
</tr>
<tr>
<td>50496</td>
<td>Hyderabad</td>
<td>India</td>
<td>132</td>
<td>67</td>
<td>46.15</td>
<td>30.00</td>
<td>71.43</td>
<td>63.16</td>
<td>50.00</td>
<td>57.14</td>
<td>42.86</td>
<td>72.73</td>
<td>30.00</td>
<td>0.00</td>
<td>50.00</td>
<td>80.00</td>
</tr>
<tr>
<td>50494</td>
<td>Mumbai</td>
<td>India</td>
<td>362</td>
<td>204</td>
<td>60.61</td>
<td>58.33</td>
<td>52.17</td>
<td>57.89</td>
<td>53.66</td>
<td>44.44</td>
<td>57.89</td>
<td>54.55</td>
<td>48.15</td>
<td>57.14</td>
<td>66.67</td>
<td>68.75</td>
</tr>
<tr>
<td>50495</td>
<td>New Delhi</td>
<td>India</td>
<td>689</td>
<td>320</td>
<td>59.26</td>
<td>62.50</td>
<td>52.27</td>
<td>56.82</td>
<td>44.12</td>
<td>44.44</td>
<td>43.75</td>
<td>37.70</td>
<td>37.21</td>
<td>39.68</td>
<td>34.62</td>
<td>37.66</td>
</tr>
<tr>
<td>50500</td>
<td>Chiyoda-ku</td>
<td>Japan</td>
<td>893</td>
<td>496</td>
<td>59.72</td>
<td>59.00</td>
<td>58.89</td>
<td>42.47</td>
<td>50.55</td>
<td>55.41</td>
<td>50.82</td>
<td>43.08</td>
<td>58.67</td>
<td>64.62</td>
<td>58.73</td>
<td>64.06</td>
</tr>
<tr>
<td>50501</td>
<td>Yokohama City</td>
<td>Japan</td>
<td>18</td>
<td>6</td>
<td>33.33</td>
<td>50.00</td>
<td>100.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>100.00</td>
</tr>
<tr>
<td>50503</td>
<td>Mexico City</td>
<td>Mexico</td>
<td>12</td>
<td>5</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>25.00</td>
<td>0.00</td>
<td>100.00</td>
<td>0.00</td>
<td>50.00</td>
<td>0.00</td>
<td>0.00</td>
<td>100.00</td>
</tr>
<tr>
<td>54555</td>
<td>Manila</td>
<td>Philippines</td>
<td>17582</td>
<td>8619</td>
<td>48.11</td>
<td>50.53</td>
<td>51.50</td>
<td>46.35</td>
<td>50.48</td>
<td>49.03</td>
<td>48.29</td>
<td>48.25</td>
<td>50.09</td>
<td>49.56</td>
<td>49.20</td>
<td>47.28</td>
</tr>
<tr>
<td>47108</td>
<td>San Juan</td>
<td>Puerto Rico</td>
<td>35</td>
<td>10</td>
<td>25.00</td>
<td>0.00</td>
<td>25.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>33.33</td>
<td>50.00</td>
<td>50.00</td>
<td>0.00</td>
<td>33.33</td>
<td>80.00</td>
</tr>
<tr>
<td>50506</td>
<td>Taipei</td>
<td>Taiwan</td>
<td>826</td>
<td>417</td>
<td>54.26</td>
<td>56.36</td>
<td>56.90</td>
<td>48.86</td>
<td>46.99</td>
<td>44.62</td>
<td>50.00</td>
<td>36.84</td>
<td>56.72</td>
<td>50.00</td>
<td>58.33</td>
<td>35.71</td>
</tr>
<tr>
<td>50140</td>
<td>London</td>
<td>United Kingdom</td>
<td>1618</td>
<td>553</td>
<td>35.64</td>
<td>35.06</td>
<td>41.76</td>
<td>34.29</td>
<td>31.95</td>
<td>37.59</td>
<td>35.66</td>
<td>25.78</td>
<td>33.59</td>
<td>41.28</td>
<td>29.47</td>
<td>28.57</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
<td></td>
<td><strong>25871</strong></td>
<td><strong>12552</strong></td>
<td><strong>49.45</strong></td>
<td><strong>51.07</strong></td>
<td><strong>57.32</strong></td>
<td><strong>43.63</strong></td>
<td><strong>47.81</strong></td>
<td><strong>45.32</strong></td>
<td><strong>47.17</strong></td>
<td><strong>44.82</strong></td>
<td><strong>47.13</strong></td>
<td><strong>43.12</strong></td>
<td><strong>49.74</strong></td>
<td><strong>46.13</strong></td>
</tr>
</tbody>
</table>
Report of the APRN Committee

Background
For the last four years, the APRN (advanced practice registered nurse) Committee has worked with the APRN Consensus Group to develop a consensus model for APRN regulation. The APRN Consensus Group consists of 26 organizations representing APRN stakeholders. The Consensus Model for APRN Regulation will be the model of the future.

In the consensus model, there are four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS) and certified nurse practitioner (CNP). These four roles are given the title of APRN. APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women’s health/gender-related or psych/mental health. APRN education programs, including degree-granting and post-graduate education programs, are accredited. APRN education consists of a broad-based education, including three separate graduate-level courses in advanced physiology/pathophysiology, health assessment and pharmacology, as well as appropriate clinical experiences. All developing APRN education programs or tracks go through a preapproval, preaccreditation or accreditation process prior to admitting students. APRN education programs must be housed within graduate programs that are nationally accredited and their graduates must be eligible for national certification used for state licensure.

The model was endorsed by the NCSBN Board of Directors in September 2008. The model APRN legislative language, which parallels the Consensus Model for APRN Regulation, was also developed by the APRN Committee and adopted during the 2008 Delegate Assembly.

After the development of the Consensus Model for APRN Regulation, the APRN Committee and the APRN Consensus Group continued meeting to develop a structure which would be used to implement and maintain the consensus model. This year they discussed how to develop the Licensure, Accreditation, Certification and Education (LACE) structure described in the APRN Consensus Model of Regulation document. A structure has been developed and plans for developing a communication system are currently underway.

This year, the APRN Committee met with a strategic consultant and identified a plan and strategies for the implementation of the legislative language, such as a fact sheet for legislators; a PowerPoint presentation, which could be used by APRN stakeholders; and an article template for the committee to write articles on the legislative language as an educational tool.

The APRN Committee also held an APRN Roundtable on May 12, 2009, in Chicago. Boards of nursing (BONs) were invited to the APRN Roundtable, an annual meeting during which the APRN Advisory Panel discusses APRN regulatory issues with a wide variety of APRN stakeholders.

Highlights of FY09 Activities
- Held the APRN Roundtable in Chicago on May 12, 2009.
- Developed a template to be used by committee members to write articles on how each APRN role will be affected by the APRN model legislative language.
- Developed a PowerPoint presentation on the APRN Consensus Model for Regulation, which was placed on the NCSBN public Web site.
- Drafted a fact sheet for federal and state legislators.
- Participated in NCSBN APRN Network Calls to enhance communication among BONs regarding APRN regulatory issues.
- Developed strategies and an implementation plan to assist BONs with implementing the APRN model legislative language.
- Collectively gave 32 presentations regarding the APRN Consensus Model in 28 states.
Future Activities

- Continue the APRN Roundtable.
- Maintain and enhance communication among APRN stakeholders, Member Boards and NCSBN.
- Assist BONs with the implementation of the new APRN legislative language.

Attachments

A. Legislative Fact Sheet
Attachment A

Legislative Fact Sheet

What the New APRN Model Act/Rules and Regulations Will Do for You

The new Advanced Practice Registered Nurse (APRN) Model Act/Rules and Regulations is based on the new Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education, which was developed over a three-year period through a consensus process and endorsed by 42 organizations. According to the Health Resources and Services Administration (HRSA), there are over 6,000 primary care health professional shortage areas involving 64 million people in the U.S. A goal of the APRN consensus model is to increase access to effective patient care by eliminating APRN practice barriers. Implementation of the new APRN model will enhance opportunities for workforce mobility and utilization.

- APRNs increase access to patient-centered health care for your constituents.
- Studies show nationally certified APRNs provide high-quality care, improve outcomes and increase patient satisfaction.
- APRNs are proven to be high-quality, effective health care providers, many of whom are primary care providers.
- APRNs graduate from nationally accredited educational programs.
- In 12 states and Washington D.C., APRNs have independent practices and outcomes are very good.
- Implementing these regulations will increase access to health care through increased number of providers.
- Licensed, independent practice leads to better tracking of outcomes, increases the transparency of billing and clarifies accountability.
- Physician enrollment in medical residency primary care training programs is decreasing, thereby compounding the current shortage of primary care providers.

What we need from legislators:

- Advocate to improve health care workforce and access issues.
- Meet with APRN leaders to discuss APRN model act/rules and regulations.
- Support licensed independent practice for APRNs to the full extent of their education and competency.
- Sponsor and support legislative change to enact the APRN model.
Report of the Awards Committee

Background
The Board of Directors (BOD) established the Awards Panel in FY01 to review and evaluate the NCSBN Awards Program. The panel was charged with selecting award recipients and developing an awards program that ensured consistency, fairness and celebrated the contributions and accomplishments of the membership. The panel, now called a committee, has continued to refine the awards program.

This year, the Awards Committee reviewed the 2008 Awards Program and the NCSBN 30th Anniversary Gala to provide the BOD with a recommendation regarding future award programs. The committee's recommendation was to hold future awards programs as an evening event. The committee recommended description, eligibility and criteria for the award categories be revised to denote inclusion of the associate membership. The committee did not recommend any new award categories as a result of changes to the current program.

Highlights of FY09 Activities
- Conducted a review of the awards program and recommended revisions to the award descriptions, criteria and eligibility to include Associate Members.
- Conducted a blind review of the award nominations.
- Selected the award recipients.
- Reported the award recipients selected by the Awards Committee to the BOD.
- Recommended that Charlene Kelly be acknowledged posthumously for a special award.
- Identified Member Boards celebrating their centennial celebration in 2009.
- Identified executive officers who were eligible for the Executive Officer Recognition Award for five, 10 and 15 years of service.
- Notified award nominees that they had been selected by the Awards Committee as an award recipient.
- Identified ways to make the recipients feel special at the awards program, such as giving them a rose and escorting them to the stage.
- Assigned committee members will read the biographies of each award recipient at the ceremony.
- Sent letters of regret to nominators whose nominee was not selected.

2009 Award Recipients:

R. Louise McManus Award
Faith Fields, MSN, RN, executive director, Arkansas State Board of Nursing

Meritiorious Service Award
Sheila Exstrom, PhD, RN, nursing education consultant, Nebraska Board of Nursing

Regulatory Achievement Award
Ohio Board of Nursing

Exceptional Contribution Award
Nancy Murphy, MS, RN, BC, CPM, education consultant, South Carolina State Board of Nursing
The BOD has voted to recognize Charlene Kelly and her many contributions to the organization through a $10,000 donation to the Charlene Kelly Scholarship Fund. An announcement and presentation of this donation will occur at the 2009 Awards Ceremony.

**Executive Officer Recognition Awards**

**5 YEARS**
- George J. Hebert, MA, RN, executive director, New Jersey Board of Nursing

**10 YEARS**
- N. Genell Lee, JD, MSN, RN, executive officer, Alabama Board of Nursing
- Mary Blubaugh, MSN, RN, executive administrator, Kansas State Board of Nursing
- Shirley Brekken, MS, RN, executive director, Minnesota Board of Nursing
- Kim Glazier, MEd, RN, executive director, Oklahoma Board of Nursing

**15 YEARS**
- Teresa Bello-Jones, JD, MSN, RN, executive officer, California Bureau of Vocational Nursing and Psychiatric Technicians

**Member Boards Celebrating 100 Years of Nursing Regulation**
- Delaware Board of Nursing
- Michigan/DCH/Bureau of Health Professions
- Missouri State Board of Nursing
- Nebraska Board of Nursing
- Oklahoma Board of Nursing
- Pennsylvania State Board of Nursing
- Texas Board of Nursing
- Washington State Nursing Care Quality Assurance Commission
- Wyoming State Board of Nursing

**Future Activities**
- Select the 2010 awards recipients; and
- Review Awards Presentation Program (including award symbols, recognition of Institute of Regulatory Excellence [IRE] Fellows and criteria for special awards) and make recommendations to the BOD.

**Attachments**
- Past NCSBN Award Recipients
- Awards Brochure/Awards Criteria
<table>
<thead>
<tr>
<th>Award Category</th>
<th>Recipients</th>
</tr>
</thead>
</table>
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
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
2008 – Lisa Emrich
        Barbara Newman
        Calvina Thomas
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

*NCBSN SPECIAL AWARD
2008 – Thomas Abram
2004 – Robert Waters
2002 – Patricia Benner
Attachment B

Awards Brochure/Awards Criteria

NCSBN Awards Program
The NCSBN awards will be announced at the 2009 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. 6, 2009, 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 entry form.
- 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 than the award he/she was originally nominated for. If this decision were made, a committee member would contact the nominator to determine if he/she is agreeable to having the nominee be given a different award.
- The Awards Committee can make recommendations for special awards to the NCSBN Board of Directors.
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 Member Board or Associate Member.

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 member or staff of a Member Board or Associate Member 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 or staff of a Member Board or Associate Member (not an executive officer or a board president).

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

DESCRIPTION OF AWARD
The Regulatory Achievement Award recognizes a Member Board or Associate Member body 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
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 or Associate Member president who has made significant contributions to NCSBN.

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

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
One
EXECUTIVE OFFICER RECOGNITION AWARD

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

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

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

AWARD CYCLE
Annually as applicable

NUMBER OF RECIPIENTS
As applicable
Report of the Chemical Dependency Committee

Background

Currently, 40 states have an alternative to discipline program. The objectives of these programs are to: (1) ensure the health and safety of the public through a program that closely monitors licensees whose ability to safely and competently practice may be impaired due to dependency on drugs or alcohol; (2) achieve earlier intervention with intent to accomplish decreased time between the licensee’s acknowledgement of chemical dependency and entry into the recovery process, while providing a means of returning the licensee to safe and effective practice in a more efficient and rapid manner, minimizing financial impact, than was achieved through the disciplinary process; and (3) provide a process for licensees to recover from impairment in a therapeutic and non-punitive process.

For FY09, the Board of Directors appointed the Chemical Dependency Committee to review discipline and alternative programs and provide recommended regulatory practices for chemically dependent licensees.

Highlights of FY09 Activities

- In order to develop elements of a model impaired nurse program, a survey instrument was developed to help the committee determine what alternative to discipline programs are currently doing and how they are doing it. The survey helps determine both the strengths and vulnerabilities of programs and identifies additional research questions that need to be addressed. The survey was distributed to all alternative to discipline programs. Out of 40 programs surveyed, 90 percent responded.

- While conducting the survey to determine what is happening among alternative to discipline programs, the committee also began conducting literature reviews to determine what should be happening. A handbook is being written which will provide recommendations on best practices for detection, prevention and intervention of chemical dependency cases based on the most current research and evidence. While nurse managers will be able to use the handbook as a resource to utilize when handling chemical dependency cases, the focus of the handbook will be on presenting evidenced-based models and best practices so that boards of nursing and alternative to discipline programs can improve and better evaluate their own programs.

Future Activities

- Complete the Handbook for Best Practices for Boards of Nursing and Alternative Programs.

- Survey disciplinary programs for nurses whose competency may be impaired because of the use of drugs and/or alcohol. This will provide a comparison with the alternative to discipline programs and identify the differences and similarities in how the two approaches address the chemically dependent nurse.

Attachments

None

Members

Valerie Smith, MS, RN, FRE
Arizona, Area I

Carol Stanford, BA
California-RN, Area I

Anjeanette Lindle, JD, BS
Montana, Area I

Nancy Darbro, PhD, RN, CNS
New Mexico, Area I, Chair

Karl A. Hoehn, JD, BA
Washington, Area I

Tom Dilling, JD
Ohio, Area II

Joan Bainer, MN, RN, CNA, BC
South Carolina, Area III

Kathy Thomas, MN, RN
Texas, Area III, Board Liaison

Michael Van Doren, MSN, RN
External Member

Kate Driscoll Malliarakis, MSN, RN, CNP
External Member

Staff

Kevin Kenward, PhD
Director, Research

Lindsey Gross
Administrative Assistant, Research

Meeting Dates

- Sept. 11-12, 2008
- Jan. 5-6, 2009
- April 6-7, 2009
- May 8, 2009 (Conference call)
- May 30 – July 1, 2009

Relationship to Strategic Plan

Strategic Initiative 2
Promote evidence based regulation that provides for public protection (regulatory excellence).

Strategic Objective 1
Review discipline and alternative programs and provide recommended regulatory practices for chemically dependent licensees for the purpose of public protection.
Report of the Continued Competence Committee

Background

Continued competence has dominated the NCSBN agenda since the early 1980s. For over a decade, committee work resulted in a series of documents supporting the need for a uniform method of continued competence across the U.S. These included the development of a conceptual framework for continued competence, definitions, standards, several position papers and models (1985, 1991, 1993, 1995 and 1996).

In 1995, the Nursing Practice and Education Committee proposed adoption of the Continued Competence Accountability Profile (CCAP) to the Delegate Assembly. This was a continued competence program based on the self-reflection/portfolio model. The Delegate Assembly acknowledged it as being interesting and innovative; however, there was concern regarding the feasibility of implementation and monitoring of the program. Subsequently, it was not adopted. NCSBN resumed work on this subject and these renewed efforts resulted in a research project examining the efficacy of a continuing education mandate and several more papers supporting the concept of continued competence.

In 2006, a Continued Competence Task Force conducted a post-entry practice analysis to determine whether any core competencies could be identified for the practice of nursing. This was accomplished through the licensed practice/vocational nurse (LPN/VN) and registered nurse (RN) post-entry practice analyses. Results of these studies revealed that there are core knowledge and skills that are required of all practicing nurses, regardless of their specialty, years of experience or geographic location. These core competencies became the content outline for a potential competency assessment instrument. Utilizing the RN and LPN/VN test specification reports and the professional judgment of the continued competency advisory panel, an external consultant was engaged to submit a proposal for the construction of RN and LPN/VN competency assessment tools, and a national pilot test of the proposed assessment tools. The final report from the consultant was presented to the 2008 Board of Directors (BOD) who requested feedback from the participants of the 2008 Midyear Meeting. A formal presentation was followed by discussions at the area meetings. A request, made by the membership, was for the development of a continued competence regulatory model. This would provide a clearer context for understanding the use of a potential assessment tool.

The BOD requested the 2009 Continued Competence Committee address the following charge:

Develop guiding principles and a regulatory model with multiple options for demonstration of continued competence.

See Attachment A for the results emerging from this charge. The committee has diligently addressed the charge and has produced a set of guiding principles and the first regulatory model of its kind for nursing. In their discussion, the committee addressed the advantages and disadvantages of this model and this information has been added as a supplement (see Attachment B).

Highlights of FY09 Activities

- Developed the Guiding Principles of Continued Competence.
- Developed a regulatory model with multiple options for demonstration of continued competence.

Future Activities

- Test the regulatory model using NCLEX® items in a six to 10 state pilot program.
- Establish a committee to advise on the implementation of the pilot program. Committee representation should be based on participation in the pilot program and representative of the 2009 Continued Competence Committee.
Focus on answering the following questions:
- Does a universal computerized diagnostic assessment identify/validate continued competency for nurses?
- What other indicators are there of continued competence for nursing?

Proposed 2010 Continued Competence Committee charges:
- Assist in the implementation of a continued competence assessment pilot project.
- If appropriate, provide input into the development of a business plan.

**Attachments**
A. NCSBN Guiding Principles and Regulatory Model for Continued Competence
B. Advantages and Challenges of the Regulatory Model
Attachment A

NCSBN Guiding Principles and Regulatory Model for Continued Competence

Introduction

Boards of nursing (BONs) have a responsibility to assure the competency of their licensees. This pertains not only to new graduates and internationally educated nurses applying for licensure by examination, but also postentry level nurses holding a license. Currently, there is a lack of uniformity among states as to what, if anything, should be required of postentry licensees. Many BONs find themselves struggling to answer questions concerning how to assure the public that nurses maintain competency throughout their careers and how to determine whether an individual that has left nursing practice for an extended period of time is competent to return to nursing practice.

Although states have attempted various approaches to ensure competency for nurses, there are no evidence based methods, with the exception of the NCLEX® exam, that measure or support this endeavor. The issue of what method is most efficient and effective continues to confound nursing regulators who are looking to NCSBN for leadership in this matter.

The need for ongoing competency requirements is not isolated to nursing. Continued competency of health care providers has been addressed by the Institute of Medicine (IOM) (2000, 2001, 2003, 2004) and a host of other commissions and organizations, including the Citizens Advocacy Center (1996, 2004); the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry (2006); and the Pew Health Professions Commission (1995). All have advocated for a process that will objectively measure competence among postentry health care professionals. NCSBN has long recognized the necessity to assess ongoing competence and has been at the forefront addressing this issue. Since 1985, when the first continued competence paper was written (Kelly, 1985), NCSBN has addressed, supported and promoted the development of a continued competence assessment for nurses.

In 2007, NCSBN renewed its ongoing commitment to continued competence in its three year strategic plan. Two strategic initiatives lay the foundation for the current work:

- NCSBN advances evidenced-based nursing regulation and regulatory solutions for public protection; and
- NCSBN is the premier organization to define and measure entry and continued competence.

Charged with the development of a set of guiding principles and a Regulatory Model for Continued Competence, the 2008-2009 Continued Competence Committee has worked diligently to analyze data and the complex issues related to this topic, while also considering feedback from Member Boards. One of the most pressing questions discussed by the committee was whether or not the assessment of competence was the responsibility of regulators and whether or not a national initiative to measure postentry level competency was necessary. The committee determined that maintaining competency to practice is a shared responsibility; it is first and foremost with the nurse. Every individual nurse is accountable for maintaining current knowledge and skills. The employer also bears responsibility and any national initiative for competence must be supplemented with additional assessment and resources from employers. Regulators, however, administer the nursing license and in doing so, are assuring the public that the practitioner is competent. Given this, regulators should provide leadership and a uniform method for assessing postentry competency.

The major thrust of a national continued competence initiative is safe patient care. This is not to suggest that nurses in the U.S. are not safe practitioners; it means that maintaining competence is integral to safe nursing practice. While a method for determining/measuring competence has been explored and discussed for decades, several contemporary factors support the need for the
development of an evidenced-based, psychometrically sound, legally defensible, professionally accepted tool for measuring competence in the 21st century. These include:

- The continuous outpouring of new knowledge. Experts state that knowledge now becomes obsolete after two and a half years.
- The public expectation that health care professionals demonstrate competency throughout their career. In a recent survey, 90 percent of private citizens polled stated they thought health care professionals were already undergoing postentry competency assessment (AARP, 2007).
- The Just Culture and Patient Safety Movements. While it is acknowledged that error is often a result of system and environmental issues, there is also a call for the remediation of practitioners that have gaps in their knowledge.

In response to their 2008-2009 charge determined by the NCSBN Board of Directors to develop a set of guiding principles and a regulatory model for continued competence, the NCSBN Continued Competence Committee has set forth a vision for continued competence in the U.S. It is hoped that this vision, based on the Guiding Principles for Nursing Regulation, will lay the groundwork for pilot projects whose data will provide answers to questions about competence assessment and bring nursing one step closer to a national model for continued competence.

References


THE GUIDING PRINCIPLES FOR CONTINUED COMPETENCE IN NURSING

1. Nursing regulation is responsible for upholding licensure requirements. Competence is assessed at initial licensure and during the career life of licensees. (Adapted from NCSBN's Guiding Principles of Nursing Regulations.)

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

3. A culture of continued competence is based on a premise that the competence of any nurse should be periodically assessed and validated.

4. Requirements for continued competence should support nurses’ accountability for lifelong learning and foster improved nursing practice and patient safety.

5. A continued competence regulatory model for nursing:
   - Includes a secure, standardized, psychometrically sound and uniformly administered diagnostic assessment;
   - Is proactive, flexible and nonpunitive;
   - Offers a choice of options to address gaps in knowledge, skills and abilities identified by a diagnostic assessment;
   - Is evidence based;
   - Meets APPLE criteria (see Definition of Terms); and
   - Is rigorously pilot tested before adoption.

6. The regulatory authority for establishing continued competence requirements should remain with the state BON.

2009 CONTINUED COMPETENCE REGULATORY MODEL FOR NURSING

Step 1: Initial diagnostic assessment of licensees
   - Is based on core competencies for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs);
   - Has a passing standard;
   - Is computer-adaptive; and
   - Is to be administered in a secure environment.

The state BON shall determine:
   - Time frame; and
   - Population.

Step 2: Dissemination of diagnostic assessment results
   - The licensee receives individual results of the diagnostic profile directly from the vendor.
   - Results indicate whether the licensee meets or falls below the passing standard.
   - The diagnostic profile describes the licensee’s strengths and areas needed for improvement.
   - The vendor sends state aggregate results to each BON.
   - Individual licensee results may be requested by the state BON.
Step 3: Follow-up actions by state BON

Each individual state BON determines follow-up actions. Possible actions may include any one or combination of the options listed below:

1. The BON elects to obtain the individual licensee results that meet the passing standard and awards one of the following:
   - Certificate of competency;
   - Certificate of recognition; or
   - Indication on license that individual has met continued competence requirements.

2. The BON elects to obtain the individual licensee results below the passing standard:
   - The BON requests further evaluation of a licensee’s knowledge and skills.
   - The BON requests the development of a competency remediation plan by the licensee.
     - The plan should be comprehensive and describe in detail the activities the licensee will complete to address knowledge gaps identified in the diagnostic profile.
     - The plan should include target dates for completion of each activity outlined in the plan.
     - The BON randomly audits licensees’ competency remediation plans and evidence of plan implementation and/or completion.
     - The BON refers the licensee to an approved practice enhancement program (pending the results of the evaluation).

3. The results of the diagnostic assessment are left to the discretion of each licensee and/or employer.
   - Licensee does his/her own follow-up.
   - Licensee who has fallen below the passing standard may repeat the diagnostic assessment at his/her option.

4. BON takes no action.

Step 4: Diagnostic reassessment requirements determined by the BON

*The word licensee refers solely to RNs and LPN/VNs licensed by a BON. It does not include any other group or profession that may be regulated by a BON.

DEFINITION OF TERMS

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

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

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

Continued competence: The ongoing synthesis of knowledge, skills and abilities required to practice safely and effectively in accordance with the scope of nursing practice.
Core competencies: Knowledge, skills and abilities identified through a practice analysis that are universal to RNs or LPN/VNs regardless of practice setting, specialty practice area and/or years of experience.

- RN competencies: Clinical judgment and provision of care, professional responsibilities, communication, inter/intra-disciplinary collaboration, supervision/management and safety.
- LPN/VN competencies: Provision of care, legal/ethical responsibilities, communication, inter/intra-disciplinary collaboration and safety.

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

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

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

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

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

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

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

Secured environment: A designated monitored testing site that meets specific standards related to test security.
## Attachment B

### Advantages and Challenges of the Regulatory Model

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provides a validated measure of continued competence.</td>
<td>1. Potential dissention/competition from other stakeholders.</td>
</tr>
<tr>
<td>2. Promotes collaboration between practice and service.</td>
<td>2. Need is not universally recognized by all nursing regulators, including members of the profession.</td>
</tr>
<tr>
<td>3. Fosters new types of collaboration.</td>
<td>3. High cost, although there may be revenue generation down the line.</td>
</tr>
<tr>
<td>4. Potential for establishing a long-term measure for continued competence.</td>
<td>4. States adopting different options does not promote uniformity.</td>
</tr>
<tr>
<td>5. A basis for other studies.</td>
<td>5. Many logistics regarding implementation and potential follow-up. This may present the greatest challenges for compact states.</td>
</tr>
<tr>
<td>6. Supports our mission.</td>
<td>6. Test format may be intimidating.</td>
</tr>
<tr>
<td>7. NCSBN has the resources and expertise to accomplish this.</td>
<td></td>
</tr>
<tr>
<td>8. Role of profession is to demonstrate competence to the public. This model may provide us with the ability to do that.</td>
<td></td>
</tr>
<tr>
<td>9. Will assist employers in demonstrating competency of staff.</td>
<td></td>
</tr>
<tr>
<td>10. Will assist employers in identifying gaps in knowledge.</td>
<td></td>
</tr>
<tr>
<td>11. Will help nurses identify their limitations.</td>
<td></td>
</tr>
<tr>
<td>12. Standard knowledge and standard language leads to evidence based regulation.</td>
<td></td>
</tr>
<tr>
<td>14. Will help us play a role in the patient safety movement.</td>
<td></td>
</tr>
<tr>
<td>17. If not us, then someone else will.</td>
<td></td>
</tr>
<tr>
<td>18. Empowering for the profession.</td>
<td></td>
</tr>
</tbody>
</table>
Report of the Commitment to Ongoing Regulatory Excellence (CORE) Committee

Background
The Commitment to Ongoing Regulatory Excellence project (CORE) was approved by the FY02 Board of Directors 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 since 2000; the last survey occurring in 2008. They are surveyed regarding five board functions: (1) discipline; (2) practice; (3) education program approval; (4) licensure; and (5) governance. Three groups of stakeholders that were directly affected by BON actions are also surveyed. These three groups included: (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 FY09 Activities
- Work has begun on developing survey instruments for the 2010 survey using a logic model. Basically, this model is a systematic and visual way to present and share one’s understanding of the relationships among available resources, the activities planned and the changes or results one hopes to achieve. The model describes the sequence of activities thought to bring about change and how these activities are linked to the results the program is expected to achieve. This approach helps create shared understanding of and focus on goals, relating the questions asked to the activities performed to projected outcomes. More work will be required before indicators are finalized.

- By the end of December 2008, all BONs received four reports: (1) a report aggregating data from all participating BONs; (2) a report for state level data; (3) a report comparing umbrella and independent BONs; and (4) a report comparing BONs by number of licensees. Half a day was devoted to the CORE Midyear Meeting sessions to assist BONs in using and interpreting these reports. Specific examples were used and attendees were walked through a process that explained the meaning of these results, setting goals based on the data and how to evaluate the attainment of these goals. Other presentations included how two states incorporate the CORE findings into their strategic objectives and how they assist in their legislative reviews.

Future Activities
- Collect and analyze data from the 2010 surveys.
- Identify top performing BONs and the reasons for their excellent performance.
- Implement strategies to increase knowledge and use of CORE performance measures.
- Compare and contrast the profiles of independent and umbrella board structure and outcomes.

Attachments
None
Report of the Disciplinary Resources Committee

Background
Comprised of seven members, plus the board liaison and three NCSBN staff members, the Disciplinary Resources Committee had extensive charges this year. In order to meet the 2009 charges, the committee had to review an extensive amount of literature, develop a survey instrument and work with the NCSBN Marketing & Communications department to ensure continuity with other resources that would be part of an outreach tool kit. The following is a report on the progress of their charges.

Develop an outreach tool kit to inform the public of the board of nursing (BON) discipline process.
In an effort not to duplicate materials previously developed or in the process of being revised, the committee worked in collaboration with NCSBN’s Marketing & Communications Department, which was already working on a tool kit for the public and the nursing profession. Two brochures related to the BON discipline process have been developed by the committee and will be a part of an NCSBN Outreach Tool kit that will contain the following resources: Your Nursing License is the Key to Your Career; A Nurse’s Guide to the Importance of Appropriate Professional Boundaries; A Consumer’s Guide to the Expected Behavior of a Health Care Provider; How Boards of Nursing Protect the Public; Your State Nursing Board Works for You: A Health Care Consumer’s Guide; and Your State Nursing Board is Here for You: A Nurse’s Guide.

Identify available alternative, early intervention programs related to practice, including advantages and disadvantages.
A survey developed by the committee was used to gather qualitative information from seven BONs that have alternative programs for practice related violations (Ohio, North Carolina, South Carolina, West Virginia-PN, Colorado, Minnesota and Pennsylvania). BONs were interviewed about the programs and their advantages and disadvantages. The data from the survey is contained within an extensive report prepared by the committee (see Attachment A). This report is intended to answer this charge and may provide assistance to BONs considering developing an alternative program for practice related violations. Below is a summary of the findings for this charge.

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes collaboration between BON and employer. Employer is the eyes and ears of the BON.</td>
<td>Facilities are hesitant to enter into a binding agreement with a regulatory BON. Many want to stay off the radar.</td>
</tr>
<tr>
<td>Utilizes Just Culture principles for improving practice and retention of nurses.</td>
<td>Difficult for institutions to proactively identify individuals who are a potential threat to patient safety.</td>
</tr>
<tr>
<td>The goal is to initiate collaborative remediation of a perceived practice deficiency before the situation rises to a level of disciplinable action and/or poses a patient safety threat.</td>
<td>If the early remediation program is truly predisciplinary (precomplaint), as opposed to being an alternative to discipline, there are no cost savings for the BON to realize in terms of diverting disciplinary cases to these alternative resolutions.</td>
</tr>
<tr>
<td>Nondisciplinary resolution permits the BON to address the situation with better timing than litigation. Cases can be addressed more expediently and remediation occurs in a shorter length of time than traditional discipline.</td>
<td>Entails a shift in resources. The BON and employer must expend much more energy towards early intervention in the hopes of realizing these disciplinary cost savings down the road.</td>
</tr>
</tbody>
</table>

Members
Sandy Evans MAEd, RN
Idaho, Area I, Chair
Trent Kelly, JD
Washington, Area I
Dennis Corrigan, RN
Ohio, Area II
Julie George, MSN, RN, FRE
North Carolina, Area III, Board Liaison
Mary A. Trentham, JD, MNSc, MBA, BS, AA, APRN
Arkansas, Area III
Jane Tallant, MSN, MS, RN
Mississippi
Robert Duhaime MBA, RN
New Hampshire, Area IV
Margaret A. Sheaffer JD, BBA, RN
Pennsylvania, Area IV

Staff
Maryann Alexander, PhD, RN
Chief Officer, Nursing Regulation
Nancy Spector, PhD, RN
Director, Education
Joan Spillis, MSN, RN
Associate, Nursing Regulation

Meeting Dates
- Sept. 15-16, 2008
- Dec. 9-10, 2008
- Jan. 29-30, 2009
- March 12-13, 2009

Relationship to Strategic Plan
Strategic Initiative C
NCSBN advances evidenced-based nursing regulation and regulatory solutions for public protection.

Strategic Objective 2
Provide models and resources for evidenced-based regulation to Member Boards.
### Advantages

- Calls deficiencies to the attention of the employer. Increases awareness of potential growing clinical deficiencies with their staff.
- May assist an employer in retaining staff nurses.
- Removing the process from the contentious public/punitive environment and designing a remediation plan in a predisciplinary collaborative context may make for more timely regulation. In addition, the practitioner may be more willing to engage in a collaborative process to address the deficiencies in their practice with a tailored action plan.
- By limiting the pool of practitioners who may participate in such programs, the BON confirms its interest in exercising its regulatory priorities responsibly. The BON is not abandoning its fundamental obligation to intervene forcefully in any case where patient care is truly at risk, but instead, is wisely exercising its discretion so as to expend resources in the most efficient way possible and stave off future serious misconduct.

### Disadvantages

- Resolution of cases prior to and without initiating formal discipline may precipitate public perception that the BON is protecting the nurse.
- Complete confidentiality may be difficult to achieve. In the majority of states, the statutory expectation is that any and all business that is conducted by its government is publicly available. As a result, there is a legal limit to the confidentiality aspect of these programs in that any such alternative resolutions, while not proactively disseminated as with any traditional disciplinary action, must still be made publicly disclosable.
- It is a challenge to assess the risk level and determine whether a nurse is a safe and appropriate candidate for a more informal and nondisciplinary regulatory approach. If the BON is too liberal in its application of the criteria, then it risks failing to remove a nurse that is a public threat. If the BON is too restrictive, the benefits of the alternative approach cannot be realized in numbers great enough to make a difference, either in cost or effectiveness.
- No amount of tailored remediation can be viewed as effective if there is no subsequent plan for reliable monitoring, preferably in the real world conditions of the workplace. Thus, the employer plays a critical role in underpinning the credibility of any such program to truly ensure public protection. Unfortunately, there is no assurance the nurse's employer is available and willing to participate in such a program. Oftentimes, the nurse is no longer working for the same employer where the practice deficiencies were identified.
- Effective hands on remedial education resources need to be available at a reasonable cost.
Update the Sexual Misconduct Handbook

Extensive research and committee input went into the development of this product. After deliberation by the committee, a decision was made to not only update this document, but to also ensure that this is a useful and practical resource for BONs. Step-by-step guidance through various cases, information on how to select an evaluator and guidelines for establishing sanctions are among the contents of the resource. Once approved by the Board of Directors, it will be finalized by the NCSBN Marketing & Communications Department for online, as well as paper distribution.

Highlights of FY09 Activities

- Developed outreach materials to be used by BONs to inform the public of the BON discipline process.
- Extensive interviews with BONs, which helped identify advantages and disadvantages of alternative, early intervention programs related to practice.
- Updated the Sexual Misconduct Handbook with an emphasis on utility and practicality.

Future Activities

- Develop model rules on sexual misconduct, including boundaries.
- Develop content for a model course on professional ethics and conduct for use in remediation and discipline.
- Conduct a conference on the disciplinary process for nurses.
- Extend the work on alternative programs for practice violations by exploring how states can implement successful programs; develop a model or best practices.

Attachments

A. Advantages and Disadvantages of Alternative Early Intervention Programs for Substandard Practice
Attachment A

Advantages and Disadvantages of Alternative Early Intervention Programs for Substandard Practice

TO: Board of Directors, NCSBN
FR: Disciplinary Resources Committee
RE: Alternatives to Discipline for Substandard Practice

Overview and Profiles of Various Programs

In 1999 the Citizens Advocacy Center (CAC), aided by a federal grant, promoted the forging of a new partnership between health care regulatory boards and the facilities that employ their licensees. The CAC proposed an agreement between boards of nursing (BONs) and various hospitals and other health care organizations to work together to identify, remediate and monitor health care professionals. This new collaboration was sought to ensure early identification of doctors and nurses with clinical deficiencies that have yet to rise to the level of substandard care that would warrant discipline. The hope was that through early intervention, such deficiencies could be remedied by a nonpunitive action plan devised amongst the three key players: the BON, practitioner and employer/facility. The proposed new approach to substandard care cases was called PreP 4 Patient Safety (the “PreP” standing for Practitioner Remediation and Enhancement Partnership).

While the CAC had launched this initial concept, one state had already begun its own version of predisciplinary alternatives.

Ohio was in the vanguard with their Practice Intervention and Improvement Program (PIIP). Statutorily authorized in 1997, this was an effort to approach the challenge of nurses who exhibited practice concerns in the same fashion that was employed in the case of chemical dependency monitoring programs. In Ohio's PIIP program, the case is reviewed by a board member at the conclusion of investigating substandard practice complaints. They determine whether the nurse's identified practice deficiency can be corrected through participation in the program, as opposed to formal disciplinary action. If the nurse is determined to be an appropriate candidate, he/she is offered an agreement to formally enter this program in lieu of discipline.

The key distinction between the CAC's original proposal and Ohio's PIIP program is that Ohio is not using PIIP as a tool for early intervention into practice deficiencies that have yet to rise to a violation of the practice act. Instead the program is used as an alternative to discipline, or an in lieu of program, patterned after its substance abuse monitoring programs. That is, Ohio is taking some portion of their substandard practice cases that could have previously resulted in disciplinary action and instead attempting to resolve them in a nondisciplinary fashion.

A licensee who is referred into the Ohio PIIP program must sign an agreement and their participation is confidential. One aspect of the agreement is a stipulation that the licensee acknowledges that their underlying substandard practice amounts to an actionable violation of the law. This stipulation was designed to prevent a situation in which a nurse who fails out of the program puts the BON at a disadvantage in prosecuting a stale case. Another aspect built into the agreement is that failure to complete the program is viewed as an aggravating factor to the underlying conduct. The heart of the agreement is an action plan that entails an educational remediation component and a workplace monitoring component.

Soon to follow Ohio's lead in exploring alternatives to discipline is North Carolina. Its BON appears to be the first to adopt such an alternative program in its purest form using the CAC model. North Carolina also made what appears to have been the greatest commitment of resources in general to this new approach in practice deficiency cases.

North Carolina developed and piloted its own version of PreP in 2001 and launched it statewide in 2004. North Carolina's program is closer to the original idea promoted by the CAC in that it
not only offers this alternative to disciplinary complaints, but also in cases where the employer reports clinical deficiencies in their nursing staff that have yet to rise to the level of practice act violations. The North Carolina program involves a new collaboration between the BON and facilities that employ nurses in an effort to prevent patient harm through early intervention. The BON enters into an agreed framework or memorandum of understanding (MOU) with the various facilities to ensure these employers report nurses with growing clinical deficiencies as possible candidates for this alternative intervention program. Collaborative early identification and remediation is achieved before the deficiencies reach the level of significant patient risk. The nurse’s employer identifies patterns/issues with the employee and they partner with the BON to develop a remedial action plan. This is similar to the employing facility’s employee assistance program relating to addiction issues, except with substantive BON involvement.

The catalyst for this initiative, according to North Carolina’s Board of Nursing staff, was found in the principles of Just Culture. This is the regulatory approach that considers not only the individual nurse’s conduct in isolation, but also includes the big picture circumstances and culture of the facility’s workplace. This adoption of Just Culture principles, along with a new partnership with employers, is the key to North Carolina’s attempts at more enlightened regulation. North Carolina’s program seeks to ensure not only that the BON understands the workplace context of the nurse’s perceived practice deficiencies, but that the employer is engaged to cure the underlying systemic issues that, if left unresolved, would set up any future practitioner working in that setting for failure. The North Carolina Board of Nursing’s uniquely independent status may be one contributing factor for why such a bold experiment could be pursued successfully.

Nearby South Carolina has been exploring its own PreP program, but not achieving the same positive results. As with its neighbor to the north, South Carolina’s program requires a candidate nurse facing discipline to sign a contract to participate. The contract sets out the conditions which usually involve remedial education followed by a workplace monitoring (shadowing) component to ensure that the education was effective and remedied the deficiency. If the nurse fails to abide by the contract, then the matter converts to a disciplinary case and is fully investigated. If they meet the conditions then no disciplinary record is publicized by the BON.

South Carolina experienced a degree of frustration in its attempts to forge a new, more collaborative relationship with employer facilities. This BON’s challenge was establishing the requisite trust and convincing nurse employers that it wanted to educate, as well as discipline. The South Carolina Board of Nursing found that it can take significant time and energy to build the political infrastructure for such a progressive endeavor. Without the wherewithal to do the heavy lifting up front, South Carolina stalled in its efforts to successfully launch such an alternative vision. South Carolina reports some success with launching their version of this partnership. However, relying on the facilities to report candidates has resulted in very low participation levels and little impact on that BON’s overall disciplinary business.

West Virginia’s State Board of Examiners for Licensed Practical Nurses reports a similar frustration with getting their experiment with PreP off the ground. General hesitancy by employers to work in tandem with the BON has been a big hurdle, especially in long term care facilities. Most employers in this setting have already terminated the nurse by the time they report the action to the BON, thus removing the chance for a workplace collaboration to ensure remediation. A key to the underlying incentive for such collaboration is the notion that the nursing shortage prompts facilities to want to keep staff, work through the problem and thus avoid unnecessary turnover. Apparently, this has not been the case in West Virginia. Instead, employers prefer to handle the problem by removing the nurse and at best, filing a complaint with the BON. Nonetheless, West Virginia reports that it has not given up on the experiment and hopes to be able to recommit soon to the effort.

The Colorado Board of Nursing experienced a similar challenge in attempting to launch an alternative disciplinary approach, citing a political landscape and regulatory environment that was not conducive. Colorado also cited inadequate resources in terms of having the necessary staff to allot to the endeavor. They report having more success in their efforts to instill notions of Just Culture into the probationary phase of its discipline.
Just Culture, as an overlay to the regulatory model, was again the underlying catalyst for change in Minnesota’s experiment with disciplinary alternatives for practice related cases. Minnesota Board of Nursing staff was trained to focus on licensee’s behavior versus the outcome. The specific tool codified into Minnesota’s law is their Agreement for Corrective Action (ACA), which can be used by any health care regulatory board in that state.

Minnesota’s ACA is used not only in response to a complaint received, but is a predisciplinary contract between the BON and licensee used in cases where the subsequent investigation indicates the source of the complaint was a knowledge deficit. As with most all of the states mentioned above, this alternative approach is limited by specific criteria. For example, Minnesota’s program does not apply to a situation in which the nurse’s behavior was intentional or reckless. However, a couple common scenarios in which Minnesota’s program is applicable include a licensee who has not stayed up to date on a particular nurse activity he/she was involved in and a supervising nurse who did not have the appropriate protocol in place for particular activity/circumstance. If a participant completes the steps outlined in the ACA, the disciplinary action is dismissed and the resolution is not published. The ACA resolution is expressly not classified as discipline and thus need not be reported either statewide or to a national database. If, however, the nurse fails to complete remedial steps, then pursuant to the agreement the matter proceeds to discipline. In this case, the nurse has already accepted that the BON will not have to prove its case according to the ACA terms. Interestingly, Minnesota’s ACA terms never contemplate worksite monitoring; the remedial terms instead have to be under the exclusive purview and control of the licensee. If the circumstances of the case warrant employer oversight, then under Minnesota’s approach, the matter would have to be resolved by a traditional disciplinary approach involving an agreed order. However, the employer/complainant is always notified of the outcome so if the nurse keeps his/her position, then the facility is aware their employee entered into an ACA.

While many of the states mentioned sought and were given express authority by their legislature to abstain from discipline in select cases, Pennsylvania, alternatively, is moving forward with a similar endeavor, but without amending its laws. The Pennsylvania Board of Nursing is instead relying on its inherent powers to exercise prosecutorial discretion to decide which cases warrant traditional disciplinary proceedings and which category of complaints may be resolved in a more informal manner.

Pennsylvania still requires that a nurse wishing to take advantage of this alternative resolution sign an agreement whereby the underlying conduct is admitted to and stipulated as a violation of the practice act. The agreement is initially presented for BON approval, but if the nurse successfully completes the remedial steps outlined in their agreement, then the matter is closed in lieu of discipline without further BON review. The matter is kept confidential in that there is no publishing of the resolution. If the nurse is unsuccessful, then the matter proceeds to a sanction-only hearing.

Unlike Minnesota, Pennsylvania contemplates significant employer involvement in their alternative program. Pennsylvania views the employer as key in designing the agreed game plan for remediation which this BON anticipates will always have a workplace monitoring component. However, it is not anticipated that the employer would sign on formally as a party to the remediation agreement.

Pennsylvania’s new alternative program is in its infancy, so at this point, it cannot speak to its success in handling a significant percentage of substandard practice complaints. The Pennsylvania Board of Nursing is looking to remain flexible as it embarks on this pilot program.

**Universal Key Features and their Challenges and Benefits**

Based on this overview of how these various states have launched PreP-like alternative programs, the following are the key features found in all such initiatives, as well as a discussion as to benefits and challenges related to each.
A Closer Working Relationship Between BONs and Employers

All of the these programs involve BONs working more in tandem with health care facilities versus merely the licensee in order to achieve its regulatory goals. In the original proposed PreP model, this involves a new partnership memorialized in written MOUs entered into by BONs and employers. Such MOUs state expectations that growing clinical deficiencies observed in staff performance will be identified and referred to the BON as a candidate for the PreP program. Most states, however, have settled for a lesser form of partnership where an employer merely plays a greater role in helping to craft and then monitor a nurse’s compliance with the action plan for remediation.

Benefits: A BON cannot best fulfill its regulatory goals in isolation and on a complaint driven basis only. It needs the employer to act as its eyes and ears on the front lines of the health care industry. True public protection through early identification and intervention cannot happen without a committed partnership between BONs and health care facilities. Moreover, by including the employer in the regulatory process, the BON has a better chance at utilizing Just Culture principles to regulate the overall practice setting as opposed to punishing individual nurses for the system in which they work.

Challenges: Facilities are hesitant to enter into a binding agreement with a regulatory board. This is especially true in states where the regulatory climate is not conducive to such intimate working relationships. For example, hospitals may have historically viewed the work of their state’s BON as heavy-handed and wish to remain at a distance. Efforts at establishing mandatory reporting are an example of the tension that exists on this political front. Trust must be forged before effective agreements can be built and relied upon. Unfortunately, BONs faced with doing more with less often lack the extra resources to commit to such an endeavor. There may also be concerns that such a soft predisciplinary reporting requirement may be susceptible to workplace abuse in terms of scapegoating, bias, etc.

Regulatory Approach that Entails: Predisciplinary/Early Intervention

All PreP like programs tout that their early intervention aspects are better at getting ahead of the curve when it comes to substandard care in comparison with traditional disciplinary models. However, before exploring these efficiencies, clarification is necessary when referring to the predisciplinary aspect of such programs.

There is an important difference between programs where the BON is attempting to remediate conduct that amounts to a violation of their practice act and where such attempts are made even before the perceived clinical deficiencies get that far. Most all such programs contemplate a remedial action plan being executed on a precharging basis. However, is that because there are not yet grounds for charges or because the action plan, once completed, will likely remove the need to discipline?

The former was the model for the CAC’s original proposed PreP program. The goal was to initiate collaborative remediation of a perceived practice deficiency before the situation arose to a level of disciplinable action and/or posed a patient safety threat. While this is an important practical distinction, especially in terms of selling the idea to stakeholders, much of this depends on the BON’s discretion and is a somewhat fluid standard. In other words, there is a thin red line between a pattern of deficiency that must be addressed with discipline and that which can be nipped in the bud through predisciplinary remediation. That being said, taking steps to remediate on a precharging basis, however that is meant, poses significant risks and benefits.

Benefits: If remediation is initiated on a predisciplinary basis in the purest sense, then the underlying premise of the CAC’s original PreP proposal was that through this collaborative early intervention process, a growing patient safety problem is eliminated before it can become more serious and result in a disciplinable action.

Even if the BON’s program does not attempt remediation until receipt of a substandard practice complaint, this arguably is a better approach to resolving low to moderate risk cases. Nondisciplinary resolution permits the BON to address the situation with better timing than...
litigation. Fully investigating and litigating a case can take months to well over a year and once a probationary solution is hammered out between parties, the events that gave rise to the concern are so dated as to make the regulatory actions seem too belated to be effective or even relevant.

Alternative resolutions also permit an employer to address growing clinical deficiencies with their staff without throwing the nurse out with the bathwater, so to speak. The facility can work with the BON to remediate the potential safety concerns and not lose their investment in that employee. It seems fair to presume that in the current market where nurses are in short supply, employers are reluctant to lose staff whose deficiencies could be cured short of the traditional fire and report remedy.

**Challenges:** If the early remediation program is truly predisciplinary (precomplaint), as opposed to being an alternative to discipline, there are no savings for the BON to realize in terms of diverting disciplinary cases to these alternative resolutions, thus avoiding normal costs associated with full investigation and litigation. Early intervention in the case of growing clinical deficiencies that have yet to violate nursing law is clearly a more enlightened approach in terms of patient safety. On one level, it seems logical for a BON to be proactive and exercise its regulatory authority prior to the nurse’s practice putting a patient at risk. However, one reason this pure model may not have caught on is because it entails an extraordinary shift in resources. The BON and employer must expend much more energy towards early intervention in the hopes they will realize disciplinary savings down the road. A transition to such a new early intervention approach must be attempted while the BON still faces its current disciplinary workload, which is usually in the context of limited resources where staff are being asked to do more with less.

Another challenge is that whenever a regulatory entity attempts to resolve their cases prior to and without initiating formal discipline, there is an automatic public perception issue. The immediate reaction by stakeholders, public, media and legislators is that the BON is protecting their own and sweeping the problems under the carpet by informal resolution.

**Heightened Confidentiality**

All such alternative programs provide some greater degree of confidentiality as to the resolution than would be the case under traditional discipline where resolutions are published and reported. In a few cases, and through new legislation or rule making, a BON has carved out an express exception to normal public disclosure expectations for any successful participation in the alternative program, similar to the substance abuse monitoring program. However, in the majority of states, the statutory expectation is that any and all business that is conducted by its government is publicly available. As a result, there is a legal limit to the confidentiality aspect of these programs in that any such alternative resolutions, while not proactively disseminated as with any traditional disciplinary action, must still be made publicly disclosable. Still, the matter can be quietly closed as otherwise resolved and only specific requests for disclosure would result in release.

**Benefits:** The less public nature of these alternative programs is a significant enticement for nurses to participate in such alternative programs. No matter what a state’s practice act cites as its underlying philosophy, health care discipline is often viewed by the respondent as punishment meted out in the public square. If a resolution can be achieved that meets all the requirements of public protection, but does not involve a broad dissemination of the results to include national databank reporting, the practitioner will likely be much more willing to engage in a more collaborative process to address the deficiencies in their practice with a tailored action plan. Indeed, the nurse may be willing to agree to a more onerous probationary scheme than would be the case with a very public disciplinary document.

**Challenges:** Even though in every case a record is kept as to how the disciplinary matter was resolved, the BON will have to confront the perception by stakeholders that they are sweeping discipline under the carpet or conducting their business behind a curtain of confidentiality. The public’s right to know, to include being affirmatively notified of what was done regarding risky conduct, will be a significant political challenge to a BON.
Limited to Select Class of Practitioners with Deficiencies

One way to fight this perception challenge is to expressly limit any such alternative program to only those cases where the alleged conduct is not so risky as to warrant traditional discipline. If the conduct at issue is such that continued practice poses an unacceptable risk of patient harm, then pursuing suspension or restriction of the license and disclosing it as public information remains the appropriate option.

Regardless of how risky the conduct, participants must have the right attitude and acknowledge that they need help and be willing to work collaboratively. Nurses whose substandard care was intentional, involved reckless disregard or who simply want to clear their name are not eligible for this program. It is also common for the participant to be asked to stipulate to the underlying facts and that the facts amount to a violation of the practice act. The benefit here to the BON is that its case does not grow stale from an evidentiary standpoint as the parties seek a predisciplinary resolution.

Cases involving serious patient injury or death may have to be expressly excluded from such alternative programs in light of political realities. This is true, despite notions of Just Culture and the proposition that outcomes should not dictate the disciplinary treatment warranted.

**Benefits**: By limiting the pool of practitioners who may participate in such programs, the BON confirms its interest in exercising its regulatory priorities responsibly. The BON is not abandoning its fundamental obligation to intervene forcefully in any case where patient care is truly at risk, but instead, is wisely exercising its discretion so as to expend resources in the smartest way possible and stave off future serious misconduct.

**Challenge**: Assessment of each case with firm criteria is key, though no such assessment is free from miscalculation. It is a challenge in itself to assess the risk level in a case where a nurse’s clinical deficiencies have come to light in the workplace and determine whether that nurse is a safe and appropriate candidate for a more informal and nondisciplinary regulatory approach. The BON must acknowledge the subjective scale they will employ in any such process of deferring certain cases away from traditional discipline models. If the BON is too liberal in its application of the criteria it risks failing to remove a real public threat. If the BON is too restrictive, the benefits of the alternative approach cannot be realized in numbers great enough to make a difference, either in cost or effectiveness.

**Involves a Remediation Action Plan**

The heart of any such alternative program is an agreed plan to address the clinical deficiencies that appear to be the cause for the alleged substandard care. The plan is developed in collaboration by the BON, the nurse in question and, in most instances, the employer. The plan should be focused, tailored and specific. The plan will usually include both an educational component, as well as some sort of subsequent monitoring aspect, ideally in the workplace, to confirm that the remedial education achieved its desired effect on the nurse’s practice.

**Benefits**: A plan for remediation of a perceived deficiency in a nurse’s practice is almost always the end result in disciplinary cases involving low to moderate risk practice deficiencies. In the traditional disciplinary model, the agreed set of probationary conditions, potentially watered down by the negotiating process, may not be the ideal method for improving practice. Moreover, there is the timeliness of the resolution. What results from months or years of investigation, litigation and no involvement of the current employer with monitoring from a distance by BON staff, may not be the best instrument to affect change in practice. Removing the design process for the remediation plan from the contentious public/punitive environment and placing it in a predisciplinary collaborative context makes for much more timely and effective regulation.

**Challenges**: No amount of tailored remediation can be viewed as effective if there is no subsequent plan for reliable monitoring, preferably in the real world conditions of the workplace. Thus, the employer plays a critical role in underpinning the credibility of any such program to truly ensure public protection. Unfortunately, there often is no assurance the nurse’s employer is available and willing to participate in such a program. Oftentimes, the nurse is no longer working for the same
employer where the practice deficiencies were identified. And as mentioned previously, there must first and foremost be a climate of trust to ensure a closer working relationship between the BON and those that employ its licensees.

Other Considerations and Unresolved Issues

Express authorization in statute or rule: While express authorization is ideal, is a statutory amendment necessary or can such a program be launched on a limited pilot basis in keeping with notions of prosecutorial discretion? That is, if a BON can close low risk substandard care cases that amount to practice act violations as below threshold, why can the BON not seek to resolve such cases first on a predisciplinary basis?

In those states that have Letters of Concern, then these tools already address and resolve the low-level substandard practice issues that make up the bulk of cases that the above alternative approach would remedy. But will a Letter of Concern truly resolve a case of potential growing patient risk when they involve no remediation expectations?

Cost related issues: Most would agree that all costs associated with the remediation plan, especially the educational component, should be born by the nurse. But even if the nurse in question can afford this, are there effective hands on remedial education resources available at a reasonable cost in your state? The nursing shortage is most pronounced in the academic arena and there are not enough teachers to train the nursing students, much less those graduates who need remediation. Or is the employer expected to provide these opportunities at the workplace?

Conclusion and Possible Next Steps

While the Disciplinary Resources Committee notes the low number of states that have successfully launched alternatives to discipline in substandard care, we feel there remains reason for optimism on this front. Current budget challenges of historical severity grip all state governments and the nursing shortage is forecast to worsen in light of demographic trends. Within this crisis, there is unique opportunity. Budget woes and shortages serve to undercut the trends of resistance to fundamental changes in a regulatory model that can be made more efficient and effective. Doing more with less is no longer merely an ideal, but an imperative.

However, Member Boards need practical tools for exploring such alternative models, whether they are considering them for the first time or revisiting these alternative schemes. Moreover, they need the best practices model for launching their exploration with greater long term success.

In an effort to take this charge by the Board of Directors to the next logical phase, this committee recommends the following possible next steps in terms of strategies to support implementation of any such initiative:

- Develop and/or gather best practices model policies/procedures to include related criteria, templates (e.g., action plans, etc.), draft statutory or rule language.
- Design a recommended implementation strategy. For example, a small scale pilot could be developed for low-level cases that might have been closed below threshold or with a warning letter in order to work out the bugs before expanding to moderate risk cases where the cost savings can be greater.
- Continue to monitor and gather data from laboratory states, especially those states just beginning to embark on such an endeavor.
- Explore how principles of Just Culture can be integrated into launching nondisciplinary alternatives in practice related cases.
Report of the Finance Committee

Background
The Finance Committee advises the Board of Directors (BOD) on the overall direction and control of the finances of the organization monitoring income, expenditures and program activities against projections. They present quarterly financial statements, and review and recommend a budget 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 independent auditors, and the annual independent audit of NCSBN financial statements. They recommend to the BOD the appointment of a firm to serve as independent 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 FY09 Activities
- Reviewed and discussed with management and the organization’s independent accountant, Legacy Professionals LLP, the organization’s audited financial statements as of and for the fiscal year ended Sept. 30, 2008. With and without management present, the Finance 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 (Attachment B).
- Reviewed and discussed the performance and the independence of Legacy Professionals LLP. Based on the review and discussion, the Finance Committee recommended the engagement of Legacy to audit the financial statements for the fiscal years ending Sept. 30, 2009, 2010, and 2011.
- Reviewed and discussed the long range forecast and proposed NCSBN budget for FY09. Recommended to the BOD approval of the FY09 budget.
- 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, on a quarterly basis.
- Conducted a search and recommended a new firm, JP Morgan Asset Management, to manage NCSBN bond investments.
- 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 the BOD that the organization is appropriately insured.
- Recommended revisions to financial policies.

Future Activities

Attachments
B. Report of the Independent Auditors FY08
Attachment A

Financial Summary Report for the Period
Oct. 1, 2008 to March 31, 2009

At March 31, 2009, the net cash position, cash and marketable securities less current liabilities, equaled $103 million. NCSBN has no significant long term liabilities except the lease for office space. Net assets decreased by $1.8 million during the first six months of the fiscal year.

Revenue

NCLEX® exam revenue for the first six months of FY09 decreased by $727,000 from the prior year for the same period. 118,801 paid registrations were processed for the six month period ended March 31, 2009. This was a 1.4 percent decrease from the FY08 count of 120,471. There were 10,149 registrations at international test sites during the first six months of the fiscal year compared to 12,731 for the same period last year.

There are currently 38 boards of nursing using Nursys® for licensure verification. Fee revenue totaling $1.1 million for Nursys verifications is up by 3.6 percent compared to the same period the prior year.

Learning Extension sales revenue increased by 10 percent for the first six months of FY09 compared to the same period for the prior year. Enrollments declined by two percent for the NCLEX-RN® Review course, which is expected to generate 75 percent of e-learning's sales revenue. Increased enrollments in other courses more than offset the decline in sales of the NCLEX-RN® Review course for the period.

As the economy remains mired in a deep recession, stock and real estate market valuations continued to decline during the second quarter. The Federal Reserve is holding short-term interest rates at very low levels, keeping the returns on short-term cash down.

The NCSBN total long-term investment portfolio, stocks, bonds and real estate, was down $1.5 million and returned -4.2 percent for the quarter. The long-term portfolio is down $8.3 million and returned -12 percent for the six month period ended March 31, 2009. NCSBN continues to hold a significant cash position. Total stock, bond, real estate and short-term cash investments are down $7.8 million and returned a net -9.5 percent for the six month period.

Expenditures

The FY09 budget includes $2.8 million for software development and $2.2 million for hardware and software purchases. $1.3 million was expended during the first six months of FY09. It is expected that spending will catch up to the budget for these items over the second half of the fiscal year. The $1.25 million budgeted for the purchase of the National Nurse Aide Assessment Program (NNAAP™) and Medication Aide Certification Examination (MACE™) intellectual property rights were expended during the second quarter.

The number of proposals for research grants received from external organizations is lower than expected. Actual grants awarded for FY09 total $934,000; $2.5 million was budgeted for the year.

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

Other operating expense variances are assumed to be timing differences and are projected to be at or near the budgeted amounts.
Financial Position
Total NCLEX registrations for the first six months of the fiscal year were down 1.4 percent. Registrations at international test centers were down by 20 percent for the same period. As in the past, the third quarter is critical, as we typically earn 39 percent of our annual NCLEX revenue during that period.

The net cash position is projected to equal $103.4 million by the end of FY09.

Six Month Summary
- Total NCLEX registrations are down by 1.4 percent and international test center registrations are down 20 percent.
- $7.8 million dollar loss on investments, -12 percent return on long term investments and -9.5 percent net return on total investments (including short-term cash).
- $934,000 in external research grants were awarded in FY09 compared to a budget of $2.5 million.
- Only 25 percent of Information Technology (IT) capital budget expended to date. Spending is expected to equal budget by the end of the year.
- Total other operating expenses should be favorable to budget for the year.
- One percent growth projected for cash position; $103.4 million expected by fiscal year end.
## NCSBN Statement of Revenue and Expense

### Revenue

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Year to Date Actual at 3/31/09</th>
<th>Annual Budget</th>
<th>Projected Actual</th>
<th>Variance</th>
<th>Year to Date as a % of Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCLEX revenue</td>
<td>25,277,350</td>
<td>62,156,000</td>
<td>62,840,000</td>
<td>684,000</td>
<td>1%</td>
</tr>
<tr>
<td>NCLEX program reports royalty</td>
<td>58,800</td>
<td>94,000</td>
<td>71,000</td>
<td>(23,000)</td>
<td>-24%</td>
</tr>
<tr>
<td>NCLEX quick results</td>
<td>222,542</td>
<td>478,000</td>
<td>441,000</td>
<td>(37,000)</td>
<td>-8%</td>
</tr>
<tr>
<td>NNAAP royalty income</td>
<td>82,757</td>
<td>57,500</td>
<td>82,757</td>
<td>25,257</td>
<td>44%</td>
</tr>
<tr>
<td>Learning Extension</td>
<td>897,869</td>
<td>2,042,600</td>
<td>2,004,000</td>
<td>(38,600)</td>
<td>-2%</td>
</tr>
<tr>
<td>Nursys license verification fees</td>
<td>1,098,846</td>
<td>2,156,000</td>
<td>2,220,000</td>
<td>64,000</td>
<td>3%</td>
</tr>
<tr>
<td>Nursys data query fees</td>
<td>7,005</td>
<td>146,500</td>
<td>109,000</td>
<td>(37,500)</td>
<td>-26%</td>
</tr>
<tr>
<td>Membership fees</td>
<td>181,500</td>
<td>181,500</td>
<td>181,500</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>NCLA Fees</td>
<td>43,000</td>
<td>43,000</td>
<td>43,000</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Government grants and other income</td>
<td>180,769</td>
<td>324,800</td>
<td>325,000</td>
<td>200</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>28,056,338</strong></td>
<td><strong>67,679,900</strong></td>
<td><strong>68,324,262</strong></td>
<td><strong>644,362</strong></td>
<td><strong>1%</strong></td>
</tr>
</tbody>
</table>

### Expense

<table>
<thead>
<tr>
<th>Expense</th>
<th>Year to Date Actual at 3/31/08</th>
<th>Annual Budget</th>
<th>Projected Actual</th>
<th>Variance</th>
<th>Year to Date as a % of Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>2,896,455</td>
<td>6,659,300</td>
<td>6,259,000</td>
<td>400,300</td>
<td>6%</td>
</tr>
<tr>
<td>Fringe benefits</td>
<td>776,232</td>
<td>1,823,300</td>
<td>1,714,000</td>
<td>109,300</td>
<td>6%</td>
</tr>
<tr>
<td>NCLEX processing costs</td>
<td>12,352,150</td>
<td>31,764,700</td>
<td>32,125,000</td>
<td>(360,300)</td>
<td>-1%</td>
</tr>
<tr>
<td>Other professional service fees</td>
<td>1,700,355</td>
<td>5,324,800</td>
<td>5,325,000</td>
<td>(200)</td>
<td>0%</td>
</tr>
<tr>
<td>Supplies and materials</td>
<td>34,943</td>
<td>110,300</td>
<td>110,000</td>
<td>300</td>
<td>0%</td>
</tr>
<tr>
<td>Meetings and travel</td>
<td>1,290,604</td>
<td>3,456,200</td>
<td>3,158,000</td>
<td>298,200</td>
<td>9%</td>
</tr>
<tr>
<td>Telephone and communications</td>
<td>157,942</td>
<td>472,900</td>
<td>473,000</td>
<td>(100)</td>
<td>0%</td>
</tr>
<tr>
<td>Postage and shipping</td>
<td>50,563</td>
<td>176,600</td>
<td>177,000</td>
<td>(400)</td>
<td>0%</td>
</tr>
<tr>
<td>Occupancy</td>
<td>442,829</td>
<td>913,600</td>
<td>914,000</td>
<td>(400)</td>
<td>0%</td>
</tr>
<tr>
<td>Printing, copying and publications</td>
<td>119,766</td>
<td>699,900</td>
<td>700,000</td>
<td>(100)</td>
<td>0%</td>
</tr>
<tr>
<td>Library/Memberships</td>
<td>63,781</td>
<td>105,700</td>
<td>106,000</td>
<td>(300)</td>
<td>0%</td>
</tr>
<tr>
<td>Insurance</td>
<td>58,929</td>
<td>58,400</td>
<td>58,000</td>
<td>400</td>
<td>1%</td>
</tr>
<tr>
<td>Equipment rental and maintenance</td>
<td>803,402</td>
<td>1,188,500</td>
<td>1,188,000</td>
<td>500</td>
<td>0%</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>1,153,021</td>
<td>3,925,600</td>
<td>3,926,000</td>
<td>(400)</td>
<td>0%</td>
</tr>
<tr>
<td>External research grants</td>
<td>74,878</td>
<td>2,500,000</td>
<td>934,000</td>
<td>1,566,000</td>
<td>63%</td>
</tr>
<tr>
<td>JRC and other expenses</td>
<td>61,116</td>
<td>708,600</td>
<td>709,000</td>
<td>(400)</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td><strong>22,036,966</strong></td>
<td><strong>59,888,400</strong></td>
<td><strong>57,876,000</strong></td>
<td><strong>2,012,400</strong></td>
<td><strong>3%</strong></td>
</tr>
</tbody>
</table>

| Surplus/(deficit)                    | 6,019,372                       | 7,791,500     | 10,448,262       | 2,656,762 |                                     |                                     |

| Investment Income                   | (7,798,268)                     | 3,900,000     | (7,798,000)      | (11,698,000) | -300%                                 |

| Capital                              | 2,558,913                       | 6,243,100     | 6,243,100        | 0          |                                     |                                     |

This statement has not been audited. Projected amounts are estimates.
Attachment B

Report of the Independent Auditors FY08

LEGACY
PROFESSIONALS LLP
CERTIFIED PUBLIC ACCOUNTANTS

REPORT OF INDEPENDENT AUDITORS

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

We have audited the accompanying statements of financial position of National Council of State
Boards of Nursing, Inc. (NCSBN) as of September 30, 2008 and 2007, and the related statements
of activities and of cash flows for the years then ended. These financial statements are the
responsibility of the NCSBN’s management. Our responsibility is to express an opinion on these
financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects,
the financial position of National Council of State Boards of Nursing, Inc. as of September 30,
2008 and 2007, and the changes in its net assets and its cash flows for the years then ended in
conformity with accounting principles generally accepted in the United States of America.

January 7, 2009
### NATIONAL COUNCIL OF STATE BOARDS OF NURSING, INC.

#### STATEMENTS OF FINANCIAL POSITION

**SEPTEMBER 30, 2008 AND 2007**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>$48,621,831</td>
<td>$43,396,299</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>190,115</td>
<td>281,767</td>
</tr>
<tr>
<td>Due from test vendor</td>
<td>5,840,113</td>
<td>5,815,288</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>507,712</td>
<td>669,196</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>1,317,641</td>
<td>1,224,221</td>
</tr>
<tr>
<td>Investments</td>
<td>66,896,909</td>
<td>59,523,245</td>
</tr>
<tr>
<td>Property and equipment - net</td>
<td>4,130,203</td>
<td>3,623,047</td>
</tr>
<tr>
<td>Cash held for others</td>
<td>291,443</td>
<td>223,704</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>$127,795,967</td>
<td>$114,756,767</td>
</tr>
</tbody>
</table>

|                      |            |            |
| **LIABILITIES AND NET ASSETS** |            |            |
| Accounts payable     | $1,294,055 | $737,882  |
| Accrued payroll, payroll taxes and compensated absences | 548,109 | 402,719 |
| Due to test vendor   | 9,941,741  | 10,256,375|
| Deferred revenue     | 338,410    | 242,304   |
| Grants payable       | 1,321,647  | 1,642,366 |
| Deferred rent credits | 323,661    | 398,359   |
| Cash held for others | 291,443    | 223,704   |
| **Total liabilities** | 14,059,066 | 13,903,709 |

| **UNRESTRICTED NET ASSETS** | 113,736,901 | 100,853,058 |

**Total liabilities and net assets** | $127,795,967 | $114,756,767 |

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

## STATEMENTS OF ACTIVITIES

**YEARS ENDED SEPTEMBER 30, 2008 AND 2007**

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination fees</td>
<td>$63,156,300</td>
<td>$61,113,670</td>
</tr>
<tr>
<td>Other program services income</td>
<td>5,698,590</td>
<td>5,335,731</td>
</tr>
<tr>
<td>Net realized and unrealized gain (loss) on investments</td>
<td>(7,471,337)</td>
<td>1,371,162</td>
</tr>
<tr>
<td>Net realized (loss) on disposal of property and equipment</td>
<td>-</td>
<td>(9,686)</td>
</tr>
<tr>
<td>Interest and dividend income</td>
<td>4,466,763</td>
<td>4,820,748</td>
</tr>
<tr>
<td>Membership fees</td>
<td>177,000</td>
<td>177,000</td>
</tr>
<tr>
<td><strong>Total revenue</strong></td>
<td>66,027,316</td>
<td>72,808,625</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EXPENSES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse competence</td>
<td>37,288,471</td>
<td>34,820,112</td>
</tr>
<tr>
<td>Nurse practice and regulatory outcome</td>
<td>6,456,365</td>
<td>6,632,842</td>
</tr>
<tr>
<td>Information</td>
<td>6,615,912</td>
<td>5,407,653</td>
</tr>
<tr>
<td><strong>Total program services</strong></td>
<td>50,360,748</td>
<td>46,860,607</td>
</tr>
<tr>
<td>Supporting services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management and general</td>
<td>2,782,725</td>
<td>2,342,066</td>
</tr>
<tr>
<td><strong>Total expenses</strong></td>
<td>53,143,473</td>
<td>49,202,673</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NET INCREASE</strong></td>
<td>12,883,843</td>
<td>23,605,952</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UNRESTRICTED NET ASSETS</strong></td>
<td>100,853,058</td>
<td>77,247,106</td>
</tr>
<tr>
<td>Beginning of year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of year</td>
<td>$113,736,901</td>
<td>$100,853,058</td>
</tr>
</tbody>
</table>

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

### Statements of Cash Flows

**Years Ended September 30, 2008 and 2007**

<table>
<thead>
<tr>
<th>Description</th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net increase</td>
<td>$12,883,843</td>
<td>$23,605,952</td>
</tr>
<tr>
<td>Adjustments to reconcile net increase to net cash provided by (used in)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>2,158,840</td>
<td>1,795,733</td>
</tr>
<tr>
<td>Net realized and unrealized (gain)</td>
<td>7,471,337</td>
<td>(1,371,162)</td>
</tr>
<tr>
<td>Net realized loss on disposal of property and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Increase) decrease in assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>91,652</td>
<td>(10,637)</td>
</tr>
<tr>
<td>Due from test vendor</td>
<td>(24,825)</td>
<td>(920,272)</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>161,484</td>
<td>(150,225)</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>(93,420)</td>
<td>(267,360)</td>
</tr>
<tr>
<td>Increase (decrease) in liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>556,173</td>
<td>278,351</td>
</tr>
<tr>
<td>Accrued payroll, payroll taxes and compensated absences</td>
<td>145,390</td>
<td>98,765</td>
</tr>
<tr>
<td>Due to test vendor</td>
<td>(314,634)</td>
<td>1,814,617</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>96,106</td>
<td>(105,163)</td>
</tr>
<tr>
<td>Grants payable</td>
<td>(320,719)</td>
<td>1,642,366</td>
</tr>
<tr>
<td>Deferred rent credits</td>
<td>(74,698)</td>
<td>(74,699)</td>
</tr>
<tr>
<td>Net cash provided by operating activities</td>
<td>22,736,529</td>
<td>26,345,932</td>
</tr>
<tr>
<td><strong>Cash Flows from Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchases of property and equipment</td>
<td>(2,665,996)</td>
<td>(2,161,270)</td>
</tr>
<tr>
<td>Purchases of investments</td>
<td>(28,323,891)</td>
<td>(30,847,870)</td>
</tr>
<tr>
<td>Proceeds on sale of investments</td>
<td>13,478,890</td>
<td>22,263,405</td>
</tr>
<tr>
<td>Proceeds on sale of property and equipment</td>
<td></td>
<td>10,649</td>
</tr>
<tr>
<td>Net cash (used in) investing activities</td>
<td>(17,510,997)</td>
<td>(10,735,086)</td>
</tr>
<tr>
<td><strong>Net Increase</strong></td>
<td>5,225,532</td>
<td>15,610,846</td>
</tr>
</tbody>
</table>

**Cash**

<table>
<thead>
<tr>
<th>Description</th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning of year</td>
<td>$43,396,299</td>
<td>$27,785,453</td>
</tr>
<tr>
<td>End of year</td>
<td>$48,621,831</td>
<td>$43,396,299</td>
</tr>
</tbody>
</table>

See accompanying notes to financial statements.
NOTES TO FINANCIAL STATEMENTS
SEPTEMBER 30, 2008 AND 2007

NOTE 1. DESCRIPTION OF THE ORGANIZATION

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

The program services of NCSBN are defined as follows:

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

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

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

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

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

Accounts Receivable - Represents amounts owed to NCSBN for services dealing with board membership fees, meeting fees and royalties. Accounts receivable at September 30, 2008 and 2007 were $190,115 and $281,767 respectively. An allowance for doubtful accounts was not considered necessary.

Investments - Investments are carried at fair value which generally represents quoted market price as of the last business day of the year. Money market funds and certificates of deposit are carried at cost and maintained within an individual investment portfolio.

The investment in the Clarion Lion Real Estate Properties is carried at estimated fair value as estimated by the investment manager.

Due from Test Vendor - Due from test vendor represents amounts owed by Pearson VUE for candidate applications received as well as rebates calculated on vendor performance and volume per contract. The amounts owed by Pearson VUE at September 30, 2008 and 2007 were $5,840,113 and $5,815,288 respectively.

Pearson VUE performs substantially all testing services for NCSBN.

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

<table>
<thead>
<tr>
<th>Property and Equipment</th>
<th>Useful Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furniture and equipment</td>
<td>5 - 7 years</td>
</tr>
<tr>
<td>Course development costs</td>
<td>2 - 5 years</td>
</tr>
<tr>
<td>Computer hardware and software</td>
<td>2 - 5 years</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>life of lease</td>
</tr>
</tbody>
</table>

Due to Test Vendor - Due to test vendor represents unpaid amounts to Pearson VUE for candidate testing, which includes approximately $6,673,000 at September 30, 2008 and $6,966,000 at September 30, 2007 for registered candidates who as of year end had not taken the exam. The amounts owed to Pearson VUE at September 30, 2008 and 2007 were $9,941,741 and $10,256,375 respectively.

Deferred Revenue - Deferred revenue consists of membership fees of $181,500 for 2008 and $177,000 for 2007 and online course revenue of $156,910 for 2008 and $65,304 for 2007.

Grants Payable - Represents Nurse Practice and Regulatory Outcome research grants that are generally available for periods of one to two years. NCSBN awarded eight grants ranging in amounts from $20,000 to $294,000 during the current year. For the year September 30, 2008, the amount remaining to be paid on grants awarded for 2008 and 2007 is $964,670 and $356,977, respectively.
NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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

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

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

NOTE 3. TAX STATUS

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

NOTE 4. CASH CONCENTRATIONS

The cash balance as of September 30, 2008 and 2007 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>JP Morgan Chase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking account</td>
<td>$782,906</td>
<td>$4,807,491</td>
</tr>
<tr>
<td>Money market account</td>
<td>15,153,219</td>
<td>-</td>
</tr>
<tr>
<td>Certificates of deposit</td>
<td>32,086,910</td>
<td>38,328,527</td>
</tr>
<tr>
<td>Wells Fargo Bank:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking account</td>
<td>562,158</td>
<td>231,140</td>
</tr>
<tr>
<td>Credit card merchant accounts</td>
<td>36,388</td>
<td>28,891</td>
</tr>
<tr>
<td>Petty cash</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>Total</td>
<td>$48,621,831</td>
<td>$43,396,299</td>
</tr>
</tbody>
</table>

NCSBN places its cash with financial institutions deemed to be creditworthy. Cash balances may at times exceed the insured deposit limits. Effective October 3, 2008, balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000.
**Note 5. Investments**

The composition of investments at September 30, 2008 and 2007 is as follows:

<table>
<thead>
<tr>
<th>Investment</th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Government and Government Agency obligations</td>
<td>13,426,931</td>
<td>13,930,820</td>
</tr>
<tr>
<td>Corporate bonds</td>
<td>22,639,119</td>
<td>21,732,084</td>
</tr>
<tr>
<td>Mutual funds:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DWS Equity 500 Index Fund</td>
<td>16,125,471</td>
<td>9,564,629</td>
</tr>
<tr>
<td>Spartan Extended Market Index Fund</td>
<td>4,901,473</td>
<td>2,404,945</td>
</tr>
<tr>
<td>Spartan International Inded Fund</td>
<td>4,533,646</td>
<td>2,709,987</td>
</tr>
<tr>
<td>Others</td>
<td>30,832</td>
<td>15,243</td>
</tr>
<tr>
<td>Clarion Lion Real Estate Properties</td>
<td>5,224,499</td>
<td>-</td>
</tr>
<tr>
<td>Money market fund</td>
<td>14,938</td>
<td>5,165,537</td>
</tr>
<tr>
<td>Certificates of deposit - JP Morgan Chase</td>
<td>-</td>
<td>4,000,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>66,896,909</strong></td>
<td><strong>59,523,245</strong></td>
</tr>
</tbody>
</table>

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

The composition of property and equipment at September 30, 2008 and 2007 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td>$1,256,482</td>
<td>$1,324,457</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>13,418,864</td>
<td>10,942,921</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>440,183</td>
<td>369,614</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15,487,258</td>
<td>12,908,721</td>
</tr>
<tr>
<td>Less accumulated depreciation and amortization</td>
<td>(11,357,055)</td>
<td>(9,285,674)</td>
</tr>
<tr>
<td>Net property and equipment</td>
<td>$4,130,203</td>
<td>$3,623,047</td>
</tr>
</tbody>
</table>

Depreciation was $2,158,840 and $1,795,733 for the years ended September 30, 2008 and 2007, respectively.

NOTE 7. OPERATING LEASE

NCSBN has a lease agreement for office space which expires January 31, 2013. The following is a summary by year of future minimum lease payments required under the office lease as of September 30, 2008:

<table>
<thead>
<tr>
<th>Year ending September 30, 2009</th>
<th>$506,950</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>522,343</td>
</tr>
<tr>
<td>2011</td>
<td>538,011</td>
</tr>
<tr>
<td>2012</td>
<td>554,276</td>
</tr>
<tr>
<td>2013</td>
<td>186,668</td>
</tr>
<tr>
<td>Total</td>
<td>$2,308,248</td>
</tr>
</tbody>
</table>

Rent expense for the years ended September 30, 2008 and 2007 was $841,932 and $837,356 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. In the year ended September 30, 2007, NCSBN instituted a 457(b) non-qualified deferred compensation plan. Eligibility is limited as it is considered a top hat plan. Retirement plans expense was $433,749 and $423,853 for the years ended September 30, 2008 and 2007, respectively.

NOTE 9. COMMITMENTS

NCSBN has entered into an agreement to purchase the intellectual property rights for the nurse aid certification examination (NNAAP) and the medication aid certification examination (MACE). In exchange for the purchase, NCSBN will pay $1,250,000 upon transfer of the NNAAP and MACE intellectual property. The exchange is expected to be completed within six months after year end.

NCSBN has entered into contracts for services and accommodations for future meetings. These contracts include penalty clauses which would require NCSBN to pay certain amounts if a meeting were to be canceled or guarantees for room blocks are not fulfilled. At September 30, 2008, the requirements to fulfill these commitments approximated $428,000.

NCSBN has also entered into various contracts for futures services. At September 30, 2008, the requirements to fulfill these commitments approximate $183,000 and are expected to be completed within one year.

During the year ended September 30, 2008, NCSBN entered into a subscription agreement to invest in an international equity fund. On October 1, 2008 NCSBN transferred cash in the amount of $2,000,000 to fund the investment.
Report of the Institute of Regulatory Excellence Committee

Background

As part of NCSBN's mission to promote regulatory excellence, a four-year fellowship program called the Institute of Regulatory Excellence (IRE) was developed for nursing regulators. The 2008-2009 year marked its sixth anniversary. Since its inception, every effort has been made to promote the growth and leadership of those participating in the program. In addition to the Annual IRE Conference, participants enhance their knowledge and skills in research design, evidenced-based regulation and/or project management. This is achieved through the development of a project related to a regulatory problem or need in their individual state.

The IRE was restructured in 2007. The committee evaluates the program, as well as the progress of the participants, on an ongoing basis. A total of 15 individuals currently participate in the program. These individuals belong to the following cohorts:

- Year 4 (2006 cohort): four participants
- Year 3 (2007 cohort): one participant
- Year 2 (2008 cohort): five participants
- Year 1 (2009 cohort): seven participants

The following is a report on the committee's 2009 charges:

- Select 2009 IRE Fellowship participants and mentors, approve fellowship project proposals and final reports
  - Seven individuals applied to the program for the 2009 cohort. The committee reviewed all applications for admission into the program and determined that all applicants met the qualifications for an IRE Fellowship. Assistance in choosing a mentor has been provided; the committee approved the mentors during their April meeting.
  - Final project reports for the 2006 cohort are due June 1, 2009. Committee members will review the reports and determine eligibility for fellowship induction. Proposals from the 2008 cohort have been reviewed and feedback has been provided.

- Advise staff on issues related to the implementation of the IRE Fellowship Program
  - Evaluation of the fellowship program occurs on an ongoing basis and the committee is constantly striving to make improvements. Exemplars from 2009 include:
    - The committee added performance measures to the IRE program. All fellowship candidates will be required to complete a self-evaluation related to these measurements. Feedback will also be given to each candidate from the mentor, as well as the committee. Feedback from this process will also be used to improve the program in subsequent years.
    - A more formalized learning plan was developed and implemented with participants given feedback about their objectives and related activities.
    - The committee has reevaluated the mentorship process. Some mentors have been unable to assist the participants with their projects because it was outside their area of expertise. NCSBN Nursing Regulation staff has taken on the role of project consultants and assists participants with the development and analysis of their projects. IRE Fellows will be asked to volunteer as mentors.
The IRE Committee requested from the Board of Directors (BOD) that an individual in their last year of the program be allowed to finish the program with approval from their executive officer and the committee. The BOD granted approval.

Biannual cohort conference calls have been instituted to allow participants to share ideas, support one another and network.

Advise staff regarding the content of the Annual IRE Conference and the Annual Induction Ceremony

The theme of the 2009 conference was discipline. This year's program had several modifications from former conferences:

An IRE orientation day was added to the program. This included presentations about the IRE program, conducting a literature review, developing a project and writing a proposal. An IRE tool kit was distributed to every participant containing valuable references and resources for project development and writing a proposal. Based on evidence and feedback from various sources, the committee determined that every participant attending the conference should attend these presentations. This ensures that everyone understands the program's expectations and is on the same page.

An emphasis was placed on challenging the participants to think, ask questions, and share ideas and perspectives. For the first time, one day of the meeting was centered on a case study. Each presentation addressed one aspect of a complex practice case. A final analysis at the end of the day involved all speakers and participants in a rich and thought-provoking discussion.

The conference was very well received by the participants. All participants gave high ratings to the speakers and felt the conference met the objectives. Many participants verbally commented that the case study and its presentations were not only a great learning experience for them, they also enjoyed the opportunity to participate and share their ideas and perspectives.

The induction ceremony was addressed by the BOD and they have requested that the Awards Committee address this issue.

Because of the need to arrange speakers in advance, the committee has already begun discussions on the 2010 conference.

Overall, the IRE continues to improve on an annual basis and provide a unique learning experience for those who participate. Membership in 2009 rose for the first time in four years. The only aspect of the IRE that NCSBN members voice concern over is the fact that the four-year program limits those who can participate. Some members are reluctant, due to time constraints, to make a four-year commitment. Board members who have less than a four-year term left are also unable to become involved.

There is no other program/conference that is so aptly geared towards meeting the learning needs of nursing regulators. The committee will continue to evaluate the program and progress of participants to make this a worthwhile and enriching experience for all who participate.

**Highlights of FY09 Activities**

- The addition of seven new IRE participants in the 2009 IRE cohort.
- The 2009 Annual IRE Conference on Discipline was one of the year's highlights, including the addition of an IRE Orientation and Research Day, and devoting one day to a complex case study.
- Addition of performance measures and a more structured learning plan to provide direction for IRE participants.
- Participation by NCSBN senior staff in the IRE program as research/project consultants.
Future Activities

- Select 2009 IRE Fellowship participants and mentors, and approve fellowship project proposals and final reports.
- Advise staff on issues related to the implementation of the IRE Fellowship Program.
- Advise staff regarding the content of the Annual IRE Conference and the Annual Induction Ceremony.
- Strategize methods for maintaining involvement of IRE Fellows in the IRE program.

Attachments

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

Background
In August 2008, NCSBN acquired exclusive ownership of the intellectual property for the National Nurse Aide Assessment Program (NNAAP™) and the Medication Aide Certification Examination (MACE™) program. NNAAP is a two-part examination consisting of a written (oral) examination and a skills evaluation. NNAAP has been administered to more than 2.5 million candidates and is the leading nurse aide assessment instrument in the U.S. MACE is a new national examination that NCSBN is developing for state regulatory agencies. MACE will help to evaluate the competence of unlicensed individuals allowed to administer medications to clients in nonacute settings, such as assisted living facilities and elder care settings.

With the new acquisition of programs that certify unlicensed, direct care workers, NCSBN gains exclusive control over the establishment of the NNAAP and MACE test plans, and ownership of exam content. Pearson VUE, the contracted test service, will be responsible for all delivery, administration, publishing (electronic and paper), sales and market development activities associated with the exams, in addition to the following testing services: eligibility screening and registration; test site scheduling; test administration (test site and Registered Nurse Evaluator management); scoring; and reporting. The registry services provided by Pearson VUE include initial certification, recertification and reciprocity management, as well as public access registry verifications through the Internet.

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

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

With the newly acquired NNAAP and MACE programs, NCSBN can continue to serve as the premier organization that advances regulatory excellence for public protection. Moving forward, NCSBN will play a pivotal role in the content development for the NNAAP and MACE programs. Pearson VUE will continue to administer the certifying exams to our client states. States participating in these examination programs, through NCSBN, will continue to provide support to licensed health care professionals who need more qualified staff at the bedside to assist in the delivery of safe, competent care.

Highlights of FY09 Activities
- Thirty-four new skills forms went into operational use July 1, 2008, across 24 states.
- In August 2008 NCSBN acquired exclusive ownership of the intellectual property for NNAAP and MACE.
- In October 2008 NCSBN established the NNAAP™ & MACE™ Examinations Department.
- In January 2009 a coordinator and statistician were hired for the department.
- In January 2009 six new NNAAP written forms went into operational use.
- The 2010 NNAAP™ Examination Test Plan and content outline will be published on the NCSBN Web site.

**Program Highlights and Test Development Activities**

**REVIEW OF NNAAP SKILLS EXAMINATION**

A Skills Review and Revision meeting was conducted by Pearson VUE for the NNAAP™ Skills Evaluation in April 2007. Due to concerns regarding the increased incidence of community-based methicillin-resistant staphylococcus aureus (MRSA), one important goal of the meeting was to review infection control standards to determine if any additional practice standards needed to be incorporated into the skills evaluation. A highlight during this review was the discussion of the use of gloves and when they are necessary. After the review and revision session with an infection control consultant, the group of SMEs reviewed the remaining skills and considered several new skills for incorporation into the skills evaluation. The final activity of the SMEs was to discuss and identify expectations of behaviors of newly certified, minimally competent, entry level nurse aides.

The SME group reviewed, revised and approved 23 existing skills and decided to delete the skill, *Measures and Records Oral Temperature Using a Non-Mercury Glass Thermometer*. The committee also developed one new skill, *Donning and Removing PPE (Gown and Gloves)*, and this skill was approved for inclusion in the NNAAP skills evaluation.

**SKILLS STANDARD SETTING MEETING**

Pearson VUE and the NNAAP™ Skills Exam Standard Setting Committee met for two days in November 2007 to conduct a standard setting meeting to set passing standards for all approved skills on the NNAAP™ Skills Evaluation. The lead test developer for Nurse Aide Services and two PhD psychometricians from Pearson VUE facilitated the meetings. The review committee consisted of registered nurses (RNs) from across the country involved in the education, evaluation and supervision of entry level nurse aides.

The meeting began with an overview of the skills examination, a review of the OBRA requirements for the exam and a discussion of the purpose of standard setting. Then characteristics of the minimally competent, entry level, certified nurse aide were identified through an extensive discussion among the committee. Included in the discussion were contrasting characteristics that may be observed in the incompetent, as well as the highly competent nurse aide. These characteristics were displayed and referenced throughout the standard setting process so that the panel could readily identify the expectations for minimal, entry level certified nurse aide competence.

Once the committee had defined the concept of minimum competency, they were asked to review the steps on Skill 1 and make an initial rating of how many points they felt were necessary to demonstrate minimum competency. The committee was asked to make their ratings independently and were encouraged to discuss the process they used to arrive at a rating. Most SMEs on the committee reported that they reviewed the steps on the skill and identified individual steps that could be missed without jeopardizing a client. Once the SMEs were comfortable with the process, they were asked to read through and independently rate the remaining 22 skills.

The results of the standard setting meeting were used to score the skills on the test forms published on July 1, 2008.

**ITEM REVIEW AND DEVELOPMENT**

From June through August 2008, six four-hour virtual item review meetings were scheduled utilizing Web conferencing technology. Participating SMEs used computer technology and a telephone conference line to view and engage in test development activities. The purposes of these meetings were to review and approve pretest items, review active items for currency,
validate the items, and review statistically underperforming items for the NNAAP written exam.

The virtual item review meeting was composed of seven SMEs from various regions of the country (Minnesota, Mississippi, Pennsylvania, Rhode Island and Washington). The SME group represented a broad spectrum of expertise in nurse aide education and practice, including teaching in and/or directing nurse aide programs, coordinating programs at the state level and evaluating the NNAAP.

The SMEs began their work with an item review orientation that included the principles of item review, explanations of important statistical characteristics to apply in the review of items, use of the NNAAP™ Written/Oral Exam Content Outline in item review and item development, and an overview of the construction and review of items.

During the item review meetings, the SMEs reviewed a total of 296 items; 93 items were approved, 19 items were deleted, 97 items were set to pretest status, and 87 items were identified as problem items and marked for further review. The SMEs also rewrote seven under performing items, which were set to pretest status.

In April 2009 NCSBN held its first NNAAP™ Item Writing and Review Workshop under the new agreement with Pearson VUE. Eleven SMEs attended the workshop and represented all four NCSBN geographic areas. The SMEs were diverse in relation to nursing specialties, experience, clinical practice settings and qualifications. Three of the 11 SMEs attended a prior item writing and review meeting held by Pearson VUE.

NCSBN implemented a similar format as the contracted test service to host the workshop. The format included an overview of NCSBN; principles of item review and item writing; item construction and exercises related to item writing; and peer review of newly written and problem items to validate currency, accuracy, entry level content, and statistical characteristics. A representative from Pearson VUE and a testing consultant were present during the workshop.

During the April 2009 NNAAP™ Item Writing and Review Workshop, 206 items were reviewed; one pretest item, 39 problem items and 166 of the newly written items from the workshop. Of the newly written items, 146 were set to pretest status.

2010 NNAAP™ Examinations Test Plan and Content Outline

On Feb. 17, 2009, the NNAAP™ & MACE™ Examinations Department held a Webinar meeting with SMEs from the four NCSBN geographic areas to review the NNAAP test plan and content outline. The SMEs reviewed the 2010 NNAAP™ Written (Oral) Examination Content Outline and Report of Findings from the 2005 Job Analysis of Nurse Aides: Employed in Nursing Homes, Home Health Agencies and Hospitals and adopted the 2010 NNAAP™ Written (Oral) Examination Content Outline. There were no major changes recommended by the SMEs to the content categories for the 2010 NNAAP content outline.

Future Activities

- Share with the public information about the NNAAP and MACE examination programs.
- Develop new test items and maintain item pools for NNAAP and MACE.
- Perform appropriate item response and statistical analyses of items for NNAAP and MACE.
- Build paper and pencil and computer-based test forms for the written cognitive component of the NNAAP examination.
- Update skills-demonstration test forms and scoring standards for NNAAP.
- Build computer-based forms for MACE.
- Conduct nurse aide and medication aide job analyses.
- Carry out standard setting exercises for the written and skills portions of the NNAAP.
Create a national bank of items using the MA-C Model Curriculum.
Conduct standard setting exercises for MACE.
Enhance the quality of NNAAP and MACE programs.
Increase the number of states that use NNAAP and MACE programs.

National Nurse Aide Assessment Program (NNAAP™) Summary of NNAAP™ Examination Results for Testing Year 2008 Pass Rates by State

<table>
<thead>
<tr>
<th>Year</th>
<th>Written/Oral</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Pass</td>
<td>Number</td>
</tr>
<tr>
<td>Alabama</td>
<td>93</td>
<td>1,557</td>
</tr>
<tr>
<td>Alaska</td>
<td>96</td>
<td>592</td>
</tr>
<tr>
<td>California</td>
<td>93</td>
<td>8,107</td>
</tr>
<tr>
<td>Colorado</td>
<td>94</td>
<td>5,212</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>74</td>
<td>622</td>
</tr>
<tr>
<td>Georgia</td>
<td>89</td>
<td>6,582</td>
</tr>
<tr>
<td>Louisiana</td>
<td>84</td>
<td>710</td>
</tr>
<tr>
<td>Maryland</td>
<td>91</td>
<td>3,528</td>
</tr>
<tr>
<td>Minnesota</td>
<td>96</td>
<td>7,795</td>
</tr>
<tr>
<td>Mississippi</td>
<td>88</td>
<td>2,927</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>100</td>
<td>12</td>
</tr>
<tr>
<td>New Jersey</td>
<td>81</td>
<td>5,264</td>
</tr>
<tr>
<td>North Carolina</td>
<td>95</td>
<td>18,791</td>
</tr>
<tr>
<td>North Dakota</td>
<td>97</td>
<td>1,107</td>
</tr>
<tr>
<td>Oregon</td>
<td>98</td>
<td>1,032</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>94</td>
<td>9,923</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>84</td>
<td>1,605</td>
</tr>
<tr>
<td>South Carolina</td>
<td>93</td>
<td>5,104</td>
</tr>
<tr>
<td>Texas</td>
<td>89</td>
<td>19,567</td>
</tr>
<tr>
<td>Virgin Islands</td>
<td>80</td>
<td>133</td>
</tr>
<tr>
<td>Virginia</td>
<td>88</td>
<td>5,476</td>
</tr>
<tr>
<td>Washington</td>
<td>93</td>
<td>6,326</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>97</td>
<td>9,794</td>
</tr>
<tr>
<td>Wyoming</td>
<td>98</td>
<td>972</td>
</tr>
<tr>
<td>TOTAL</td>
<td>92</td>
<td>122,738</td>
</tr>
</tbody>
</table>

Attachment
A. 2010 NNAAP Written (Oral) Examination Content Outline
### 2010 NNAAP™ Written (Oral) Examination Content Outline

The revised content outline is based on the findings from the *2005 Job Analysis of Nurse Aides* published by the National Council of State Boards of Nursing (NCSBN) in May 2006. The examination content outline will be effective January 2010.

The NNAAP written examination is comprised of 70 multiple-choice questions; 10 of these questions are pretest (non-scored) questions on which statistical information will be collected. The NNAAP oral examination is comprised of 60 multiple-choice questions and 10 reading comprehension (word recognition) questions.

<table>
<thead>
<tr>
<th>Content Domain</th>
<th>2010 Content Outline</th>
<th>Prior Content Outline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weighting of Content Domain</td>
<td>Number of Questions in Domain</td>
</tr>
<tr>
<td><strong>I. Physical Care Skills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Activities of Daily Living</td>
<td>13%</td>
<td>8</td>
</tr>
<tr>
<td>1. Hygiene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Dressing and Grooming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Nutrition and Hydration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Elimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Rest/Sleep/Comfort</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Basic Nursing Skills</td>
<td>40%</td>
<td>24</td>
</tr>
<tr>
<td>1. Infection Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Safety/Emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Therapeutic/Technical Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Data Collection and Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Restorative Skills</td>
<td>8%</td>
<td>5</td>
</tr>
<tr>
<td>1. Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Self Care/Independence</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>II. Psychosocial Care Skills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Emotional and Mental Health Needs</td>
<td>13%</td>
<td>8</td>
</tr>
<tr>
<td>B. Spiritual and Cultural Needs</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td><strong>III. Role of the Nurse Aide</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Communication</td>
<td>8%</td>
<td>5</td>
</tr>
<tr>
<td>B. Client Rights</td>
<td>5%</td>
<td>3</td>
</tr>
<tr>
<td>C. Legal and Ethical Behavior</td>
<td>3%</td>
<td>1</td>
</tr>
<tr>
<td>D. Member of the Health Care Team</td>
<td>8%</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>60</td>
</tr>
</tbody>
</table>
Report of the TERCAP® Committee

Background
The number of Member Boards interested in using the data collection instrument Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®) continues to increase. Currently, 14 Member Boards are participating in TERCAP by submitting data and five Member Boards are initiating the implementation phase of TERCAP. Between August 2008 and March 2009, the number of TERCAP cases submitted has tripled. A few Member Boards are exploring using TERCAP, seeking board of nursing (BON) approval or investigator buy in.

Some Member Boards are not yet able to participate in TERCAP due to lack of resources, time and support within umbrella boards, in which the BON has no oversight over investigators. It is understood by the committee that TERCAP requires a paradigm shift by Member Boards when investigating cases and determining issues beyond those directly attributable to the nurse. There is also a difference in the purpose of TERCAP and what investigators have considered necessary for proving up a case that may go to administrative hearing.

1. Provide Member Board resources for the use of TERCAP.

TERCAP Webinars have been conducted with 10 different Member Boards in attendance. A new data reporting Webinar was created for Member Boards to access their own data.

Member Boards continued to be supported by TERCAP committee members and NCSBN staff. Newly interested and participating Member Boards are updated through bimonthly TERCAP user calls and documented highlights from those calls that were initiated this year. We have begun to have users share actual cases as an exercise to assist in the determination of the primary and secondary practice breakdown categories.

At the Midyear Meeting, information was provided about TERCAP by committee members. An updated TERCAP® Overview subsequently sent to all executive officers has been updated (Attachment A), along with the TERCAP® Research Criteria (Attachment B). Information about TERCAP was also shared at the 2009 Attorney/Investigator Symposium.

Data summaries are provided to participating Member Boards to acknowledge their contributions and as a resource for quality improvement. The frequency that individual Member Boards answered questions as unknown is provided to encourage submission of quality data. As part of the continuous quality improvement process, changes were made to the page breaks in the online data collection instrument that resulted in a significant decrease in the amount of time users spend submitting data online.

2. Advise staff on the content of the 2009 TERCAP® Roundtable.

The TERCAP committee members were initially very involved in advising staff on the content of the TERCAP® Roundtable. In the December 2008 report to the Board of Directors, the research department staff advised, based on a power analysis, that 1,300 cases would be required to carry out the desired statistical analysis. The committee would like to share TERCAP study findings as soon as it is responsible and practical to do so. The committee recommended the TERCAP® Roundtable not be presented during this fiscal year. The basis for this recommendation is the insufficient number of complete data categories to report findings at this time.

3. Determine the implications of the aggregated data analysis.

In November 2008 the research department staff analyzed 137 cases submitted to TERCAP since March 2008. The low number of cases, in addition to a large amount of unknown or missing data, meant that no valid or significant results could be drawn from the data.

Subsequently, the committee discussed the possibility of prioritizing the TERCAP questions and selecting less data for analysis than required by the original 11 research questions. A data set consisting of 32 questions (out of a potential 60 questions) was identified. In February 2009 the research department analyzed these selected data on 243 cases submitted between March 2008...
and January 2009. Analysis of the selected questions revealed a significant number of unknown responses and high margins of error for most of the questions, thereby thwarting the ability to make any valid conclusions. The committee decided not to share the data available from the smaller data set and, as always intended, to continue to have all the TERCAP questions completed for future aggregate data analysis.

There were 360 cases submitted from March 2008 through April 2009. The 14 participating Members Boards have submitted anywhere from two to 141 cases. The majority (45 percent) of the cases submitted to date are from one Member Board. The research department will conduct additional analysis from time to time throughout the remainder of FY09 as more cases become available.

**Highlights of FY09 Activities**

- Provided assistance to the 14 Member Boards submitting cases online and the five Member Boards beginning to implement TERCAP.
- Reviewed and provided feedback on the data analysis from the cases submitted in TERCAP 2007 and TERCAP 2008, determining to only use the data provided in TERCAP 2008.
- Implemented quality improvement processes to improve the quality of Member Board data and the national aggregate data.

**Future Activities**

- Develop and implement a plan to increase data collection.
- Evaluate the TERCAP protocol to improve the quality of the data collection process.

**Attachments**

A. TERCAP Overview

B. TERCAP Research Criteria
TERCAP® Overview

Taxonomy of Error, Root Cause Analysis, and Practice-responsibility (TERCAP®) is a data collection instrument designed to collect information for the purpose of identifying the root cause(s) of nursing practice breakdown. Practice breakdown is defined broadly as the disruption or absence of any of the aspects of good practice. The seminal research project, which gained knowledge from nurse practice breakdown experiences reported to boards of nursing, helped create the instrument to support prevention of practice breakdown. Since 2001, the practice breakdown project, through the work of various NCSBN committees, has included such consultants as Dr. Patricia Benner, Dr. Marie Farrell and Dr. Kathy Scott.

Since boards of nursing possess a rich source of data which can be used to determine causes of nursing error, they are well positioned to add to the body of knowledge surrounding practice breakdown. The TER CAP instrument has been designed for and made available to all NCSBN member boards of nursing, after completion of a standard NCSBN educational offering. The instrument allows for standardized, comprehensive and consistent data collection by investigators and facilities reporting cases to boards of nursing. The online instrument includes explanations and examples of the question and answer selections through an automatic online link to the TERCAP Protocol. The NCSBN research department will perform aggregate data analysis on the secure and confidential information submitted online to NCSBN.

Cases meeting the following criteria will be included in the NCSBN aggregate data analysis:

1. The case involves a randomly selected practice breakdown case or all practice breakdown cases reported to a participating board of nursing.
2. The case involves a nurse who was involved in the practice breakdown.
3. The case involves one or more identifiable patients (if more than one patient was involved, data are to be gathered and submitted on the patient with the most harm or risk of harm).
4. The case results in some type of board outcome (disciplinary action, alternative program, non-disciplinary action, referral to other agency) other than case dismissal.
5. The case allows for all or almost all of the data collection instrument fields to be completed.
6. Ideally, TERCAP is used on cases when a nurse is initially reported to a board of nursing to ensure that the information requested in the data fields can be obtained.
7. Cases involving diversion / substance abuse / chemical impairment should be included only when they are associated with practice breakdown.

TERCAP® consists of the following sections:

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Profile</td>
<td>Health Care Team</td>
</tr>
<tr>
<td>Patient Outcome</td>
<td>Nurse Profile</td>
</tr>
<tr>
<td>Setting</td>
<td>System Issues</td>
</tr>
<tr>
<td>Intentional Misconduct or Criminal Behavior</td>
<td>Board of Nursing Outcome</td>
</tr>
</tbody>
</table>

Eight practice breakdown categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Medication Administration</td>
<td>Intervention</td>
</tr>
<tr>
<td>Documentation</td>
<td>Prevention</td>
</tr>
<tr>
<td>Attentiveness/Surveillance</td>
<td>Clinical Reasoning</td>
</tr>
<tr>
<td>Interpretation of Authorized Provider’s Orders</td>
<td>Professional Responsibility/Patient Advocacy</td>
</tr>
</tbody>
</table>
Since the goal of TERCAP is to isolate the precipitating cause(s), one primary category, which is the most relevant and direct cause of the practice breakdown and, if applicable, a secondary category of practice breakdown are required to be selected by member boards completing TERCAP. Prioritization of categories is to identify the root cause of the practice breakdown. It is generally up to the member board staff that investigated a case to determine the most applicable practice breakdown category for each case submitted.

The TERCAP data instrument also includes questions relating to whether willful negligence and/or intentional misconduct occurred. These areas of inquiry were initiated prior to the Institute of Medicine’s (IOM) Recommendation 7-2: “The National Council of State Boards of Nursing, in consultation with patient safety experts and health care leaders, should undertake an initiative to design uniform processes across states for better distinguishing human errors from willful negligence and intentional misconduct, along with the guidelines for their application by state boards of nursing and state regulatory bodies having authority over nursing.” (Keeping Patients Safe: Transforming the Work Environment of Nurses. IOM, 2004, pg. 5.)

The overall goal of TERCAP is to promote patient safety by better understanding nursing practice breakdown and by improving the effectiveness of nursing regulation. The ultimate goal is to develop and maintain a database of practice breakdown cases, contributed to NCSBN from all member boards, to perform aggregate data analysis to share with the regulatory bodies to plan, implement, evaluate and sustain new strategies. Effective change requires partnership with educators, practicing nurses, facility leadership and other policy leaders. This rich data source will help support change and can be used to develop proactive regulatory strategies for the promotion of patient safety.

TESTIMONIALS

“When I started in my new position at the Idaho Board of Nursing, I wasn’t sure how to approach a complaint against a nurse…I wanted to be sure I covered all the aspects of an investigation so that the board could make informed decisions. I thought to myself, isn’t there a document or some sort of checklist of questions that could guide a uniform approach? Fortunately, my executive officer had tapped into a resource before I came to the board: TERCAP. Reviewing some of the older documents produced by NCSBN, I learned a bit about the history and development of this data collection instrument. I discovered there were processes in place to not only comprehensively gather the information, but there was an opportunity to submit the data online. Thus, I can view the data that I submit for my board and have a more uniform method for investigations while NCSBN can conduct data analysis in the aggregate on all the data submitted.”

Jan Edmonds, MSN, RN, Director for Professional Compliance, Idaho Board of Nursing

“Having worked with TERCAP since its inception, I have seen this project evolve from a research project to what is now - a significant and essential component of the North Dakota Board of Nursing investigative process. The interview process, including investigative techniques and interview questions, has been streamlined to better capture nurse, team and system issues. The national research data obtained from TERCAP will lead the future of nursing regulation as it relates to error and practice breakdown.”

Karla Bitz, PhD, RN, FRE, Associate Director, North Dakota Board of Nursing

“We find that integrating TERCAP as part of the investigation, for nurse and non-nurse investigators alike, provides increased awareness of circumstantial factors that might have been beyond the nurse’s control. TERCAP contributes consistency in the identification and review of these factors in cases. We now have every investigator beginning each case by starting the TERCAP process, and we have even developed our own inter-rater reliability process so that everyone understands the questions and answer choices from which to select. Although I was skeptical at first and thought there were too many questions, we have found that it does not take as much time as we thought it would. Plus, the quality of our investigations has improved across the board through using TERCAP.”

J.L. Skylar Caddell, RN-BC, Lead Investigator, Texas Board of Nursing

“As a new executive officer for an NCSBN member board, I had the goal of meeting with nurse executives around the state to establish a collaborative working relationship. TERCAP was one of the projects shared with those executives. It gave us an opportunity to work together in defining how best the board and health care facilities could collaborate to report and address practice breakdown. The idea was well received and has forged a new partnership between the board and the facilities that provide nursing care across Kentucky.”

Charlotte Beason, EdD, RN, NEA, Executive Director, Kentucky Board of Nursing
Attachment B

TERCAP® Research Criteria

TERCAP® Research Criteria

Taxonomy of Error, Root Cause Analysis and Practice-responsibility (TERCAP®) data to be submitted for NCSBN’s national data collection research project

Cases meeting the following criteria will be included in the NCSBN aggregate data analysis:

1. The case involves a randomly selected practice breakdown* case or all practice breakdown cases reported to a participating board of nursing.
2. The case involves a nurse who was involved in the practice breakdown.
3. The case involves one or more identifiable patients (if more than one patient was involved, data is to be gathered and submitted on the patient with the most harm or risk of harm).
4. The case results in some type of board outcome (disciplinary action, alternative program, non-disciplinary action, referral to other agency) other than case dismissal.
5. The case allows for all or almost all of the data collection instrument fields to be completed.
6. Ideally, TERCAP is used on cases when a nurse is initially reported to a board of nursing to ensure that the information requested in the data fields can be obtained.
7. Cases involving diversion /substance abuse/chemical impairment should be included only when they are associated with practice breakdown.

TERCAP is not meant for cases in which the nurse enters an alternative program where there is no investigation or determination that there was practice breakdown.

*Practice breakdown is defined broadly as the disruption or absence of any of the aspects of good practice. Often those are cases involving errors or near misses.
Report of Transition to Practice Committee

Background
The following were the charges of the Transition to Practice Committee and a general description of their activities to meet the charges.

1. **Recommend an evidenced-based regulatory model for transition to practice.**

Committee members built more detail into the transition to practice model, focusing on input from Member Boards, stakeholders and the literature.

2. **Collaborate with Member Boards and stakeholders regarding a future regulatory model.**

Committee members formally sought input from Member Boards and 14 stakeholders through a fact sheet (Attachment B), which provides a compelling argument that transition to practice should be implemented through regulation, and the model description (Attachment C), for the purpose of communicating our vision of the model.

3. **Identify strategies for implementation of the model.**

Committee members developed a tool kit for Member Boards, which is available on the NCSBN Web site. The tool kit will continually be built, with the particular components being listed under Highlights and Accomplishments.

4. **Develop model rules.**

Committee members developed model rule language (Attachment A), but they recommend that the model rules not be voted on until pilot data have been analyzed. The pilot studies will provide us with valuable information on the cost to boards of nursing, the resources needed and how to best regulate transition to practice.

Highlights of FY09 Activities
The Transition to Practice Committee collaborated with NCSBN's membership and 14 stakeholders to gain insight into further developing the evidence based transition to practice model that last year's committee members developed. Building on the input from the NCSBN membership and stakeholders, as well as further review of the literature, the members of the committee built more detail into the transition model and updated the evidence grid. Strategies to implement the model were identified, and members of the committee developed an online tool kit to for the implementation phase of this initiative. The timeline for the transition to practice initiative was envisioned and is captured on the dashboard (Attachment E). Specific highlights from this year's committee include:

- Sought Member Board feedback on the model at the Midyear Meeting and via e-mail.
- Hosted a collaborative conference call with the following organizations to gain their input:
  - Advisory Board Company
  - American Association of Colleges of Nursing
  - American Nurses Association
  - American Organization of Nurse Executives
  - Association of Community Health Nursing Educators
  - Joint Commission
  - National Association of Directors of Nursing Administration – Long Term Care
  - National Association for Practical Nurse Education and Service
  - Advisory Board Company
  - American Association of Colleges of Nursing
  - American Nurses Association
  - American Organization of Nurse Executives
  - Association of Community Health Nursing Educators
  - Joint Commission
  - National Association of Directors of Nursing Administration – Long Term Care
  - National Association for Practical Nurse Education and Service

Members
Janine Baxter, MSN, RN
Idaho, Area I
Debra Werner, MSN, RN
New Mexico, Area I
Marcy Echternacht, MS, RN,
APRN-CNS, BC
Nebraska, Area II, Chair
Lanette Anderson, JD, MSN, RN
West Virginia-PN, Area II
Greg Howard, LPN
Alabama, Area III, Board Liaison
Carol Komara, MSN, RN
Kentucky, Area III
Pamela Zickafoose, EdD, RN,
CNA-BC, CNE
Delaware, Area IV
Carol Silveira, MS, RN
Massachusetts, Area IV
Mary Botter, PhD, RN
Vermont, Area IV
Cynthia VanWingerden, MS, RN
Virgin Islands, Area IV
Carol Reinick, PhD, RN, FAAN,
NEA-BC
American Organization of Nurse
Executives

Guest Member
Jean Barry, MSN, RN
Director of Regulatory Policy,
Canadian Nurses Association

Staff
Nancy Spector, PhD, RN
Director, Regulatory Innovations
Qiana Hampton, MBA, MHRM
Administrative Assistant,
Regulatory Innovations

Meeting Dates
- Nov. 18-19, 2008
- Jan. 7-8, 2009
- March 9-11, 2009
- March 25, 2009 (Conference Call)

Relationship to Strategic Plan
Strategic Initiative C
NCSBN advances evidence based nursing regulation and regulatory solutions for public protection.
Strategic Objective 2
Provides models and resources for evidence based regulation to Member Boards.
- National League for Nursing
- National Nursing Staff Development Association
- National Student Nurse Association
- Professional Nurse Educators Group
- University HealthSystem Consortium
- Versant

Developed a tool kit for implementing the model with the following components:
- Model rule language (Attachment A)
- Transition to practice fact sheet (Attachment B)
- Transition to practice model description (Attachment C)
- Transition to practice FAQs (Attachment D)
- Transition to practice dashboard (Attachment E)
- Transition to practice goals/premises/definitions (Attachment F)
- Transition to practice verification form (Attachment G)
- Transition to practice article (Attachment H)
- Transition to practice evidence grid (Attachment I)

Extensive discussion was held about the development of the modules for new nurses. It is essential that these modules not be “reteaching” of content, but instead, should incorporate experiential learning. The committee members envision designing interactive modules, which allow opportunities for deliberate practice, such as the use of virtual reality, avatars and computer simulation.

Committee members also discussed the need to develop interactive modules for preceptor development, as well as using cutting edge Internet technologies for connecting new nurses to preceptors in rural areas or in areas where preceptors aren’t readily available.

Committee members heard from NCSBN and stakeholders about the importance of piloting the transition to practice program and plans were made for developing pilot studies.

Members of the committee recommended that NCSBN convene an advisory panel to assist NCSBN's Research Department with developing outcome measures. The advisory panel should be consulted throughout the piloting period. It is critical that the pilot research be rigorously planned and conducted so that nursing can use the data to persuade legislators, policy makers, private and public funding sources, and consumers that transition to practice is necessary for public protection.

Committee members revised the description of the model to reflect input from Member Boards and stakeholders, as well as new information:
- Clarified that orientation and transition to practice can be done at the same time.
- Clarified that the preceptorship is normally six months in length, but it can be individualized.
- Specialty was changed to specialty content for clarity; utilize research was changed to evidence based practice.
- Reviewed and made some minor revisions on our definitions and developed a definition for deliberate practice.
Committee members discussed at length the various functions that are needed to make this vision of a comprehensive transition to practice program, implemented through regulation, a reality. They recommended that NCSBN hire a consultant to develop a business plan that will address all the areas highlighted on the dashboard (Attachment E), including preceptor development, research, funding, pilots, module development and marketing. The dashboard was designed to present the key elements of the Transition to Practice Initiative on a timeline from 2009-2011.

Committee members met with NCSBN’s Marketing & Communications department about branding our Transition to Practice Initiative; a plan is currently in development.

NCSBN’s Marketing & Communications Department has assisted committee members with designing marketing materials for the tool kit, and the NCSBN Interactive Services Department has developed an interactive and user-friendly online tool kit display.

Future Activities
Committee members recommend that the Transition to Practice Committee continue for another year to complete the following:

- Develop essential elements for the pilot study.
- Develop essential elements for the new nurse modules.
- Develop essential elements for preceptor training.

Attachments
A. Model Act and Rules for Transition to Practice
B. Transition to Practice: Promoting Public Safety
C. Description of Transition to Practice Model
D. NCSBN’s Transition to Practice Model: Frequently Asked Questions
E. Transition to Practice Committee Dashboard
F. Goals of NCSBN’s Transition to Practice Model
G. Transition to Practice Verification Form
H. Transition to Practice Article
I. Transition Evidence Grid
Attachment A

Model Act and Rules for Transition to Practice

Grey highlighting indicates changes to current model rules.

Article VI. – Licensure (Practice Act)

Section 9. Renewal of RN/LPN/VN Licenses.

Registered nurses and licensed practical/vocational nurse licenses issued under this Act shall be renewed every <> years according to a schedule established by the board.

Effective <> all newly licensed nurses during their first year of practice in the U.S. will be required to complete a transition to practice program that meets the criteria as established by the board.

A, B, and C, follow.

6.9 Renewal of Licenses (Rules)

The renewal of a license must be accomplished by <date determined by the board>. Failure to renew the license on or before the date of expiration shall result in the forfeiture of the right to practice nursing in this jurisdiction.

All newly licensed registered nurses (RN) and licensed practical/vocational nurses (LPN/VN) will be required to complete a transition to practice program during their first year of practice in the U.S. The program will be specific to the scope of practice of RNs and LPN/VNs. Transition to practice programs include the following:

A) A minimum 6-month preceptorship with ongoing support through the first year of practice.

B) Precepted experiences with deliberate practice which incorporate:
   1. Specialty content in the area of practice
   2. Communication
   3. Safety
   4. Clinical reasoning
   5. Prioritizing/organizing
   6. Evidence based practice
   7. Role socialization
   8. Delegating/supervision

C) Opportunities for reflection.

D) Ongoing formal and informal feedback.

Preceptors will complete a standardized course, including, but not limited to:

A) Scope of practice

B) Supervision of newly licensed nurses

C) Providing opportunities for reflection

D) Providing feedback

E) Adult learning principles

F) Content referred to in 6.9 (B)
6.9.1 Notification to Renew
At least <> days before the expiration date of a license, the board shall notify the licensee that it is time to renew and inform the licensee of the timeliness and options for completing the application.

6.9.2 Application for Renewal of License as a Registered Nurse or Licensed Practical/Vocational Nurse
An applicant for license renewal shall submit to the board the required fee for license renewal, as specified in Chapter 14, and a completed application for license renewal that provides the following information: (continues with A., B., C., then add the following:)

D. Evidence of completion of a transition to practice program, if applicable, specified in 6.9.4 below.

6.9.4. License Renewal Transition to Practice Requirement for RNs and LPN/VNs.
A. Purpose: To promote public safety by supporting newly licensed nurses during their critical entry period and progression into practice.

B. When newly licensed registered nurses or licensed practical/vocational nurses have finished the first year of practice, they will:

1) Complete a Transition to Practice Verification (TPV) form approved by the board.
2) Present a completed TPV form to the board, after the first year in practice, in order to renew the license.

Change 6.9.4 to 6.9.5:

The board shall renew the license of each renewal applicant who complies with the requirements listed in 6.9.2, 6.9.3 and 6.9.4, if applicable.

Continue with rest of the model rules.
Transition to Practice: Promoting Public Safety

THE PROBLEM

- **Complex Health Care Needs**: Newly licensed nurses are expected to care for sicker patients with multiple conditions in increasingly complex health care settings.
- **Practice Readiness**: Educators and employers agree that there is an education to practice gap in nursing, particularly related to experiences with risk management.
- **Expertise Gap**: Ten percent of a typical hospital’s nursing staff is comprised of new graduate nurses.
- **Variable Transition Experiences**: Excellent transition programs exist. However, both orientation and transition experiences for newly licensed LPNs and RNs are tremendously variable and may be nonexistent in some practice settings.
- **Risk for Practice Errors**: Several studies show that new nurses experience increased stress three to six months after hire; data has shown that increased stress levels are risk factors for patient safety and practice errors.
- **Turnover/Retention**: 35 to 60 percent of new nurses leave a position in their first year of practice, resulting in an estimated replacement cost of $46,000 to $64,000 or higher, per nurse.

THE IMPACT

- **Medical Errors**: Medical errors are the eighth leading cause of death; $17 billion is spent annually on preventable errors. Annually, there are 2,300 hospitalization deaths due to errors/million admits, whereas comparatively, there are 0.43 deaths/million airline passengers.
- **Newly Licensed Nurse Errors**: More than 40 percent of newly licensed nurses report making medication errors.
- **Life-Threatening Complications**: Studies indicate 50 percent of new graduates would fail to recognize life-threatening complications due to lack of experience.
- **Patient Safety**: Decreased staffing, use of inexperienced staff and increased turnover rates have a negative influence on patient safety and health care outcomes.
- **Error Reduction and Better Outcomes**: An NCSBN study shows newly licensed RNs report significantly fewer errors when they have had a transition program with specialty content. Another study finds that a mentoring program with new RNs is related to improved patient outcomes.
- **Cost Savings**: Studies show that transition programs reduce first-year turnover from 35 to 60 percent to six to 13 percent; institutions that provide transition programs report positive return on investment (ROI) from 67.3 to 884.7 percent.
- **Response**: A panel of nursing leaders at NCSBN’s Transition Forum on Feb. 22, 2007, representing practice, education and regulation, supported the need for a national, standardized transition to practice model implemented through regulation.

THE PROPOSED SOLUTION

Adopt the transition to practice regulatory model (see back) that is designed to promote public safety by supporting newly licensed nurses. The model has been designed to be:

- **Flexible** (institutions could meet the module criteria individually or in partnerships, or the modules will be available on the Web)
- **Robust** (across all settings and inclusive of all levels of licensed nurses)
- **Evidence-based**

Verification of successful completion of a transition program will be required at the first license renewal.
Section II: 2009 NCSBN Annual Meeting
Report of Transition to Practice Committee - Attachment B: Transition to Practice: Promoting Public Safety

REFERENCE

3. Beecroft et al. (2007); Fink et al. (2008); NCSBN data presented at a national forum, entitled “Transition of New Nurses to Practice: A Regulatory Perspective,” in Chicago, February 22, 2007; Williams et al. (2007).
5. Advisory Board Company (2006); Beecroft et al. (2001); Keller et al. (2006); Pine & Tart (2007); Williams et al. (2007).  

Refer to the 2009 Evidence Grid at https://www.ncsbn.org/363.htm for complete citation of sources.
Attachment C

Description of Transition to Practice Model

NCSBN’s Transition to Practice model is intended to be collaboratively implemented with education and practice, but through regulation. Collaboration will be essential for this model to be successful. Educators are the experts in curriculum design and evaluation and will be able to assist with the design of the transition modules. Practice provides a crucial link that will provide new graduates with planned practice experiences with qualified nurses to mentor them. Nursing regulators provide new graduates with information on their scope of practice, the Nurse Practice Act, and maintaining their license throughout their careers. If adopted, regulation will be able to enforce the transition program through licensure.

This is an inclusive model, which would take place in all health care settings that hire newly graduated nurses and for all educational levels of nurses, including practical nurse, associate degree, diploma, baccalaureate and other entry-level graduates. The new graduate must first take and pass the NCLEX®, obtain employment and then enter the transition program.

The preceptors in this model will be trained and most will work one-on-one with newly graduated nurses, though in some settings team preceptorships may be used. This model is strongly dependent on a well-developed preceptor-nurse relationship. Novice nurses will learn the importance of being a seasoned, dedicated preceptor and the responsibility to transition new nurses into practice. In the future, becoming preceptors and mentors for new nurses will be an expected part of professional nursing.

In this model orientation is defined as teaching the policies and procedures of the workplace, as well as role expectations. Therefore, orientation is separate from the concept of transition to practice. Transition to practice is defined as a formal program designed to support new graduates during their progression into practice.

The eight transition modules for this model include delegating/supervising, role socialization, evidence-based practice, prioritizing/organizing, clinical reasoning, safety, communication, and specialty content. These were identified from the literature and from successful transition programs. These modules could be presented at the institution where the new nurse works, in a collaborative program with other institutions, or via the Internet. The Transition to Practice Committee is working with NCSBN’s E-Learning Department on the feasibility of developing a Web site with the online learning modules and with linking new nurses to preceptors.

Feedback and reflection are essential parts of this model and must be integrated throughout the entire transition program. This should be built into the preceptor-nurse relationship, but also should be maintained after the six-month transition period is complete.

The time period for this Transition Regulatory Model will be six months, though it is expected that the new graduate will have ongoing support for another six months. At the end of the year, the new RN is expected to have met the Quality and Safety Education for Nurses (QSEN) competencies. The QSEN competencies, developed by experts from across the health care disciplines, are based on the Institute of Medicine’s (IOM) recommended competencies for health care professionals and include patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. The Transition to Practice Committee members already have developed some definitions of competencies for practical nursing, based on the QSEN definitions for RNs. The Transition to Practice Committee also has been working with NCSBN’s Research Department to develop outcome competency measures. If NCSBN develops a continued competency model, it is anticipated that there will be some changes in this model so that these two models will be congruent.
In order for the new graduates to maintain licensure after one year in practice, it will be incumbent upon them to provide the Board of Nursing with a Transition to Practice Verification (TPV) form, which will be signed by the new graduates, their preceptors and their supervisors, verifying the new nurse has met all the requirements of the jurisdiction’s transition program. In many states new drivers have similar requirements for maintaining their license after their first year of driving. In 2008 the Commission of Collegiate Nursing Education (CCNE) has developed standards for accrediting transition programs that use the UHC/AACN model, and it is hoped that accreditation of transition to practice programs will continue, thus assisting with standardization.

©2009 The National Council of State Boards of Nursing (NCSBN®) is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories — American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. The College of Registered Nurses of British Columbia is an associate member.

Mission: The National Council of State Boards of Nursing (NCSBN), composed of Member Boards, provides leadership to advance regulatory excellence for public protection.

For more information, please contact Nancy Spector, PhD, RN at 312.525.3657 or nspector@ncsbn.org.
Attachment D

NCSBN’s Transition to Practice Model: Frequently Asked Questions

1. Q. Why should Boards of Nursing consider regulating transition to practice?
   A. Please see our Fact Sheet, which outlines the compelling argument that transition to practice programs should be implemented through regulation: https://www.ncsbn.org/363.htm. As background to this work, NCSBN studies in the early 2000s found that new graduates and employers cited transition to practice as a problem. For example, one NCSBN study reported that new nurses were expected to practice independently in a mean of eight days after the first day of hire. Other NCSBN studies found that fewer than 50% of the employers reported that new graduates were prepared to practice safely and competently. In further studies NCSBN found that well-planned, post-hire transition programs had better outcomes than pre-graduation clinical immersion programs and were related to fewer practice errors and fewer risks for practice breakdown. In an extensive literature review NCSBN also found that post-hire transition programs were linked to fostering better practice outcomes and safer practice.

2. Q. How was the model designed?
   A. NCSBN’s Transition to Practice Committee spent a year analyzing the available evidence from transition to practice programs, published and unpublished. Data were retrieved from international, national, and individual studies and projects and were outlined in our Evidence Grid, available here: https://www.ncsbn.org/363.htm. The model was derived from the evidence and in concert with the Boards’ mission of public protection.

3. Q. Are you seeing this as a failure of education and/or practice in nursing?
   A. Absolutely not! Health care delivery in the U.S. is becoming increasingly complex, necessitating the use of sophisticated technologies and the need for systems thinking in order for nurses to practice safely. Further, more than ever before nurses are caring for sicker, older, and more diverse patients with myriad chronic conditions. In order to keep up with these changes, NCSBN is proposing that nursing needs to regulate that critical period between education and competent practice where the novice nurse needs practice experience and support from competent nurses in order to develop professionally.

4. Q. Are the modules “re-teaching” didactic content that you are assuming the newly licensed nurses did not effectively learn?
   A. No! The modules will not be designed as didactic courses. The modules will build on the nurse’s educational experiences, providing opportunities for deliberate practice. For example, there will be interactive practice exercises designed for newly licensed nurses in areas that are critical for public protection, such as experiences with: priority setting; delegating and supervising; making decisions in a fast paced environment; communicating with other health care professionals; and implementing risk management principles.

5. Q. What about cost?
   A. All published studies have shown positive return on investment for the workplace when well-planned transition programs are implemented. However, we recognize that the start-up of these programs might require some out-of-the-box thinking. We encourage partnerships between practice agencies, as well as between practice and education, in developing a transition program that would meet the jurisdiction’s criteria.
is investigating the possibility of small start-up grants as well as federal funding for the employers. One of the purposes of NCSBN's pilot studies will be to investigate the cost/benefit ratio for employers as well as the cost to Boards of Nursing.

6. Q. How can this be implemented in rural areas?
   A. NCSBN is planning to develop online modules and online connections with preceptors that could be used if the facility does not have the resources to develop a transition to practice program. The online connection for preceptors would also be valuable in those settings where there might be a paucity of preceptors, such as correctional institutions or schools.

7. Q. What if an agency already has an excellent residency program?
   A. As long as it meets the criteria of our model, it would be acceptable. Many of the current models out there meet our criteria. An underpinning of our model is that it was designed to be flexible (we won't mandate the program to be used) and robust (inclusive of all settings and all education levels of nurses).

8. Q. What about preceptor training?
   A. Our model has preceptor training built in. We will have set criteria for preceptor training, and we will develop modules for those agencies that do not have resources to train their preceptors. However, we absolutely think it's essential for preceptors to be adequately trained.

9. Q. During the time of the 6-month preceptorship is the newly licensed nurse considered part of the work schedule?
   A. At the beginning of the relationship the preceptor will work very closely with the newly licensed nurse, providing much support and feedback. However, as the relationship develops (and this will be on an individual basis), that newly licensed nurse will be supported to work more independently since the goal of this relationship is to foster safe and competent practice by allowing for experiential learning.

10. Q. Must it be a one-to-one preceptor relationship?
    A. While some research has found the one-to-one relationship between preceptor and newly licensed nurse to be more effective than multiple preceptors, this might not always be feasible. Furthermore, new studies have found that team preceptorships can be effective. Therefore, a one-to-one preceptorship won't be required; the workplace should decide what works better for their situation.

11. Q. Will NCSBN mandate transition to practice programs across all Boards of Nursing?
    A. No! Because of state's rights, NCSBN does not have the authority to mandate regulation in the Boards of Nursing. If our members support this initiative, we will make the recommendation and will assist those Boards that want to implement transition to practice to do so.

©2009 The National Council of State Boards of Nursing (NCSBN®) is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories — American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. The College of Registered Nurses of British Columbia is an associate member.

Mission: The National Council of State Boards of Nursing (NCSBN), composed of Member Boards, provides leadership to advance regulatory excellence for public protection.

For more information, please contact Nancy Spector, PhD, RN at 312.525.3657 or nspector@ncsbn.org.
Attachment E

Transition to Practice Committee Dashboard

<table>
<thead>
<tr>
<th>J</th>
<th>F</th>
<th>M</th>
<th>A</th>
<th>M</th>
<th>J</th>
<th>A</th>
<th>S</th>
<th>O</th>
<th>N</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>Business Plan Consultant</td>
<td>Development</td>
<td>Review existing programs/models</td>
<td>Establish content areas</td>
<td>Develop selection criteria</td>
<td>Develop modules</td>
<td>Research</td>
<td>Appoint Advisory Board</td>
<td>Develop outcome measures</td>
<td>Identify project manager and site consultants</td>
</tr>
<tr>
<td>2010</td>
<td>Preceptor Development</td>
<td>Interview and select</td>
<td>Develop modules</td>
<td>Research proposal</td>
<td>Identify potential funding sources</td>
<td>Foster partnerships for funding</td>
<td>Facilitate cost containment and cost-effectiveness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>Business Plan Consultant</td>
<td>Development</td>
<td>Research</td>
<td>Appoint Advisory Board</td>
<td>Develop modules</td>
<td>Research proposal</td>
<td>Identify potential funding sources</td>
<td>Foster partnerships for funding</td>
<td>Facilitate cost containment and cost-effectiveness</td>
<td></td>
</tr>
</tbody>
</table>
### Report of Transition to Practice Committee - Attachment E: Transition to Practice Committee Dashboard

<table>
<thead>
<tr>
<th>Year</th>
<th>Pilots</th>
<th>Modules</th>
<th>Marketing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>Analysis and projection for pilots</td>
<td>Identify module elements</td>
<td>Identify resources available to Boards and Pilot sites</td>
</tr>
<tr>
<td></td>
<td>Identify pilots elements</td>
<td>Develop selection criteria for pilots</td>
<td>Develop talking points</td>
</tr>
<tr>
<td></td>
<td>Develop pilots locations</td>
<td>Pilots launched</td>
<td>Estimate cost of marketing</td>
</tr>
<tr>
<td></td>
<td>Identify module elements</td>
<td>Develop modules goals and content</td>
<td>Identify resources available to Boards and Pilot sites</td>
</tr>
<tr>
<td></td>
<td>Develop modules goals and content</td>
<td>Create interactive modules</td>
<td>Hold collaborative calls</td>
</tr>
<tr>
<td>2010</td>
<td>Identify pilots elements</td>
<td>Develop pilots locations</td>
<td>Identify resources available to Boards and Pilot sites</td>
</tr>
<tr>
<td></td>
<td>Develop pilots locations</td>
<td>Pilots launched</td>
<td>Hold collaborative calls</td>
</tr>
<tr>
<td></td>
<td>Identify module elements</td>
<td>Develop modules goals and content</td>
<td>Identify resources available to Boards and Pilot sites</td>
</tr>
<tr>
<td></td>
<td>Develop modules goals and content</td>
<td>Create interactive modules</td>
<td>Hold collaborative calls</td>
</tr>
<tr>
<td>2011</td>
<td>Identify pilots elements</td>
<td>Develop pilots locations</td>
<td>Hold collaborative calls</td>
</tr>
</tbody>
</table>
Goals of NCSBN’s Transition to Practice Model

Goal for Transition to Practice: To promote public safety by supporting newly licensed nurses during their critical entry period and progression into practice.

Premises:
- The mission of the Boards of Nursing is the protection of public health, safety, and welfare.
- Nursing regulators recognize the value of evidence-based models in their responsibility of public protection.
- Transitioning new nurses to practice is best accomplished when practice, education, and regulation collaborate.
- Transition to practice programs should occur across all settings and all education levels.
- Regulation criteria for transition programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection.
- Transition program outcomes are consistent with the knowledge, skills and attitudes required for safe and effective provision of nursing care.

Definitions:
- Competent – The ability to demonstrate an integration of the knowledge, attitudes, and skills necessary to function in a specific role and work setting. (Modified from American Association of Critical-Care Nurses, Preceptor Handbook).
- Deliberate practice – Focused learning with an engaged learner that involves repetitive performance of psychomotor or cognitive skills, coupled with rigorous assessment, informative feedback, and the opportunity for reflection.
- Orientation – The process of introducing staff to the philosophy, goals, policies, procedures, role expectations, and other factors needed to function in a specific work setting. Orientation takes place both for new employees and when changes in nurses’ roles, responsibilities, and practice settings occur. (ANA’s Scope and Standards of Practice for Nursing Professional Development).
- Preceptor – A competent nurse who has received formal training for the preceptorship role.
- Preceptorship – A formal relationship between a qualified preceptor and a newly licensed nurse that facilitates active learning and transition into practice.
- Transition to Practice – A formal program of active learning, implemented across all settings, for all newly licensed nurses (registered nurses and licensed practical/vocational nurses) designed to support their progression from education to practice.

©2009 The National Council of State Boards of Nursing (NCSBN®) is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories — American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. The College of Registered Nurses of British Columbia is an associate member.

Mission: The National Council of State Boards of Nursing (NCSBN), composed of Member Boards, provides leadership to advance regulatory excellence for public protection.

For more information, please contact Nancy Spector, PhD, RN at 312.525.3657 or nspector@ncsbn.org.
## Transition to Practice Verification Form

| NAME:___________________________________________________ | License #: ____________________ |
| ADDRESS:__________________________________________________ | CITY/STATE/ZIP: ________________ |
| PHONE DAY: ______________________ | PHONE EVE: ______________________ |
| DOB: ______________________ | SCHOOL OF NURSING: ________________ |
| SSN: ______________________ | OCCUPATION/EMPLOYER: ________________ |
| PHONE: _________________________________________________ | PRECEPTOR NAME: ______________________ |

**Transition Program Successfully Completed & Full Requirements of Transition to Practice Were Met.**

| EMPLOYER: ______________________ | DATE: ______________________ |
| NURSE: ______________________ | DATE: ______________________ |
Attachment H

Transition to Practice Article

Toward an Evidence-Based Regulatory Model for Transitioning New Nurses to Practice

NCSBN is developing an evidence-based regulatory model for transitioning new nurses to practice. Several factors have inspired this inquiry, most notably, the Institute of Medicine’s reports of medical errors and the need to transform health care education. In addition, there is an increased complexity of care for sicker patients with multiple conditions, a continued need for systems thinking and an exponential growth of technological advances. Furthermore, the shortage of nurses and nursing faculty is expected to continue into the future, thus affecting the transition of new nurses to practice.

There have been some national calls for a formal transition program for new nursing graduates, including from the Joint Commission (Joint Commission White Paper, 2002), the draft of the Carnegie study of nursing education recommendations and in a synthesis of national reports (Holfer, 2008). Several standardized transition programs around the country have been very successful and worldwide transition programs are being designed (NCSBN, 2008a). Additionally, the Commission on Collegiate Nursing Education (CCNE) has developed an accreditation process for residency programs.

Last year NCSBN’s Transition to Practice Committee identified the evidence that supports a transition regulatory model (see model below). Committee members will continue to work this year to refine the model, making it feasible for boards of nursing to implement and develop consensus for the model across regulation, education and practice. (Please refer to the Transition Evidence Grid [NCSBN, 2008a] and the NCSBN Transition to Practice Report [NCSBN, 2008b] for an explanation of the available evidence supporting the NCSBN’s transition regulatory model.)

NCSBN’s transition regulatory model will be implemented through regulation, though collaboration across education, regulation and practice will be essential for this model to be successful. Educators are the experts in curriculum design and will be able to assist with the design of transition modules. Practice, providing a crucial link that will equip new graduates with planned, precepted practice experiences. Regulators provide new graduates with information on their scope of practice, the Nurse Practice Act, and must be integrated throughout the entire transition program. Regulation will enforce the transition program through licensure. This is an inclusive model, which would take place in all health care settings that hire newly graduated nurses at all educational levels of nursing, including practical nurses, associate degree, diploma, baccalaureate and other entry-level graduates. It is also intended to be feasible so that many of the current standardized transition programs will meet the requirements of this model.

The new graduate must first take and pass the NCLEX® exam, obtain employment and then enter the transition program. The preceptors in this model will be trained to work one-on-one with newly graduated nurses. A preceptor will work with the same graduate throughout the six-month transition program. This model is highly dependent on a well-developed preceptor-nurse relationship; the importance of this relationship is supported in the research. Novice nurses will understand the importance of learning from a seasoned, dedicated preceptor, thus encouraging these nurses to see themselves as preceptors to new nurses in the future. Therefore, it is hoped that this will bring about cultural change in nursing whereby becoming a preceptor and mentor will be an expected part of professional nursing.

Orientation, defined as being instructed on the policies and procedures of the workplace as well as role expectations, is required before entering the transition program. Therefore, orientation, according to this model, is separate from the concept of transition to practice, which is defined as a formal program designed to support new graduates during their progression into practice. The eight transition modules supported in the literature (NCSBN, 2008a, NCSBN, 2008b) for this model include: delegating/ supervising; role socialization; utilization of research; prioritizing/ organizing; clinical reasoning; safety, communication; and specialty content. These modules could be presented at the institution where the new nurse works, in a collaborative program with other institutions or via the Internet. The Transition to Practice Committee envisions the development of a Web site with online learning modules, as well as a way to connect new nurses to preceptors in those settings or regions of the country where preceptors are in short supply.

The time period for this Transition Regulatory Model will be six months, though it is expected that the new graduate will have ongoing support for an additional six months. At the end of the year, the new nurse is expected to have met the Quality and Safety Education for Nurses (QSEN) competencies. The QSEN competencies (now QSEN.org), developed by experts across the health care disciplines, were based on the IOM competencies and include: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics.

Lastly, feedback and reflection are essential parts of this model and must be integrated throughout the entire transition program. This should be built into the preceptor-nurse relationship, while also being maintained after the six-month transition period is complete. It is the vision of this model that new nurses will be required to provide their board of nursing with evidence of completing all the requirements of this standardized transition program in order to maintain their license after the first year in practice. This model will be voted on at the NCSBN Annual Meeting in 2009. If this regulatory transition model is adopted, each jurisdiction will decide whether or not to implement it or to adapt it to meet the particular needs of their state or territory.

Please contact Nancy Spector, PhD, RN, at nspector@ncsbn.org for further information.

REFERENCES


<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Canadian Nurses Association's Guide to Preceptorship and Mentoring</td>
<td>General guide for setting up a mentoring and preceptorship for novice nurses.</td>
<td>Relevant terms defined, Benefits cited, Costs explored, Steps for developing a successful program identified, Preceptor/mentoring competencies identified</td>
<td>Reviewed literature</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>Flying Start in Scotland</td>
<td>Web-based transition program launched in January 2006. Over 1,200 new nurses have taken part in the program. Approximately 200 hours of didactic content, taking about 2.5 hours per week. Uniqueness in being a Web-based program.</td>
<td>Mentors are assigned, Connections with peers/mentors can be accomplished online, Online modules include: Communication, Clinical skills, Teamwork, Safe practice, Research for practice, Equality and diversity, Policy, Reflective practice, Professional development, Career pathways</td>
<td>Currently they are interviewing with an independent research team to evaluate the program.</td>
<td>1 year</td>
</tr>
</tbody>
</table>

### Project | Description | Measurement | Length | Status/Results
--- | --- | --- | --- | ---
3 | Ireland
   - For regulation, this document, also available online, would be helpful: “Requirements and Standards for the Midwife Registration Education Programme,” 2000.
   - International
   - In Ireland they transferred from an apprenticeship 3-year program to a 4-year program in 2002.
   - Their implementation committee recommended a 36-week rostered year in the final year of the program.
   - Students are paid on the first point of their scale for staff nurses during the transition program. During this period the students are still in their education program.
   - This is accomplished through regulatory mandate.
   - Ireland
   - Project Description Elements Measurement Length Status/Results
4 | Portugal
   - “Nursing Intermate” Report not available yet.
   - International
   - Through regulation, the country of Portugal is beginning to develop a regulatory transition model.
   - This program is being designed from a regulatory mandate.
   - Portugal
   - Project Description Elements Measurement Length Status/Results
5 | Advisory Board Company
   - As soon as their report is approved they have promised to send it to us, and they’d like to see a copy of NCSBN’s Transition Model.
   - Advisory Board Company
   - A typical nursing staff now comprises more than 10% new graduates, and while 90% of academic leaders believe their students are fully prepared to practice, only 10% of the hospital and health system nurse executives believe their new nurses are fully prepared to provide safe and effective care. The findings provide ideas for promising opportunities for improving practice readiness.
   - Advisory Board Company
   - They triaged the 36 critical nurse competencies, looking at relative curricular emphasis, versus new graduate proficiency. Of the 36 competencies, the following had the least relative curricular emphasis and the least new graduate nurse proficiency:
     - Follow up
     - Initiative
     - Understanding quality improvement
     - Completion of tasks within expected timeframe
     - Track multiple responsibilities
     - Conflict resolution
     - Delegation
   - The Center developed parallel survey tools for academic and frontline nursing leaders using an iterative process, incorporating input from 100 experts. At the heart of both survey tools was a common set of 36 nursing competencies.
   - Center researchers collected results via an online survey tool from 5,700 frontline nurse leaders and more than 400 nursing school deans, directors, and department chairs.
   - The 2006 publication from the Nursing Executive Center presented exemplars for transition programs. Of the 9 programs highlighted, 6 had 1-year programs; 1 had a 7-month program; 1 was 22 weeks; 1 was 14.5 weeks.
   - Advisory Board Company
   - A specific length of a program was not promoted, though best practices for accelerating practice readiness were presented. Best practices (which included detailed components an implementation) were:
     1. Targeted clinical rotations
     2. Expert clinical instruction
     3. Exceptional student experiences
   - It is not necessary to customize an entirely different transition strategy for each new graduate. A rather consistent approach (such as a standardized transition program) would be possible.
   - Advisory Board Company
   - It is important to prioritize new graduate’s most pressing needs (See Elements above).
   - Advisory Board Company
   - Recommend partnerships between practice and education.
   - Advisory Board Company
   - While many programs have been positive, collaborative prehire initiatives are important.
   - Advisory Board Company
   - National
<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>2002 American Health Care Association Survey</td>
<td>N/A</td>
<td>Collected information from 6 nursing staff positions on:</td>
<td>N/A</td>
<td>+ Annual turnover of RNs, LPNs, and DONs is 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• The number of vacant positions as of June 30, 2002</td>
<td></td>
<td>+ 2/3 of facilities reported it was harder to recruit RNs and LPNs in 2002, compared to previous year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• The number of employees who have left these facilities from Jan. 1 through June 30, 2002</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Relative difficulty in recruiting key nursing staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>Survey completed by 6,155 U.S. nursing homes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Elements</td>
<td>Measurement</td>
<td>Length</td>
<td>Status/Results</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>7</td>
<td>AHRQ: Medical Errors: The Scope of the Problem: An Epidemic of Errors Report from Agency for Healthcare Research and Quality, retrieved February 23, 2009, from: <a href="http://www.ahrq.gov/qual/errback.htm">http://www.ahrq.gov/qual/errback.htm</a></td>
<td>N/A</td>
<td>Summary of reports on national governmental data.</td>
<td>N/A</td>
<td>Errors occur in settings other than hospitals, including physicians’ offices, nursing homes, pharmacies, urgent care centers, and care delivered at home. For example, investigations from the MA State Board of Registration in Pharmacy estimate that 2.4 million prescriptions are filled improperly each year in that state.</td>
</tr>
<tr>
<td>National</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical errors cost the nation approximately $36 billion annually with about $17 billion being related to preventable errors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>From IOM 1999 report “To Err is Human: Building A Safer Health System,” 44,000 to 98,000 people die each year from medical errors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>According to a national poll, 42% of respondents have been affected by a medical error, either personally or through a friend or relative. 32% of the respondents indicate the error had a permanent negative effect on the patient’s health. Respondents rated the healthcare system as moderately safe (4.9 on a scale of 1-7), with 7 being “very safe.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>In another survey, Americans are “very concerned” about being given the wrong medication (61%), being given medications that negatively interact (58%).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A landmark study on medical errors found that 70% were preventable, another study showed that 54% of surgical errors were preventable.</td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Elements</td>
<td>Measurement</td>
<td>Length</td>
<td>Status/Results</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
<td>--------</td>
<td>---------------</td>
</tr>
</tbody>
</table>
• Stress was reported as an important issue for new graduates (in one study 58% of new graduates were highly stressed). Seeking social support led to turnover intention, and the explanation may be that reflected failure to obtain the necessary support within the system.  
• Lower scores on skills self-confidence and perceptions of competency contributed to turnover intention. Reported that other studies show preceptor support, reasonable expectations, praise and opportunities for interaction build confidence.  
• Lower scores for enjoyment in one’s job contributed to turnover intention.  
• When nurses are satisfied with their jobs and pay and feel committed to the organization, the odds of turnover intention decrease.  
• 24-month employment following this program ranged from 83%-98% (overall 84%). |

This national study of the Versant Residency program reported on the relationship of new nurse turnover intent with individual characteristics, work environment variables, and organizational factors and to compare new nurse turnover with actual turnover in the 18 months of employment following completion of a residency. As background evidence, a 35-60% turnover rate for new graduates was reported from the literature. They presented data of the influence of turnover decreasing patient safety and health care outcomes. Further, changes in staffing decrease the effectiveness of team-based care on patient units, resulting in less effective working relationships and ultimately affecting patient care.

A prospective design was used with data collected from 1999 to 2007 (seven years of data were used). The study respondents (n=889) participated in a standardized residency program.

Tools included: Skills Nursing Competencies Rating Scale: Self Report; Slater Nursing Competencies Rating Scale: Self-Report, Conrow’s Nursing Role Competency Scale; Ways of Copying Revised; Conditions for Work Effectiveness Questionnaire, Schutzenhofer Professional Nursing Autonomy Scale; Clinical Decision-Making Scale, Work Satisfaction Scale, Nurse Job Satisfaction Scale, Leader Empowerment Behaviours Scale, Group Cohesion Scale, Organizational Questionnaire, Turnover Intent, and actual turnover.
<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Behrens, Michael J.</td>
<td>September 10, 2000, investigative report, Chicago Tribune</td>
<td>National</td>
<td>Analyzed 3 million state and federal computer records to create a database that quantifies the role nurses play in medical errors.</td>
<td>N/A</td>
<td>Federal and state computer records reviewed, though author acknowledges that they are incomplete.</td>
</tr>
</tbody>
</table>

* From 1995-2000 at least 1,720 hospital patients have been accidentally killed and 9,584 others injured by nurses across the country. For example:
  - 418 killed, and 1,356 injured, by RNs operating infusion pumps incorrectly.
  - 216 patients were killed, and 439 injured, by RNs who failed to hear alarms of lifesaving equipment.
  - 119 patients killed, and 564 injured, by unlicensed, unregulated nurse aides, not adequately supervised by RNs.
  - Author concludes that these deaths and injuries are due to cuts in staff and other resources.
  - Illinois state disciplinary records show an increasing focus of investigations on temporary (agency, traveling) nurses, and most were linked to lack of knowledge or unfamiliarity with patients.
<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
</table>
| 10 Carnegie study | Part of larger national study. Research design was qualitative ethnography utilizing interviews (total of 588 individual interviews), focus groups, review of curricula, and observations in the classroom and clinical facilities in excellent nursing programs. Furthermore 3 national surveys were conducted with members of the American Association of Colleges of Nursing, the National League of Nursing, and the National Student Nurse Association. | Recommendation 9.b. states: We recommend residency training programs lasting at least one year focused on one area of nursing care to be offered in all health care delivery institutions. | 1. Ethnographic qualitative study | 1 year | Conclusions related to this initiative:  
- 3 apprenticeships were studied, including cognitive, clinical judgment and knowledge and ethical comportment. It was found that these apprenticeships must be integrated.  
- Students and faculty alike pointed to need for yearlong residency programs.  
- Nearly no planned interdisciplinary experiences took place in prelicensure programs.  
- Few students reported confidence in detecting subtle clinical changes in their patient’s condition and little follow-through was possible in prelicensure programs.  
- Recommend students continue to care for 1-2 patients in their prelicensure program; researchers think larger patient care assignments will create a gap in the student’s understanding of the nurse-patient relationship due to insufficient time for learning and reflection. |

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Report of the 2006 Practice, Regulation and Education (PRME) Committee, after being charged by the Board of Directors to identify evidence for the rules and regulations at boards of nursing. It was developed following a rigorous systematic review of related nursing education research outcomes and NCSBN research on nursing education.</td>
<td>Identified these education broad areas that are supported by the evidence:</td>
<td>Methodology available in the final report. Utilized the following levels of evidence:</td>
<td>N/A</td>
<td>Systematic review identified:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Assimilation to the role of nursing was identified as a major element, and this includes transition to practice programs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• The systematic review identified feedback and reflection as integral threads in pre- and postlicensure learning.</td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Elements</td>
<td>Measurement</td>
<td>Length</td>
<td>Status/Results</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
<td>--------</td>
<td>---------------</td>
</tr>
<tr>
<td>T2</td>
<td>Fink, R., Krugman, M., Casey, K. &amp; Goode, C. (2008). The graduate nurse experience: Qualitative residency program outcomes. JONA, 38(7/8), 341-348. National</td>
<td>These are qualitative results from the UHC/AACN residency program; data have been generated since 2002, using 37 academic sites with more than 5,000 graduate nurses. The purposes of this study were to analyze the qualitative data from larger study and to determine if the themes they identified could be used convert open-ended questions to quantitative questions. A convenience sample of 1,058 graduates hired between May 2002 and September 2003 and who had fully completed the program were used. Of these respondents, 434 completed the surveys for all three periods. Excellent examples of student “stories” and comments were provided.</td>
<td>See the University HealthSystem Consortium/American Association of Colleges of Nursing report for specifics of the residency.</td>
<td>Residency program is one year long.</td>
<td>* Reported difficulty with skills, particularly as they moved into a more independent role and more complex situations. * 24% were stressed at baseline; 11% were stressed at 6 months; 18% were stressed at 12 months. * 8% reported no role difficulties at baseline, 28% had none at 6 months, and 58% had none at 1 year. * Transition difficulties included role changes, lack of confidence, workload, fears, and orientation issues. * When asked what could be done to help residents feel more supported, 24% at baseline, 34% at 6 months and 43% at 12 months reported they already felt supported. Some areas where they expressed needing more support included feedback, mentorship, manager support, preceptor support, skills practice, discipline, patient care discussion, gradually increased ratios, and introductions to physicians and staff. * The UHC/AACN residency quantitative and qualitative data support that outcome measures dip at 6 months, making this a “critical” period for graduate nurses. * Graduate residents expressed high satisfaction with their chosen career. * Frustration with work environment, including unrealistic ratios, tough schedules, futility of care, and lack of support from ancillary personnel. * Consistent with other studies, new nurses are developmentally unable to exercise intuition about subtle changes in patients.</td>
</tr>
</tbody>
</table>

### Project Description Elements Measurement Length Status/Results

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Hofler, L. D. 2008. Nursing education and transition to the work environment: A synthesis of national reports. Journal of Nursing Education, 47(1), 5-12. National</td>
<td>2-part process to identify reports and to analyze their content. First organizations were identified (using experts), and then each site was used to retrieve and analyze their work. They purposely did not include regulatory agencies and NCSBN because “their mission is to protect the public.” They identified 15 organizations and 35 reports.</td>
<td>Reports identified were between 1995-2005. For inclusion, each report: • Was published by a nursing professional organization. • Included recommendations about nursing education and the transition of nurses to the work environment. • Did not focus primarily on regulatory issues.</td>
<td>The data were reviewed for themes, which were then cross-compared from each report to develop an understanding of the recommendations. Five thematic categories were identified.</td>
<td>N/A</td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Elements</td>
<td>Measurement</td>
<td>Length</td>
<td>Status/Results</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
<td>--------</td>
<td>---------------</td>
</tr>
</tbody>
</table>
| 14      | Joint Commission White Paper (2002), entitled: “Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis” | 23 esteemed healthcare professionals, from nursing and other disciplines, representing education, practice and regulation, developed a white paper that calls for a “standardized, postgraduate nursing residency program,” similar to that from ACGME, with funding to support the training. | Suggested areas of emphasis include:  
  - Team training  
  - Support of nursing orientation  
  - Support of in-service and continuing education  
  - Creation of career ladders  
  - Seek federal support for the transition programs | |  

Reported on the high cost of nurse turnover; assuming a turnover rate of 20 percent, with a hospital employing 100 nurses, it will cost about $5,520,000 to replace them (research shows it costs $46,000 to replace a medical/surgical nurse and $64,000 to replace a critical care nurse).  

Cites evidence from the Illinois state disciplinary records that cite temporary nurses having increasingly more medical error investigations (relates patient safety to retention rates).  

Provides data to support new nurses receiving little orientation/transition.  

Flexner Report of 1910 made medical residencies obligatory, no such requirement exists for nursing.  

Medical residencies are partly paid for by medicare monies and are standardized through ACGME.  

### Project 15: National Post-Baccalaureate Graduate Nurse Residency Program

**Description:**
This was a description of the UHC/AACN residency program with background literature that supports transition to practice. Increased stress in the new graduate, the education-practice gap, and first-year turnover were discussed; they reported literature that estimates the cost of replacement of a nurse as high as $81,000; indirect costs include preceptor exhaustion, decreased morale, time managers spend interviewing.

**Measurement:**
- McCloskey-Mueller Satisfaction Scale
- Gerber Control Over Practice Scale
- Casey-Fink Graduate Nurse Experience Survey
- UHC Demographic Database
- Investigator Developed Residency Evaluation Form

**Status/Results:**
- These were preliminary results (first 6 sites); more up-to-date results were provided in the UHC/AACN section. However, this report found:
  - Transition to practice in not completed for 9-12 months, particularly because of stress, self-perceived competency, setting priorities, and these are related to safety.
  - Cost of residency is less than costs to recruit new nurses.
  - Turnover rate for this early report of the residency program was 8%.
  - Report goal for establishing a national model with sustainability for federal reimbursement.

**Length:**
1 year, phase one 1:1 baccalaureate prepared preceptor; phase two for second 6 months the resident continues with monthly seminars with a resident facilitator. In phase two the residents are encouraged to find a mentor and construct a career plan.
<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Evaluative study of the aggregate of transition programs they fund, through participation is voluntary. 12 of the HRSA-funded sites agreed to take part. Questions: Are there differences between: Hospital vs. home health • Length (less than 6 mos. vs. more than 6 mos.) • Classification of residents (new graduates vs. reentry) • Degree • Magnet status • Unit of employment • HRSA vs. UHC/AACN</td>
<td>N/A</td>
<td>Gerber’s Control Over Nursing Practice Scale • McCloskey/Mueller Satisfaction Scale • Casey-Fink Grad Nurse Experience Survey • These tools were also used in the UHC/AACN study</td>
<td>10 weeks - 3 years</td>
<td>Many of the groups did not have large numbers. They found significant differences between: Program start and finish, which supports these programs. • No differences between hospital and home health residents; this provides some support for including all settings. • No differences between less than 6-month-long programs and over 6-months (except shorter programs felt they were better paid), though numbers were small. • There were differences between new graduates and nurses who change specialties. • No differences between educational groups. • Residents in magnet hospitals were more satisfied. • There were differences across specialties. • There were differences between the HRSA and UHC/AACN residents.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>NCSBN Employer Survey (2004)</td>
<td>Surveys completed by 1,230 employers from all settings.</td>
<td>N/A</td>
<td>N/A</td>
<td>Employers answered &quot;yes definitely&quot; to overall preparation to provide safe, effective care: ADN – 41.9% (n=321) BSN – 41.9% (n=239) Diploma – 48.8% (n=106) LPN – 32.9% (n=237)</td>
</tr>
<tr>
<td>19</td>
<td>NCSBN Interim Results of Post-Entry Study</td>
<td>Longitudinal, qualitative study of new nurses with 1,111 e-mail responses to date. LPN responses not coded yet.</td>
<td>N/A</td>
<td>Email responses with qualitative analysis about how competence develops</td>
<td>Implications for transition to practice: The diversity of practice settings and extreme acuity of hospital settings suggest a site-specific transition program with a preceptor for the first year. The narratives demonstrated a real need for novice nurses to revisit action and decisions and reflect on alternate pathways (i.e., need to debrief and reflect). Need for role clarification relative to LPNs and PCAs. Supervision of LPNs or PCAs was either minimal or totally absent.</td>
</tr>
<tr>
<td>20</td>
<td>NCSBN’s Transition Study (2006)</td>
<td>NCSBN conducted a survey on 628 new nurses and 519 new LPNs related to transition to practice issues. Survey was investigator constructed.</td>
<td>N/A</td>
<td>Survey was investigator constructed</td>
<td>LPNs assigned to care for patients earlier and caseload heavier 38.9% of RNs participated in &quot;ships&quot; + orientation 16.2% of LPNs participated in &quot;ships&quot; + orientation Graduates of ADN programs were more likely than BSN graduates not to have a &quot;ship&quot; Across nation, transition programs were quite variable Research Brief is available online.</td>
</tr>
</tbody>
</table>
### Project Description Elements Measurement Length Status/Results

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
</table>

Project: Transition experiences vary, with those in hospitals more likely to have internship experiences and longer programs.

Aims:
- To describe the transition experience of newly licensed LPNs/VNs
- To identify factors that influence transition to practice of LPNs/VNs
- To examine the impact of the transition experience on clinical competence and safe practice issues of newly licensed LPNs/VNs.

N/A Design: non-experimental, comparative, nurse-preceptor dyad.

Clinical competence defined by 35 questions on core set of functions, with validation by preceptors. Cronbach’s alpha=.93. Content validity and construct validity established. Tool for practice errors contained 21 items.

N/A

Average length of a transition program was 4.7 weeks. Because effect size (mean length of transition programs) was so small, there was not much evidence to be gleaned from those in transition programs vs. those without programs.

### Section II: 2009 NCSBN Annual Meeting Report of Transition to Practice Committee - Attachment I: Transition Evidence Grid

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>NCSBN data presented at a national forum, entitled &quot;Transition of New Nurses to Practice: A Regulatory Perspective,&quot; in Chicago, February 22, 2007.</td>
<td>N/A</td>
<td>NCSBN's Clinical Competency Assessment Scale – 35 items assessing 4 dimensions of clinical competence</td>
<td>N/A</td>
<td>Preceptors and new graduate ratings were similar with competence ratings (no significant differences); conversely, new RNs reported significantly more practice errors than their paired preceptors did.</td>
</tr>
<tr>
<td></td>
<td>National: RNs</td>
<td></td>
<td>NCSBN's Practice Errors Survey – 21 items measuring practice errors. Survey was investigator constructed and validation and reliability established</td>
<td></td>
<td>Areas new nurses acknowledge weaknesses: utilize research; recognize when demands exceed capability; delegating and supervising. Vulnerable period (less competent; more stress) was 3-6 months when new graduates were less supervised.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>During first 3 months, those with a primary preceptor rated themselves as performing at significantly higher levels than those without the primary preceptor.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When more competent in clinical reasoning ability – significantly fewer errors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When more competent in communication and interpersonal relationships – significantly fewer errors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When transition programs (in hospital setting) addressed specialty, significantly fewer errors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Stress was positively related to practice errors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Highest stress levels occurred in 3-6 months of practice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19% who had an internship program reported they were likely to leave their position within 6 months; 33% without an internship program reported they were likely to leave their position within 6 months.</td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Elements</td>
<td>Measurement</td>
<td>Length</td>
<td>Status/Results</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>23</td>
<td>National Survey of Nursing Home Workforce Satisfaction (2006)</td>
<td>N/A</td>
<td>Utilized confidential surveys completed by employees and returned to MyinnerView during 2006. Psychometrics of the instrument were good. To delve more deeply into employee concerns, they identified priority items. Then they calculated a priority rating on how each item ranked, both in terms of its average score and the strength of its correlation with workplace recommendation. These top ratings (see results column) reflect areas where most nursing homes need improvement and where the greatest impact in satisfaction is likely.</td>
<td>N/A</td>
<td>Generally found good satisfaction of nursing home employees. The priority listings were very relevant for our transition work: 1) help with job stress; 2) management listens; 3) management cares; 4) training to deal with difficult residents; and 5) training to deal with difficult family members.</td>
</tr>
<tr>
<td></td>
<td>Collected satisfaction data from 106,858 staff working in 1,933 nursing homes in every state, except Alaska.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### National

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>This was an NCSBN national study new graduate RNs and LPNs with a focus on medication errors. The surveys were sent to stratified random samples of 1000 RNs (65.3% return rate) and 1000 LPNs/VNs (62.3% return rate).</td>
<td>N/A</td>
<td>Investigator designed tool with new nurse self reports.</td>
<td>N/A</td>
<td>+ 40% of the new LPN/VNs graduated were employed in long-term care facilities with 38% hospitals and 17% in community or ambulatory care settings. + 87% of the new RN graduates were employed in hospitals, with 6% in long-term care facilities and 4% in community or ambulatory care settings. + 63% of the new RN graduates were employed in urban/metro areas, while 47% of the new LPN/VN graduates were employed in urban/metro areas. + 49% of the new RN graduates and 41% of the new LPN/VN graduates made errors or were involved in errors. + Of the errors, 73% of the new RN graduates and 71% of the new LPN/VN graduates were involved with medication errors. Forty percent of the new RN graduates and 47% of the new LPN/VN graduates were involved with errors related to patient falls. + Some of the reasons for errors included inadequate staffing (74% of the new LPN/VN graduates and 30% of the new RN graduates), communication (44% of new RN graduates and new LPN graduates), and inadequate orientation (27% of the new LPN/VN graduates and 18% of the new RN graduates). + In hospitals new RN graduates cared for an average of 3 patients in their first assignment, and that occurred on an average of 8 days after being hired. New LPN/VN graduates cared for an average of 4 patients and that occurred on an average of 6 days after being hired. + In nursing homes new RN graduates averaged 25 patients at the start, whereas LPN/VNs cared for an average of 26 patients on their first assignment.</td>
</tr>
</tbody>
</table>
### Project 25
**University HealthSystem Consortium/American Association of Colleges of Nursing (UHC/AACN)**

- **Description:** This is another national, standardized model that is being implemented in 34 states in university healthcare settings in 24 states.
- **Elements:**
  - Core curriculum with focus on leadership, research-based practice, professional development, communication, critical thinking, patient safety, and skills.
  - Clinical guidance with a preceptor.
  - Access to a resident facilitator for role development and guidance.
  - Residents also participate in usual orientation procedures for that institution.
- **Measurement:** They collect data on skill development and support, perceptions of control over practice, job satisfaction, retention, and demographics.
- **Tools include:**
  - Casey-Fink Graduate Nurse Experience Survey
  - Gerber's Control Over Nursing Practice Scale
  - McCloskey Mueller Satisfaction Scale
- **Length:** 12 months
- **Status/Results:** Ongoing


### Project 26
**Versant:**

- **Description:** Implemented in over 30 organizations nationwide, and they have over 5 years of data (over 3,000 residents). Unique in that it supports a cultural change by incorporating committees within the agency to oversee and plan activities, by including preceptors, mentors, and trained facilitators, being based on a business model, and being a national, standardized model.
- **Elements:** Developed using Ohio State University’s DACUM method; includes some specialty curriculum.
- **Measurement:** Some of the tools used include:
  - Professional Subscale from Corwin's Nursing Role Conception Scale
  - Schapsenhufer Professional Nursing Autonomy Scale
  - Skills Competency Self-Confidence Survey (investigator designed)
  - The Slater Nursing Competencies Rating Scale
  - The Organizational Commitment Questionnaire (OCQ)
  - The Anticipated Turnover Scale (ATS)
- **Length:** 18-22 weeks (while the program lasts only 18-22 weeks, from personal communication we found that the preceptorship and/or mentoring often continue)
- **Status/Results:** Ongoing


*www.versant.org*
<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>California Institute for Nursing and Health Care</td>
<td>A collaborative project in California where they are working to redesign nursing education. Their work groups include: Academic/Service Partnerships; Professional and Clinical Role Development; Economical Models for Funding Education; Collaborative Education; Faculty Recruitment and Development; Simulation; New Graduate Transition: Residencies; Out of the Box – Big Bold Steps for Innovation and Evaluation; and Synthesis Advisory Team.</td>
<td>Regarding the transition programs only: Using medical terminology of “attending” nurse who will be with new nurses for 3 years. Developing collaborative partnerships. Goal is to go across all settings. Using the Oregon Model for inspiration, would like a seamless movement from ADN to BSN degrees in nurses. Are exploring long-term funding. Study demonstration models. Compile standards for new graduates based on evidence.</td>
<td>N/A</td>
<td>Recommend 1 year of transition, and 3 years to move to proficiency</td>
</tr>
<tr>
<td>28</td>
<td>Kentucky’s legislation</td>
<td>Legislation for 120 hours of precepted experience within nursing program (directly before graduation) and 120 hours after graduation with the employer, but before fully licensed.</td>
<td>Education and practice are both responsible. Monitored through regulation. Must pass NCLEX within 6 months. Integrated practicum in education and clinical internship following graduation. Across settings and education levels.</td>
<td>NCSBN and a Kentucky University measured outcomes.</td>
<td>120 hours of precepted experiences before and after graduation.</td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Elements</td>
<td>Measurement</td>
<td>Length</td>
<td>Status/Results</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>29</td>
<td>Massachusetts Department of Public Health Board of Registration in Nursing: &quot;A Study to Identify Evidence-Based Strategies for the Prevention of Nursing Errors&quot; - Preliminary Data Report available from NCSBN</td>
<td>Descriptive study of nursing errors found in 78 complaint cases involving 34 RNs and 44 LPNs who practiced in nursing homes in Massachusetts; sampling technique was presented.</td>
<td>N/A</td>
<td>Used a case analysis format with data being collected using a modified Taxonomy of Error, Root Cause Analysis and Practice Responsibility (TERCAP™) audit instrument.</td>
<td>Seven of the 44 LPNs were licensed for 12 months or less; there were no novice RNs in the analysis. Applicable to the Transition to Practice initiative, errors were linked to inexperience to particular clinical events; lack of familiarity with the practice setting, lack of consistently assigned preceptors and the adequacy of the novice nurse’s transition program. Interruptions challenged the novice LPNs who made errors, thus affecting their organizational, prioritizing, communication, delegation, and task completion skills. Study calls attention to the potential patient safety benefit of a novice nurse transition program that provides sufficient time, supervision, and support to new nurses.</td>
</tr>
<tr>
<td>30</td>
<td>Mississippi Office of Nursing Workforce Nurse Residency Program</td>
<td>6-month residency/internship program, which is implemented through the Mississippi Office of Nursing Workforce.</td>
<td>* Coordinator * Weekly meetings/seminars * 2 weeks of a general orientation * Includes NCLEX reviews * Unit orientation (or specialty content) included * Work up to a full patient load * Preceptors will mentor 1-2 residents/interns</td>
<td>Factor Analysis of Tool (Halfer-Graf Job/Work Environment Nursing Satisfaction Survey): * Resourcefulness – 4 items * Mutual respect – 3 items * Empowerment – 4 items * Nonjudgmental work environment – 2 items * Becoming part of a team – 3 items * Lifelong learner – 3 items * Degree of job fit – 2 items</td>
<td>3-6 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Measurement</th>
<th>Study Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>North Carolina's Transition program</td>
<td>NCSBN's Clinical Competency Assessment Scale – 35 items assessing 4 dimensions of clinical competence. NCSBN's Practice Errors Survey – 21 items measuring practice errors. NCSBN's Risk for Practice Breakdown Tool – Error index. Population-specific transition programs for NC.</td>
<td>N/A Data collection taking place now, and study will be completed by summer of 2009. Pre-internship retention was 75%, after program is 93%. 48% of interns were recruited from out of state. Increased satisfaction. Informal survey of long-term settings showed positive response to the transition program.</td>
</tr>
<tr>
<td>32</td>
<td>Vermont Nurse Internship Program (VNIP)</td>
<td>Program components include: managed care, long-term care, infection control, nutrition, quality improvement, pain management.</td>
<td>Minimum 10 weeks, specialty care internships require up to 12 months.</td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Elements</td>
<td>Measurement</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 33 | Wisconsin Nurse Residency Program (WNRP) | Statewide with 40 plus hospitals, including a large rural group, which is a unique aspect of this program. They have enrolled over 300 new graduates in this program. | • Clinical coach  
• Learn to think like a professional  
• Meet once a month  
• Reflection and feedback  
• Focus on  
• Critical thinking  
• Systems  
• Failure to rescue  
• Best practice  
• EBP  
• Delegation  
• Communication | They look at job stress, organizational commitment, clinical decision making, and behavior in the professional role. Tools include:  
• Porter and Steers Organizational Commitment  
• Jenkins’ clinical decision-making  
• Professional Nursing Behavior | 12 months | Just finished 3 year HRSA report and have a grant for another 3 years. Are looking to possibly collaborate with NC SB0N on use of our transition tool. Will focus on preceptors this time. Increase of retention; rural settings found it highly beneficial. |
• Interviews with patients and nurses  
• Practicing skills of dressing changes and ambulation | Videotapes  
• Interviews with patients and nurses | N/A | Had short orientation of 3 weeks | While the nurses became more efficient, they made the same omissions after 14 months:  
• Contaminated wounds  
• Misuse of gloves  
• Failed to wash hands  
• Dangerous tube removal  
• Interviews with patients showed caring over the year  
• Inadequate physical support during ambulation  
• Privacy not maintained  
Conclusion: Limited orientation/transition program did not allow for reflection and/or feedback so that the same errors were made. Results are relevant for regulation and public protection. |

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>Children's Memorial Hospital, Chicago</td>
<td>Designed an internship program to bridge the gap between the academic and service settings. Based on Benner's and Kramer's classic research. Program includes 80 hours of classroom content. Unique aspects include: Web-based delivery of content, professional transitioning that allows for a safe environment for sharing mistakes they made or almost made, opportunities to rotate throughout clinical areas, phased preceptor model; preceptors receive 5% hourly pay differential; code debriefing for support.</td>
<td>Classroom learning, Family, Assessment, Safety, Pain, Abuse, Diversity, Skills labs, Precepted orientation, Professional transitioning sessions, Clinical learning exchanges, Clinical mentors, Code debriefing</td>
<td>1-year program</td>
<td>Recruitment and retention, Recruitment increased by 28%. 7% reduction in nurse vacancy rate, Decrease in turnover from 29.3% to 12.3%, Cost savings of $707,608 per year, Steadily improved nurse satisfaction.</td>
</tr>
<tr>
<td>36</td>
<td>Dartmouth-Hitchcock Transition program</td>
<td>To date, 375 residents have been through this residency program. There is a didactic portion of the program and various tracks of the program. Classes include about 40 hours of didactic content and 40 hours of simulated learning. The uniqueness of this program is the focus on simulation, and especially for low frequency but high risk events.</td>
<td>Preceptor assigned in first week, Ongoing support of preceptors, clinical education, clinical specialist after program ends, Didactic includes: health systems, information management, safety, and clinical/functional. Focus on an improving novice response to “failure to rescue.” Reflection/debriefing focus, Focus on high-risk, low frequency situations, as well as high frequency, commonly occurring clinical events. Didactic concepts include: Systems, Information management, Safety, Functional</td>
<td>12 weeks, though institution provides ongoing support</td>
<td>Weekly self-ratings of confidence, competence, readiness for independent practice, Nurse Residents Readiness for Entry into Practice Competence Questionnaire, adapted from Babenko-Mould’s Self-Efficacy for Professional Nursing Competencies Instrument. Weekly simulator evaluation.</td>
</tr>
</tbody>
</table>

Personal communication: Hospital mortality and cardiac arrests fell after program instituted. However, these data should be cautiously considered because at the same time the organization started an early response team. All three measures of confidence, competence, and readiness to practice increased significantly after the program. Great improvements in IV medications, use of equipment, and response to physiologic emergencies after program (attributed to simulations).
### Project 37

**Description**
Description of ongoing work with the Performance Based Development System (PBDS) used in 500 health care agencies and 46 states.

**Elements**
- Clinical reasoning/critical thinking
- Clinical coaching
- Nontraditional strategies (not spelled out)
- Patient situations that require application, analyzing, and synthesizing

**Measurement**
Analysis of PBDS tools

**Length**
10-12 weeks find positive results

**Status/Results**
- 35% of graduates met employer expectations for clinical judgment
- Examples given where 50% of the new nurses would miss recognizing life-threatening situations

---

### Project 38

**Description**
Purpose of the study was to identify the human performance factors that characterized novice nurse near-miss/adverse-event situations in acute care.

**Experience since completion of a nursing program ranged from 6 months to 12 months.**

**Elements**
- Clinical reasoning/critical thinking
- Clinical coaching
- Nontraditional strategies (not spelled out)
- Patient situations that require application, analyzing, and synthesizing

**Measurement**
8 Retrospective interviews of novice nurses about details of near-miss or adverse-event situations. Interview team consisted of:
- Faculty member with expertise in complexity
- Faculty member with expertise in critical care and the human performance framework
- PhD prepared engineer with expertise in human performance

**Length**
Findings suggest support up to 1 year following graduation

**Status/Results**
- Themes surrounding near-miss/adverse-event cases:
  - Clinically focused critical thinking
  - Seeking assistance from experienced nurses
  - Knowledge of unit and workflow patterns
  - First-time experiences
  - Time constraints
  - Hand-offs
  - Influence of peer pressure and social norms
  - Losing the big picture
  - Novice assisting novice

Of the 12 recruited participants, 7 had at least 1 near-miss event, and 1 provided 2 events. Most, but not all, errors were related to medication administration. Study pointed out the importance of novice nurses being able to reflect about their own patient situations and those of others.
<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>Study conducted in 19 hospitals in Switzerland for a period of 2 working weeks on 23 novice nurses (first 18 months). Stressful events were recorded by the novice nurses, and chronic work characteristics were rated by trained observers, thus providing more validity to this study than those with only self-reports.</td>
<td>Participants were instructed to document every stressful situation they experienced, requiring an open-ended discussion followed by quantitative items. Compliance with safety regulations was measured with one item, and observers rated chronic job stressors and control on the Instrument for Stress Oriented Task Analysis. Observations were complemented by interviews with the employees, supervisors, and colleagues and consulting with organization documents, if necessary.</td>
<td>N/A</td>
<td>• 62 events, or 2.65 events per person, were related to patient safety. • Safety events included: documentation, near misses with medication, incomplete patient briefing, delays in care, patient casualties (falls, etc.). • Stressors, most notably concentration demands and lack of control, related endangered patient safety. • Recommendation: training of novice nurses should address the association between workload and patient safety and should education nurses in self-management strategies for stress.</td>
</tr>
<tr>
<td>40</td>
<td>This is further research from the Children's Memorial Hospital program in Chicago, Illinois. The study compared 84 new graduates that were in the pre-implementation group (hired between September 2001 and August 2002) and 212 in the post-implementation group of the internship program (hired between September 2003 and August 2005). This study was unique in that it compared graduates who had an internship program with those who did not. They reported from the literature a high replacement cost of replacing nurses who leave ($44,000 or their annual salary).</td>
<td>See the Children's Memorial report for specifics on the internship program.</td>
<td></td>
<td>• Job satisfaction was significantly higher when the new graduates had participated in the internship program than when they had not. • Pre-internship turnover was 20% compared to post-internship of 12%. • It took 18 months for satisfaction to increase in some areas.</td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Elements</td>
<td>Measurement</td>
<td>Length</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
<td>--------</td>
</tr>
</tbody>
</table>
| 41      | Exploratory-descriptive case study approach, with qualitative and quantitative data collection and analysis. | Elements (from literature) of opportunities putting graduate nurses at risk for error:  
- Inadequate education  
- Inadequate supervision  
- Workplace bullying  
- Hierarchical structures inhibiting performance  
- Poor planning and scheduling of work  
- Poor skill mix  
- Heavy workload  
- Time pressure | Over a 12-month period and in 5 phases, 6 questionnaires, focus groups, and interviews. The 4 sampling units included: graduate nurses, key stakeholders, patient outcome data, and literature. Data were analyzed using content and thematic analysis strategies. A total of 63 questionnaires were completed. Additionally, 35 focus group and individual interviews were completed with new graduates and key stakeholders. Patient outcome data included: variance analysis of planned care against outcome; number of incident reports, patient complaints, and patient feedback. | N/A | "Deficit education" is not appropriate for teaching new graduates to avoid errors. That is, don't provide education with the idea that there is a knowledge deficit. Instead, the experiential aspects must be stressed.  
None of the graduates, having been introduced to clinical risk management, was directly involved in a preventable adverse event resulting in patient harm.  
New graduates personal characteristics for managing risks include:  
- Being (hyper) vigilant of limitations as a beginner.  
- Asking for assistance without fearing they’d be perceived as “not coping.”  
- Actively seeking supportive supervision.  
- Actively seeking to decrease their workload. |
<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>Exploratory descriptive case study: 2 cohorts of graduate nurses undertaking a 12-month graduate nurse transition program.</td>
<td>N/A</td>
<td>Quantitative and qualitative data collection and analysis strategies were used.</td>
<td>12-month period in 5 phases. 6 survey questionnaires and 35 in-depth individual and focus group interviews.</td>
<td>Sample took part in a 12-month transition program. Clinical risk management was integrated by students within 3-4 months. Novice nurses were able to integrate patient safety with the system during the 12-month program, within 3-4 months. Incident reporting increased from 2.6% at first to 9.8% over the 12 months because at first the novice nurses were reluctant to report incidents, but with support in learning about risk management, they learned to complete incident reports. Key indicators validating that novice nurses developed this integration included familiarity with: Geographical layout of hospital. Hospitals' policies regarding patient risk assessment tools. Processes of evidence-based practice. Incident reporting.</td>
</tr>
<tr>
<td>43</td>
<td>Exploratory-descriptive case study approach, incorporating both qualitative and quantitative analysis. The study was conducted over 12 months.</td>
<td>N/A</td>
<td>Used 6 survey questionnaires to neophyte nurses. Descriptive data was sought on: graduate nurse self reported confidence and competence, particularly with safety, evidence-based practice, managing risk in patients, seeking advice, recognizing limitations, making decisions, reporting incidents, and understanding risk management. Additionally, 35 individual and focus group interviews were conducted.</td>
<td>The period of support was largely dependent on the graduate, though they recommended at least 4 months duration.</td>
<td>Definition of support: A process that aids, encourages, and strengthens and thereby gives courage and confidence to a new graduate nurse or a group of new graduates to practice competently, safely, and effectively in the levels and areas they have been educationally prepared to work. Support themes: Availability. Approachability. Being able to ask questions. Prompted to engage in best practices. Benevolent surveillance. Feedback. Giving reassurance. Backup. Reflection (they call it “debriefing”).</td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Elements</td>
<td>Measurement</td>
<td>Length</td>
<td>Status/Results</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
<td>-------------</td>
<td>-------</td>
<td>---------------</td>
</tr>
<tr>
<td>44</td>
<td>A 3-year academic-hospital partnership was developed to create a mentoring program for nurses to improve the workplace environment. Nurses Supporting Nurses. This program was targeted for new graduates and new hires, though any staff RN was welcome to apply for the mentee role. Ninety-two mentor-mentee teams were formed. The program was particularly focused on changing the culture of the workplace. Two hospitals with quite different organizational characteristics were utilized for the project. The purpose was to identify future bedside leaders who would assume supportive roles, thereby changing the culture of the unit.</td>
<td>• Hospital liaison to champion the project, and this liaison was key to the success. • Interactive workshops on culture mindedness, which included team building. • Creation of detailed Web pages, including videos of mentors. • Sociometric analysis of RN camaraderie and informal leadership. • Educational sessions on nurses supporting nurses. • Cultural competence was presented. • Speed meetings to help select mentors. • Other sessions included team building, conflict resolution, communication, time management, healthcare system, financial concerns, quality care, patient satisfaction, and safety • Quarterly mentor support meetings.</td>
<td>• Overall nurse satisfaction • Decisional involvement • Cultural communication competency • Retention and vacancy • Patient satisfaction with nursing care • 3 nurses sensitive areas, including falls, pressure ulcer prevention, and proper use of restraints</td>
<td>3-year</td>
<td>• Personality and learning styles are not the basis of successful mentor-mentee teams. • Most nurses believed they were culturally competent and that the environment supported cultural sensitivity. • Most nurses wanted more control over their working conditions. • Improvements in patient and nurse satisfaction. • Improvement in nurse vacancy and turnover. • Improvement related to fall and pressure ulcer prevention and on the proper use of restraints. • Using $100,000 per RN replacement charge, the 2 hospitals had a cost savings of $2.5 million.</td>
</tr>
</tbody>
</table>

### Project Description Elements Measurement Length Status/Results

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>Launch into Nursing: a collaboration between the University of Texas M.D. Anderson Cancer Center and The University of Texas Health Science Center at Houston, School of Nursing. Keller, J. L., Meekins, K. and Summers, B. L. (2006). Pearls and pitfalls of a new graduate academic residency program. JONA. 36(12), 586-598. Individual</td>
<td>Describe the design of a collaborative academic residency program for graduate nurses.</td>
<td>Academic leadership course has become cornerstone. Also included simulations, including “Friday Night in the E.R.,” Introduction to workplace resources, which included project, small group discussions, introductions to a variety of roles, etc. Socialization was very important, as it has been cited as linked to retention and safety. Each was matched to a trained “clinical coach.” Describes their curriculum map in detail. Will be helpful with module design. Areas from curriculum map include: Communication, Systems thinking, Safety, EBP, Socialization, QI. Outcomes measured, with various tools: Progress to competent nurse (Benner), Knowledge, Retention, Intent to leave, Job satisfaction, Employee engagement, Competence in clinical leadership, Comprehension of Magnet essentials, Evidence-based practice techniques, Commitment to lifelong learning, Culture of support, Cultural competency, Role as patient advocate, Successful acculturation, Accountability.</td>
<td>12 months</td>
<td>Education, at its best, cannot prepare for acculturation into a work group, using a newly learned language in practice, becoming proficient in a wide range of absolutely necessary skills, and gaining a sense of the wider world of health care. Incorporates reflection and feedback. Turnover at 1 year was 10.8%. Cost was $1,000 per resident. Estimated that cost of replacing 1 nurse was $60,000</td>
</tr>
<tr>
<td>46</td>
<td>Merry, M. D. &amp; Brown, J. P. (2000). From a culture of safety to a culture of excellence: Quality science, human factors, and the future of healthcare quality. Journal of Innovative Management, 7(2), 29-46. Individual</td>
<td>Report of the sigma gap in healthcare, which is the gap between performance and potential performance.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Note: N/A indicates not applicable or not provided.*
<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Elements</th>
<th>Measurement</th>
<th>Length</th>
<th>Status/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>Literature review describing the impending expertise gap in clinical nursing, as a result of the nursing shortage, the aging and retiring workforce, nursing's desirability as a profession, the aging faculty, and the faculty shortage.</td>
<td>N/A</td>
<td>Excellent review of the literature, with citing of evidence and figures to make their point.</td>
<td>Recommended a state-mandated yearlong mentorship or residency program for new graduate nurses.</td>
<td>From literature review concluded that graduates need &quot;several months&quot; (p. 160) to become minimally proficient and to feel confident about decision making.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>When new graduates miss life-threatening events (as cited above from del Bueno research), they can put patients at risk. Cite statistics where once CPR is needed, 27% of adults and 16% of children survive.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>In the late 1980s 4% of nurses were employed outside of nursing, by 2004 that has risen to 16.8%.</td>
</tr>
<tr>
<td>48</td>
<td>Methodist Hospital of Houston and the University of Texas, Houston, Health Science Center: Pine, R. and Tart, K. (2007). Return on investment: Benefits and challenges of a baccalaureate nurse residency program. Nursing Economics. 25(1), 13-18, 39.</td>
<td>See UHC/AACN for elements.</td>
<td>See UHC/AACN.</td>
<td>1-year program</td>
<td>Besides aggregate results as reported by UHC/AACN, for this particular organization:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Turnover The return of investment was $823,680 (benefit) ÷ $93,100 (cost) = 8.847 or ROI (%) of 884.7</td>
</tr>
<tr>
<td>49</td>
<td>Sir Charles Gardiner Hospital Centre for Nursing Education, Australia: Designed to guide the newly graduated registered nurse through the first year of practice. It provides a supportive and structured learning environment, allowing nurses to develop. This program is unique in that nurses must meet their outcomes and then receive a certificate for satisfactory performance.</td>
<td>Specific program and participant outcomes</td>
<td>Professional development journal contains:</td>
<td>12-18 months of practice</td>
<td>No results yet, but will forward them to NCsBN.</td>
</tr>
</tbody>
</table>
|         |             | Specific program and participant outcomes | - Checklists  
- Self-evaluation  
- Preceptor feedback  
- Skills acquisition sheet  
- Self-directed learning package record  
- Specialty achievement record |          | |
|         |             | Specific prerequisites |          |        | |
|         |             | 6 months of surgery and 6 months of medical |          |        | |
|         |             | Study days and graduate seminars |          |        | |
|         |             | Assigned preceptor |          |        | |
